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Form MG11(T)

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3) (a) and 5B; MC Rules 1981, r.70)

REID

LIVE

Statement of: REID, RICHARD IAN

Age if under 18: over 18 (if over 18 insert 'over 18') Occupation: CONSULTANT GERIATRICIAN

This statement (consisting of 27 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything which I know to be false or do not believe to be true.

Signed: R. Ian Reid Date: 24/10/2005

I am Doctor Richard Ian REID MB, ChB. I reside at the address detailed overleaf. I qualified at Glasgow in 1974.

I became a Member of the Royal College of Physicians (United Kingdom) in 1978, a Fellow of the Royal College of Physicians and Surgeons of Glasgow in about 1988 and a Fellow of the Royal College of Physicians (London) in about 1990.

My General Medical Council registered number is 1341171.

Experience

1. House Officer (Medicine) at Royal Alexandra Infirmary, Paisley, Scotland from August 1974 to January 1975.

2. House Officer (Surgery) at Stirling Royal Infirmary, Stirling, Scotland from February 1975 to July 1975.

3. Senior House Officer (Obstetrics and Gynaecology) at Paisley Maternity Hospital, Paisley, Scotland from August 1975 to January 1976.

4. Senior House Officer (Geriatric Medicine) at the Victoria Geriatric Unit, Glasgow from February 1976 to July 1976.

Signature Witnessed by: Code A

5. Senior House Officer (Cardiology) at the Glasgow Royal Infirmary, Scotland from August 1976 to April 1977.

6. Registrar in General Medicine at the Kilmarnock Infirmary, Kilmarnock, Scotland from May 1977 to July 1979.

7. Senior Registrar in Geriatric Medicine at Portsmouth and Southampton Hospitals from August 1979 to July 1982.

8. Consultant in Geriatric Medicine at Southampton General Hospital from August 1982 to March 1998.

My current role which I began in April 1998, is as Consultant in Geriatric Medicine and Medical Director of East Hampshire Primary Care Trust (formally Fareham and Portsmouth Health Care Trust). I am based at the Queen Alexandra Hospital, Cosham.

I have a full time National Health Service contract which consists of 11 (eleven) programmed activities (PAs) per week. One programmed activity is 4 hours. I have an 'On Call' responsibility and work weekends (Saturday and Sunday on roughly one weekend in six basis).

I began the responsibility of looking after 'In Patients' at Gosport War Memorial Hospital in mid-February 1999.

This continued for a period of about 14 months unti about May 2000.

As Consultant to Gosport War Memorial Hospital I had a responsibility for the in patients on Dryad Ward of the hospital.

In this role I supervised the work of Doctor Jane BARTON , a local General Practitioner who, in addition to her work in general practice, worked as 'Clinical Assistant' at Gosport War Memorial Hospital.

In the absence of Dr BARTON I supervised the work of any 'locum' or partners at her general practice who covered her responsibilities for her.

It was also my role to supervise the work of any Specialist Registrar who was attached to me on Dryad Ward at Gosport War Memorial Hospital.

I undertook a weekly ward round of Dryad Ward which I usually conducted on Monday afternoons.

During the ward round I would visit each of the in patients on Dryad Ward.

I was accompanied on my ward round by the Clinical Assistant, Dr Jane BARTON, every two weeks, if she was available to do so.

I also provided consultant cover to Daedalus Ward, the other consultant led ward at the Gosport War Memorial Hospital, when my colleague Dr A LORD was on leave or unavailable. This was a reciprocal arrangement with Dr LORD who would normally cover my leave periods or unavailability. In the event of myself and Dr LORD being unavailable for long periods of time then locum consultant cover would be sought. However for short periods of absence then no locum cover was arranged. If the Clinical Assistant, Dr BARTON, was experiencing a particular problem regarding the management of a patient, then I would expect the Clinical Assistant to contact me to seek advice or to ask me to attend Dryad Ward to carry out an examination of the patient or see relatives who had concerns.

If my advice was sought by the Clinical Assistant then I would expect a note to be made on that patient's clinical notes by the Clinical Assistant. Dr Jane BARTON is a very experienced doctor and as such it would be a serious clinical problem relating to the treatment of a patient that would require her to seek such advice.

If a problem arose requiring a Consultant input during any short term unavailability of both

myself and Dr LORD then I would expect the Clinical Assistant to contact the Elderly Medicine Office at the Queen Alexandra Hospital, Portsmouth, to obtain the required consultant input.

The clinical notes of the patient are where a record is kept of the clinical treatment of a patient.

I would expect a note to be made on the clinical notes on a patient's admission to the hospital, giving a brief history and the results of any examination and treatment.

