**Sheila Gregory born** Code A **died 2.11.1999**

Pauline Gregory told us that her Nan was a compassionate, kind, cantankerous and extremely independent lady. Pauline spent a lot of time with her Grandparents and was very attached to her Grandmother.

She confirms the fall in August 1999 which causes the fracture of the hip for which she is admitted to Haslar.

She was critical of the care at Haslar on the grounds that her mother was in a chair where her feet did not touch the ground.

She could not walk far and had some pain in her hip.

She was transferred to Gosport and was happy there. She thought the nurses were lovely and she was doing her physio but then her condition starts to deteriorate and if anything there seems to be a communication problem. Nan becomes withdrawn and goes on to the syringe driver but the situation is not explained to Pauline.

It is confusing that on 20th November her Nan seems to be quite alert and bright but by 21st November she seems to have faded completely.

Evidence was then read from **Mr Misra** the orthopaedic surgeon who undertook the operation which he records as quite unremarkable. He says that this was an elderly lady who had a routine right dynamic hip screw operation with no serious complications.

**Dr Reid** in his evidence details the care as he recalls it from his ward round.

On 13th September 1999 he note that she is leaning to the left, poor appetite, confused and poor inhaler technique.

On 27th September she is generally less well then documents a slow decline through to the end of September and in particular on 15th November records that she is less well, chest infection, frailer and bouts of nausea.

He does note the prescription of diamorphine, hyacine and medazalam on 3rd September and feels that was inappropriate on the grounds that Mrs Gregory was not terminally ill. However whilst the drugs were prescribed they were not administered. He did recall the conversation with Dr Barton about proactive prescribing and fully accepted that that was the norm. She commanded great respect from the staff and so far as he was aware there had been no complaints from patients, relatives or nursing staff that he was aware of.

**Jill Hamblyn** statement was read and she does little more than document the death and the fact that on the 20th November 1999 Sheila Gregory is started on diamorphine 20mgs sychlazine 50mgs as a replacement for the oramorph.

**Freda Shaw** is the Staff Nurse working with Sister Hamblyn and she documents the history of Sheila Gregory and that she pronounced life extinct on 22nd November 1999.

Again Dr Barton gave evidence recounting the history and she confirmed that she had written up the diamorphine 20 to 200mgs Hyacine 200 to 800mcgs and medazalam 20 to 80mgs but accepts that in doing so it was not with the intention that they should be administered but rather that they would be available the so called proactive prescribing.

She documents progression of analgesia initially with paracetamol, thioridazine for night sedation but that on 7th October she is complaining of acute pain she has a cocktail of drugs including paracetamol, thioridazine and temazapan.

She then documents the slow decline and on 17th November oramorph is prescribed and administered. Thereafter oramorph is given regularly and there is a query as to whether she suffered a further CVA.

The following day she seems to be developing congestive cardiac failure and the oramorph would have assisted that condition. She started on diamorphine at 20mgs on a syringe driver on 18th November together with 50mgs of cyclizine and when she is seen by Dr Reid her medication is checked by him and he withdraws frusemide and it is almost certain at that stage that Sheila Gregory is dying.

**Professor Black** said that Sheila Gregory was a 91 year old lady with a number of serious chronic diseases. She had a very poor prognosis and whilst he is critical of the weakness in documentation.

He details the transfer on 3rd September and that there has been a neurological event ie: a small stroke. Sheila Gregory seems to make no progress for two months and he is no doubt that she is not going to recover. He confirms the opiates to deal with breathlessness and she effectively dies on 22nd November as a result of her failure to recover from the operation.

He considers the cause of death:
1a Pulmonary Embolus
II Cardiac Failure

Dr Wilcock can not see the justification for the prescription of diamorphine, hyacine and medazalam on the day of transfer but that is an example of the proactive prescribing.

However he said that the opioids were an appropriate treatment for breathlessness.

He has no doubt that by 17th November Mrs Gregory was in heart failure although he is critical that there is no medical view at that point.

He notes Mrs Gregory's decline over a number of weeks and that would be in keeping with a natural decline into the terminal phase.

He is critical again about the lack of assessment.

The use of opioids to relieve breathlessness was in order because whatever her situation her condition was not going to improve and was not susceptible to treatment. His view was that the 20mgs of diamorphine was within the range that he would have expected. In particular Miss Ballard asked him about the rate of decline and it was in keeping with a natural decline.

**Dr Wilcock** gave evidence that Sheila Gregory had a fall and fractured her hip and had a dynamic hip screw fitted on 16th August 1999.

He said that she had been given occasional doses of weak opioid analgesics and she was transferred to Driad Ward on 3rd September 1999. Because of pain in her wrist she was given paracetamol which continues until 23rd October 1999.

Throughout October and November various pains are described and by 19th November 1999 she is breathless, has pain in shoulder and was given frusemide but no additional analgesia. He was concerned that diamorphine was being given for distress, he did not consider that that was appropriate. That is directly at variance with Professor Black.

He confirmed that on 20th November a syringe driver is set up with 20mgs of diamorphine and Mrs Gregory dies the following day. He is concerned that there was no assessment of her condition.

Mr Jenkins pointed out that Professor Black had considered the treatment entirely appropriate after Mrs Gregory had been in hospital for three months and that diamorphine was an appropriate drug for the breathlessness. Dr Wilcock felt there had been insufficient investigation of the breathlessness and he is again concerned about what is being treated.

In response to Miss Ballard Dr Wilcock confirmed that Mrs Gregory's decline was entirely in keeping with a natural decline.