I would also expect a prescription sheet to be written up detailing any drugs prescribed on admission (see separate statement dated 04/10/2004).

The clinical notes of a patient would then be maintained by the Clinical Assistant or doctor covering that responsibility, myself as Consultant, with entries from other clinical staff when consulted regarding the management of a patient.

A nursing record is also commenced on admission of a patient and this is maintained by the nursing staff. During my ward round of Dryad Ward I would visit each patient, read their clinical notes, examine the prescription sheets and obtain additional information from the nursing staff, provided from the nursing records. This information is usually verbally provided and it would be unusual for me to read the nursing record of a patient.

This information together with information I have obtained myself as a result of any examination I have made of the patient, would form the basis of any note that I made on the patient's clinical notes.

If there were no marked change in the patient's condition, treatment or management then I would not expect any entry to be made on a patient's clinical notes by the Clinical Assistant.

However I would usually make a note on the clinical notes of every patient I saw during my ward round.

Included in my notes on the clinical notes would be any instructions regarding the clinical care of a patient to the Clinical Assistant.

In 1999 I was the Consultant Geriatrician in Elderly Medicine, part of my responsibilities included Dryad Ward at the Gosport War Memorial Hospital.

I have been asked to detail my involvement with the patient Sheila GREGORY , DoB Code A I do not remember this patient or the subsequent treatment that was administered. I have been shown the medical records relating to the patient Sheila GREGORY, exhibit reference BJC/21 . I can confirm that I have written the following entries:

130999 (13/09/1999)
Leaning to L = (Left) whilst standing
Poor appetite
Confused but witty
Poor inhaler technique - try nebuliser
I REID

200999 (20/09/1999)
Managing nebuliser
V poor appetite
Mobilising 1 - 2 steps æ help of two persons
Check routine bloods
I REID

270999 (27/09/1999)
(1) Appetite sl - (slightly) improved
? Mood improving - continue Fluoxetine
(2) Generally less well, no obvious physical signs
(3) Catheterised
(4) Occ (occasional) faecal incontinence

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I REID

041099 (04/10/1999)
Much better motivated
Needs help of one person (occ 2) for most activities
Occ agitation needing Thioridizine (tranquilliser)
Still occ faecal incontinence
Still needs encouragement to eat and drink
I REID

On page 69 of the medical records I have written the following entries:

111099 (11/10/1999)
Still v. dependent
Delightfully (USU) = (usually) *confused!*
Needs nursing home placement
I REID

181099 (18/10/1999)
IC (= incontinent) *unformed faeces withhold Lactulose pro.tem*
Refer for nursing home care
I REID

251099 (25/10/1999)
Can walk æ frame with persuasion ++
Needs 1-2 to transfer, dress, etc.
Catheterised
Only occ faecal incontinence
I REID

011199 (01/11/1999)
Episode of vomiting today - seems well now

Signed: R. Ian Reid

Signature Witnessed by: Code A

Still soft, mushy stools - ↓ (= reduce)

Mg (oh) 2 10mls b.d (Magnesium hydroxide) *Laxative*

I. REID

151199 (15/11/1999)

Less well

- chest infection

- frailer

- occ bouts of nausea

O/E (= on examination) *Apyrexial*

P (= pulse) - *84/min Reg - HS - loud*

V.S → axilla

°OED (= Oedema)

Continued present R (treatment)

Except Thioridizine to P.R.N.

I. REID

On page 70 of the medical records I have written the following entry:

'*Further decline*

Comfortable

Opening eyes to speech - short verbal response

P - (= pulse) uncontrolled AF

RESP rate - 24/min

- chest clear at present

Stop Frusemide (Diuretic)

Continue Diamorphine

I. REID

Ward rounds at Dryad Ward consisted of myself together with the senior nurse in charge of the ward. This was normally the ward sister or in her absence a staff nurse. I was sometimes

accompanied by a specialist registrar. At this time it was Dr RAVINDRANE (the post of specialist registrar was a training post in elderly medicine).

On alternate weeks Dr BARTON would normally be present on the ward round. My ward rounds would be conducted on Monday afternoons. These would take between two and half to three hours to complete.

A ward round was conducted by seeing every patient on the ward. On average each patient would take eight to nine minutes to see. I would ask the nursing staff and Dr BARTON, if she was present, if there were any problems. If there were, where appropriate, I would examine the patient. I would then make decisions about the patient's management.

It was also usually my practice to view the prescription sheet and make any appropriate changes. It was normal practice to write my own entries in the notes, even when accompanied by other medical staff.

The reason that Dr BARTON only attended every fortnight was because my colleague, Dr Althea LORD, also conducted a ward round on a Monday afternoon on the Daedalus Ward in the Gosport War Memorial Hospital and was accompanied by Dr BARTON. To clarify this Dr BARTON accompanied me on ward rounds on alternate weeks.

It was my understanding that, other than when Dr BARTON was on holiday, she visited Dryad and Daedalus Ward daily in her capacity as Clinical Assistant. This was every morning Monday to Friday at 0730 hrs to review any patients identified by the nursing staff as having a medical problem. I also understand that she visited most, if not every, afternoon to check in new patients and review any other medical problems which may have arisen. I also understand that she would come in, in her own time to speak to relatives.

To clarify the entries that I have written in the medical notes commencing on page 67 of exhibit BJC/21 where I have written *Leaning to left whilst standing*, firstly I would have normally reviewed the previous entries in the medical notes. I note that on the 06/09/1999 that Dr

RAVINDRANE has recorded that the patient had a left sided facial droop. He has also recorded the results of a neurological examination which appeared to be otherwise normal.

In view of this I may have been looking for other neurological signs and have subsequently recorded that in my entries.

At this stage I would have been probably considering whether the patient might have had a very mild stroke.

Poor appetite - this is self explanatory.

Confused by witty - this probably means that Mrs GREGORY was not fully orientated in time and place and was providing amusing answers to my questions.

Poor inhaler technique - try nebuliser - this almost certainly reflects the fact that the nursing staff had told me that Mrs GREGORY found it difficult to co-ordinate the use of an inhaler and I suggested the use of a nebuliser. (This does not require manual dexterity).

290999 (29/09/1999) Managing nebuliser - this refers to the fact that the nursing staff had reported that using a nebuliser was successful.

V poor appetite - again this would have been reported by the nursing staff to me. Poor appetite can be due to physical or mental causes.

I would have noted from the prescription sheet (page 165/BJC/21) that the patient had been prescribed on the 07/09/99 Fluoxetine, 20 milligrams, once daily with the first dose being given from the 08/09/99.

Fluoxetine is an anti depressant (this drug is manufactured by a number of pharmaceutical companies, one of whom markets this drug under the name Prozac).

Variable confusion - this would have been reported to me by the nursing staff, but it may also have been my own observation.

Mobilising 1 - 2 steps æ help two persons - this may have been reported to me by the nursing staff but it was usually my practice to assess patients' walking for myself.

Check routine bloods - I have asked for this to be done because of the poor history of appetite and variable confusion. This was in order to exclude a physical cause for these symptoms. It is likely that these tests would have been done the following day and the results would have been available on the ward in the next two to three days. I would not see them until the following week.

Dr BARTON would see the results of the blood tests whenever they arrived on the ward, whether they were normal or abnormal. She would take whatever action was necessary.

270999 (27/09/1999)

(1) Appetite SL = slightly improved - this entry is self explanatory.

? mood improving - continue Fluoxetine - this would have been reported by the nursing staff and my question mark about whether the patient's mood was improving could have reflected both the views of the nursing staff and my own observations.

As anti depressants can take some weeks to be effective and as Mrs GREGORY had been on anti depressants for just under three weeks, I felt it would be important to continue the prescription of Fluoxetine.

(2) Generally less well - no obvious physical signs - this could have reflected both the observations of the nursing staff and my own observations.

It is likely that this also reflected the fact that physical examination had failed to reveal any abnormalities.

It is also likely that these observations included measurement of temperature, pulse, blood pressure and respiratory rate.

(3) Catheterised - this indicates the presence of a drainage tube in the bladder.

(4) Occ faecal incontinence - this means occasional loss of control of bowels and this would have almost certainly been reported to me by the nursing staff.

041099 (04/10/1999)

Much better motivated - this statement reflects the fact that poor motivation can be a symptom of depression and implies that the improved motivation could well be due to the prescription of Fluoxetine.

Needs help of one person (occ 2) for most activities - This is self explanatory in that the patient's acts of daily living - washing, dressing and toileting required the help of one, or occasionally two, persons.

Occ agitation needing Thioridizine - this agitation would have been reported to me by the nursing staff. I would have also observed from the prescription sheet that Mrs GREGORY has been prescribed Thioridizine which is a tranquilliser. The does was 10 milligrams which was to be administered on a PRN (= as required) basis.

This is the lowest dose which is normally prescribed and was appropriate. This drug was first administered on 01/10/1999.

Still occ faecal incontinence - this again would have been reported to me by the nursing staff. This is not an uncommon problem in elderly patients who are confused.

Still needs encouragement to eat and drink - this would have been reported to me by the nursing staff.

111099 (11/10/1999) Still very dependent - this would have been reported to me by the nursing

staff.

Delightfully (usually) confused - this statement would have been made as a result of my own observations as well as those of the nursing staff.

Needs nursing home placement - this statement reflects my view that further attempts to rehabilitate Mrs GREGORY to a level where she would be able to manage again at home were not going to be successful and that because of her level of dependency she would need care in a nursing home rather than a residential home. At this stage I felt that Mrs GREGORY should be considered for a nursing home for continuing care.

181099 (18/10/1999) I/C (= incontinent) unformed faeces withhold Lactulose protein - this would have been reported to me by the nursing staff and it means that Mrs GREGORY was losing control of her bowels and that her bowel motions were of a soft porridge-like consistency. This can be caused by Lactulose and hence my instruction to withhold it for the time being.

The prescription and administration of Lactulose would have been appropriate until this stage, if her bowel motions had been formed until this time.

Refer for nursing home care - Mrs GREGORY was on the Dryad Ward for rehabilitation. It reflects that I no longer felt that rehabilitation to her home address would be successful and that a move should now take place to transfer Mrs GREGORY to a nursing home.

This would normally be done by discussing with the family and by making a referral to Social Services. Nursing staff would normally make a referral to Social Services for assessment and placement in a nursing home.

251099(25/10/1999) Can walk with frame with persuasion ++ - this means Mrs GREGORY was physically able to walk with the aid of a walking frame but that she was extremely reluctant to do so (++= very reluctant).

Needs one to two to transfer, dress etc - this would have been reported to me by the nursing staff and confirms that there had been no improvement in these activities. The referral for nursing home care continued to be appropriate.

Catherised - this is self explanatory.

Only occ faecal incontinence - this is self explanatory. This would again confirm that nursing home rather than residential home care would be appropriate.

011199 (01/11/1999) Episode of vomiting today - seems well now - this would have been reported to me by the nursing staff, and is self explanatory.

Still soft mushy stools - ↓ Mg (OH) 2 10 mls bd - this would have been reported by the nursing staff and because of this I had taken the decision to reduce the dose of Magnesium hydroxide which is a laxative. It had been initially prescribed at 20 mls bd which is twice daily. It was reduced because of the soft stools.

From examining the prescription sheet it does not appear that Mrs GREGORY ever received any magnesium hydroxide. This is probably because it is normal practice to allow nursing staff to use their discretion in respect of the administration of laxatives and anti diarrhoeal drugs according to how the patient's bowels are reacting.

On page 136 of the medical notes Loperamide has been prescribed, this is a drug used to control loose stools and diarrhoea. It was written up on 18/10/1999 first administered on 29/10/1999 @ 1150 hours; it was also administered on the 01/11/1999 @ 0715 hours.

151199 (15/11/1999) Less well, chest infection, frailer, occ bouts of nausea - this would have been reported to me by the nursing staff and may have also been as a result of my own observations.

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O/E (= on examination) *Apyrexial, P-84/min reg HS - loud VS →axilla - neck.*

°OED (= no oedema), *chest clear, legs* √√ - this reflects the results of my examination which revealed that Mrs GREGORY's pulse was 84 beats per minute and regular. This is a normal pulse rate. It also indicates that I have listened to her heart and that this revealed a loud systolic murmur which radiated to both the axilla and to the neck. To clarify this entry, a murmur is a sound which is due to turbulent flow of blood through a valve in the heart. The term "systolic" refers to its timing in relation to each cycle of contraction of the heart muscle. In Mrs GREGORY's case I thought it possible that the cause of this condition was either narrowing of the aortic valve or a leaking mitral valve or a combination of both.

This murmur had previously been noted. Her records show that she had this murmur from at least 1995.

°OED - no oedema means that there was no swelling of Mrs GREGORY's legs.

Chest clear - means that on listening to Mrs GREGORY's chest and lungs I was unable to detect any abnormality.

These findings in total mean that Mrs GREGORY did not have any new problem with her heart or lungs and there was no evidence of heart failure or a chest infection.

Legs √√ - this refers to the fact there was no swelling of her legs or evidence of thrombosis.

Continue present R (= continue present treatment), except change Thioridazine to PRN - this means that I felt that there was no need to change any of Mrs GREGORY's treatment other than reducing the regular dose of tranquilliser to receiving it only on 'as required' basis.

Mrs GREGORY was prescribed Thioridazine 10 milligrams twice daily on a regular basis commencing 07/10/1999.

Further decline - this statement is likely to have been made in relation to report from the nursing staff and from Dr BARTON's notes on the 18/11/1999. I have noted that Dr BARTON has recorded

further deterioration in general conditions
start oral opiates in a small dose
please make comfortable
I will speak to granddaughter
I am happy for nursing staff to confirm death
? further CVA?

This suggests to me that on 18/11/1999 Dr BARTON felt that Mrs GREGORY was terminally ill that she might have sustained a further stroke - Cerebro vascular accident (CVA) and that the overriding priority was to keep Mrs GREGORY comfortable.

Where I have shown *further decline* this probably means that Mrs GREGORY had deteriorated more since being seen by Dr BARTON on 18/11/1999.

Comfortable - this means that Mrs GREGORY appeared to me to be peaceful and not in any pain or distress.

Opening eyes to speech - short verbal response - this reflects my attempt to access Mrs GREGORY's conscious level.

P (= pulse) *uncontrolled AF,* (= atrial fibrillation) - this means a rapid irregular rhythm of the heart. It would appear from her records that Mrs GREGORY has intermittently had this problem in the past. This condition can cause patients to become unwell but it can also develop when patients become unwell from another cause.

Resp rate - 24/per min.

Chest clear at present - this means that when I examined Mrs GREGORY her breathing rate was 24 breaths per minute. This is higher than normal and could be an early sign of a chest infection or pneumonia developing. However on listening to Mrs GREGORY's chest there was nothing abnormal to be found at that time.

Stop Frusemide - Frusemide is a diuretic which are drugs used in the treatment of heart failure when fluid starts to accumulate in the body (normally in the legs or lungs or both).

However as I have recorded that Mrs GREGORY was only opening her eyes to speech it is highly likely that at this time Mrs GREGORY would have ceased to eat and drink.

Continuing Frusemide would have meant that she was at increased risk of dehydration, hence my decision to stop the Frusemide.

Continue Diamorphine - I have written this instruction because Mrs GREGORY appeared to be very comfortable on the present dose of Diamorphine without being over sedated.

Overall although I cannot remember Mrs GREGORY I feel that it is likely that at this stage I felt that she was dying.

I have been asked to comment on why there is a break in the medical records commencing from page 67 (BJC/21) of seven day intervals.

The reason there is a break of seven days in the medical records is that consultant ward rounds are conducted on a weekly basis. The previous entry on the 06/09/1999 which was conducted by Dr RAVINDRANE (at that time in September 1999 Dr RAVINDRANE was the senior registrar in elderly medicine and he usually accompanied me on my weekly ward rounds).

The fact that the entry for 06/09/1999 was written by Dr RAVINDRANE was probably due to the fact that I was on holiday.

Ward rounds would normally consist of Dr RAVINDRANE and myself together with the senior nurse in charge that day and on alternate weeks, Dr BARTON.

A ward round consisted of seeing each patient and making an assessment of the patient. A record of the assessment is then made in the notes. The reason for recording this informed assessment is to ensure continuity of care. It is my normal practice to record any change in medication. Any change in medication that I indicated could be written up by Dr BARTON, Dr RAVINDRANE or myself.

The prescription sheets have six sections with the following purposes:

Page 1 is a cover page with general information.
Page 2 is for once only and as required drugs (PRN).
Page 3 is for regular drugs.
Page 4 is for regular drugs.
Page 5 is for daily review prescriptions.
Page 6 is titled "For Nursing Use Only - Exceptions to Prescribed Orders".

To clarify the prescription sheets as laid out within the medical records of exhibit BJC/21 the following may assist for the date 03/09/1999:

Page 153 of the medical records = Page 1 of the prescription sheet.
Page 154 of the medical records = Page 2 of the prescription sheet.
Pages 155, 157, 159 of the medical records = Page 3 of the prescription sheet.
Pages 161, 163, 165 of the medical records = Page 4 of the prescription sheet.
Page 166 of the medical records = Page 5 of the prescription sheet.
Page 160 of the medical records = Page 6 of the prescription sheet.

In relation to the prescription sheets for the 07/10/1999.

Page 135 of the medical records = Page 1 of the prescription sheet.

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Page 136 of the medical records = Page 2 of the prescription sheet.
Page 137, 139, 141 and 143 of the medical records = Page 3 of the prescription sheet.
Page 145, 147, 149 and 151 of the medical records = Page 4 of the prescription sheet.
Page 152 of the medical records = Page 5 of the prescription sheet.
Page 144 of the medical records = Page 6 of the prescription sheet.

In relation to the prescription sheets dated 18/11/1999.

Page 183 of the medical records = Page 1 of the prescription sheet.
Page 184 of the medical records = Page 2 of the prescription sheet.
Page 186 of the medical records = Page 3 of the prescription sheet.
Page 188 of the medical records = Page 4 of the prescription sheet.
Page 187 of the medical records = Page 5 of the prescription sheet.
Page 185 of the medical records = Page 6 of the prescription sheet.

I have read the entry written by Dr BARTON on 03/09/1999 on page 66 of the medical record which relates to the admission of Mrs GREGORY when she was transferred to Dryad Ward from Haslar Hospital. The entry gives a brief summary of Mrs GREGORY's medical problems and functional status.

I have been asked to comment about the last line of the entry which reads as follows:

I am happy for nursing staff to confirm death.

It would only be normal practice to make such a statement if it was felt that the patient was close to death.

It would appear to be at variance to previous entries which refer to *gentle rehab ? nursing home.* If Dr BARTON felt at this stage that this lady was medically stable, had rehabilitation potential, this was an inappropriate statement to make. I cannot recollect whether I noted this statement or whether I discussed this statement with Dr BARTON.

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On 13/09/1999 which is when I conducted my ward round from referring to my entry in the notes, I feel that it was unlikely that death was imminent. However I note that Mrs GREGORY was 90 years old and the fact that Dr BARTON had suggested *gentle rehabilitation* would suggest to me that Dr BARTON felt that this very elderly lady was physically frail.

I have been asked to comment on the drugs prescription chart which were written on 03/09/1999, page 159 of exhibit BJC/21 refers. This prescription sheet is divided into drugs which are to be regularly administered and those to be given as required (PRN). It would be my normal practice to review all the drugs which are being prescribed regularly and to note the frequency of the administration of the "as required drugs". The following drugs have been prescribed, to be given on a regular basis, by Dr BARTON on the 03/09/1999:

Thyroxine 100 mcgs once daily - Thyroxine is used in the treatment of an under active thyroid gland. This is highly likely to be an appropriate dose and this was confirmed by a blood test taken on 21/09/1999 which showed that the levels of thyroid hormone in the blood stream was adequate.

Ferrous sulphate in a dose of 200 mgs, three times daily - This is an iron supplement used in the treatment of iron deficiency anaemia. This is an appropriate dose. This drug continued to be administered until 29/09/1999, after which it was stopped.

I note that a blood test taken on 21/09/1999 showed that Mrs GREGORY was no longer anaemic and it is likely that when this information became available, Dr BARTON stopped its prescription.

Lactulose 15 mls twice daily - this is a laxative and this is an appropriate dose. This was commenced on 03/09/1999. She received this regularly until 14/10/1999. Between 15 - 18th October some doses were withheld. Between 19th - 23rd October no Lactulose was administered. Further doses were given on 24th and 25th of October, after which the prescription was crossed off. This is normal practice if a drug is no longer required.

Senna tablets, two to be taken night - Senna is a laxative used for the treatment of constipation, this was commenced on 03/09/1999. Mrs GREGORY received the Senna tablets fairly regularly until 14/10/1999 after which it appears she was not given anymore. (Lactulose softens the stools. Senna assists bowel mobility).

Atrovent inhaler, two puffs, 4 times daily - Atrovent is used in the treatment of asthma and wheeziness. It is likely that Mrs GREGORY had been taking this for some time as it was prescribed on admission. This dose is entirely appropriate.

Becloforte inhaler, 1 puff, twice daily - this is a steroid and is used to prevent attack of asthma and wheeziness. The dose is entirely appropriate and it is likely Mrs GREGORY had been on this drug for some time.

On pages 161, 163 and 165 of the medical records the following drugs were prescribed on 06/09/1999:

Paracetamol elixir 500? 1 gm QDS (= 4 x daily). This commenced on the 06/09/1999 and was administered daily until 07/10/1999 when the prescription was re-written as recorded on page 143.

Aspirin 75 mg 1 daily. This was prescribed by Dr RAVINDRANE on 06/09/1999 and administered from 07/09/1999 until 06/10/1999 when the prescription chart was re-written.

Fluoxetine 20 mg 1 daily. This was prescribed by Dr BARTON 07/09/1999 and administered from 08/09/1999 until 06/10/1999 when it was re-written as recorded on page 143 of the medical records.

Daktacort cr (= cream). To be administered twice daily to skin. This was prescribed by Dr BARTON on 13/09/1999 and was administered until 17/09/1999. This cream is used in the treatment of dermatitis, eczema and itching.

Ipratropium nebuliser (normal). (This is the same as Atrovent). This was prescribed by me in a dose of 200 mcg by inhaler form twice daily commencing on 13/09/1999 and this continued to be administered fairly regularly until 06/10/1999.

Budesonide nebuliser 250 mcgs by inhalation twice daily. This was prescribed by me. I presume this was prescribed on 13/09/1999 and was administered from 14/09/1999 until 04/10/1999. This drug is designed to prevent attacks of wheeziness and asthma.

On page 154 of the medical records on 03/09/1999 the following drugs were prescribed on as required basis (PRN):

Co-dydramol 2 tablets up to 4 times daily - this is a simple pain killer and given that Mrs GREGORY had recently had a fractured hip repaired and as it was planned to rehabilitate Mrs GREGORY, I feel that it was appropriate to prescribe this in case she suffered from pain on attempting to mobilise. This is an appropriate dose.

Prochlorperazine 5 mgs, 3 times daily - this is an anti nausea drug which was probably prescribed as co-drydamol can sometimes cause nausea and vomiting. I feel that it was reasonable to prescribe this drug. The dose prescribed was appropriate.

Oramorph 10 mgs in 5 mls - this is an opiate drug which is a strong painkiller. The dose prescribed was 2.5 - 5 mls to be taken up to four hourly. This is administered orally. 2.5 - 5 mls means that the dose prescribed was 5 - 10 mgs. This is an appropriate dose for a patient in severe pain or distress. There is no record that Mrs GREGORY was in any pain or distress and I feel that this prescription was inappropriate at this stage on Mrs GREGORY's admission in the absence of any documented pain.

Zopiclone 3-75 mls, mgs 1 at night - this is a sleeping tablet, I feel that its prescription and dosage on an as required basis was entirely appropriate.

On page 166 of the medical records there is the daily review prescription sheet. This section of the prescription sheet is infrequently used and was on the reverse of the prescription sheet used at that time. The circumstances in which this section is used is when a prescribed drug needs daily review, usually to titrate the dose of drug according to a patient's condition or the results of investigations. The following drugs have been prescribed on 03/09/1999:

Diamorphine 20-200 milligrams to be given subcutaneously over 24 hrs on an as required basis - Diamorphine is an opiate (a strong painkiller). The prescription was that this drug would be administered by a syringe driver .

Hyoscine 200-800 micrograms to be given subcutaneously over 24 hrs via a syringe driver - this drug is used to dry up oral secretions.

Midazolam 20-80 mgs to be administrated subcutaneously via syringe driver over 24 hrs - this drug is a sedative and is used to relieve distress.

I feel it was inappropriate to prescribe these drugs at this stage in the absence of any documented pain or distress and in the absence of any documentation that Mrs GREGORY was terminal ill.

This is not normal practice both in respect of the prescription of these drugs at this stage and the dosage ranges.

It is my usual practice to review every patient's drug chart on a ward round. However because this section is on the reverse and is infrequently used, I do not remember noticing the prescription of these drugs. I did not have a conversation with Dr BARTON about this particular prescription.

I do remember having one conversation with Dr BARTON about a variable dose prescription of Diamorphine in relation to one particular patient whom I cannot identify nor when this took place. I believe Sister HAMBLIN was present. As I remember this was prescribed for a

patient who was in pain and its prescription was, I felt, appropriate. My concern was about the range of dosage. I got the impression Dr BARTON was not happy about being challenged about her practice.

Dr BARTON told me that the reasons she did this. Firstly she was a full time GP and Chair of the Gosport Primary Care Group . She was not always immediately available and therefore was concerned that if a patient should develop severe pain or distress, nursing staff would be able to administer appropriate medication to the patient in a timely way as there could be a delay of some hours before she could attend to the patient.

Dr BARTON also told me that she was assisted in covering the wards when she was not available eg, when on holiday, by the other partners in her general practice. She told me that some of her partners were reluctant to attend the hospital when called by the nursing staff and that again the prescription of these drugs allowed the nursing staff to relieve pain and suffering without delay.

As far as I can recollect Sister Gill HAMBLIN was present when I had this discussion with Dr BARTON. Gill HAMBLIN confirmed that some of Dr BARTON's partners from the practice were reluctant to attend. I also remember hearing informally from other members of staff that some of Dr BARTON's partners were reluctant to attend the hospital. I do not remember specific names being mentioned.

I had been working in the Gosport War Memorial Hospital Dryad Ward for just a few months. Previously I had worked at Moorgreen Hospital in Southampton where we had a full time clinical assistant present Monday to Friday 9.00am (0900) to 5.00pm (1700) and therefore it was easy to respond to changes in patient's conditions. I had not worked before in a hospital where the day to day cover was provided by a full time GP working as a part time clinical assistant.

Although I was unhappy with this I accepted her explanation having been made aware of the difficulties she was experiencing in her General Practice. I trusted Dr BARTON because she

was an experienced GP, she was highly regarded locally and she was trusted and respected by the nursing staff. She always responded to their needs for help and support.

Also I believe Dr BARTON had been working in the Gosport War Memorial Hospital for eleven years prior to 1999. I had been working there at that time for six months.

I know that all of my colleagues who had worked there, before me, with Dr BARTON in the GWMH had great respect for her. There had been no complaints from the patients, relatives or the nursing staff that I am aware of in the eleven years that she had been working there. In view of this, I would not expect to offer the same level of supervision to Dr BARTON as I would to a trainee doctor.

I also trusted the nursing staff in using their discretion appropriately, in relation to the use of opiates and I do not recollect anything other than the minimum dose initially being administered to patients.

As far as I can ascertain these drugs mentioned so far were all prescribed to Sheila GREGORY on admission/day of transfer on 03/09/1999. I would add that I may not have noticed the Oramorph prescribed on the 03/09/1999 recorded on page 165 of the medical notes (BJC/21). I see from the prescription chart that none had been administered by the 13/09/1999 which is the first time that I saw this patient.

On page 143 of the medical notes, which is the prescription sheet, the following drugs were prescribed:

The first regular drugs prescribed commenced 07/10/1999.

Thyroxine 100 mcgs 1 daily was prescribed by Dr BARTON. This prescription continued until at least 15/11/1999. This is a continuation of the Regular drugs prescribed on 03/09/1999 (page 159 of the medical notes refer).

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Lactulose 15 mls bd. This is a continuation of drugs prescribed on 03/09/1999 (page 159 of the medical records refer).

Senna Tabs 2 once daily. This is a laxative. This is a continuation of the prescription sheet of the 03/09/1999 as recorded on page 159 of the medical records.

Fluoxetine elixir 20 mgs in 5 mls. This was prescribed on 07/10/1999. It is an anti depressant and was administered once daily as per prescription from 07/10/1999 until 17/11/1999. This is an appropriate dose.

Dispersible aspirin 75 mgs 1 daily. This is frequently used for the prevention of stroke and/or heart attacks. This continued to be prescribed until 03/11/1999. Dispersible aspirin is used because it thins the blood. This was originally prescribed by Dr RAVINDRANE on 06/09/1999. Dr BARTON has continued this prescription quite appropriately.

Paracetamol elixir 250 mgs per 5 mls, 1 Gm QDS (= 4 x a day). To the side of this entry is written PRN. It appears that it was administered regularly until 21/10/1999 after which it was only occasionally administered. This is an entirely appropriate dosage. Paracetamol is a mild painkiller.

On page 151 of the medical notes the following drugs have been prescribed by Dr BARTON:

Thioridazine 10 mg twice daily. This was prescribed by Dr BARTON and commenced on the 07/10/1999. This was administered until the 31/10/1999. In relation to this entry I cannot explain why there is a line crossing out the 1800 entries from 23/10/1999 until 31/10/1999.

Thioridazine continued to be administered in mornings only at 1000 until at least 03/11/1999. Thioridazine is a tranquilliser and is used in the management of patients who are distressed or agitated. This is an appropriate dose which reflects my note of 04/10/1999 as recorded on page 68 of the medical records. The drug was changed on the 07/10/1999 from PRN (as required) to twice daily. This is likely to reflect the fact that the patient was becoming increasingly agitated.

This prescription has been crossed out after 14/11/1999, I am unable to state the reason why. I note that I requested this prescription to be stopped on 15/11/1999 during my ward round.

Temazepam 10 mg 1 at night. This is a sleeping tablet. This is an appropriate dose. The presumption would be that Mrs GREGORY was having difficulty sleeping. It was first prescribed 07/10/1999 and was continued until at least 15/11/1999.

Magnesium hydroxide 20 mls bd (= twice daily) was prescribed on 27/10/1999 and administered until 01/11/1999 when the prescription was crossed out and the dose reduced to 10 mls twice daily. It is a laxative used in the treatment of constipation. This amended prescription was continued until at least 15/11/1999.

Cefaclor 250 mg per 5 mls, 5 mls 3 x daily for 5 days. This is an anti-biotic and it was prescribed on 01/11/1999 and continued until 06/11/1999. It is commonly used in the treatment of urinary tract infections and chest infections. There is no entry as to why this prescription was made. This dose of Cefaclor is an appropriate dose and it is good practice to prescribe anti-biotics for a limited time eg 5 days.

On the same prescription sheet following from page 151 of the medical records recorded on page 136 of the medical records the following "as required" prescriptions have been entered:

Gaviscon liquid 10 mls PRN. This was prescribed by Dr BARTON on 08/10/1999. Gaviscon is used in the treatment of wind and indigestion and was administered once only on the 23/10/1999.

Oramorph 10 mg, 2.5 mls. This was prescribed in a dose of 2.5 - 5 mls four hourly by Dr BARTON on 08/10/1999 and 5 mg (2.5 mls) administered once at 2020 on 17/11/1999. This is a small and appropriate dose for a patient in pain or distress; however there is no record in the medical notes. Therefore I cannot say whether this was appropriate. It is not normal practice to prescribe Oramorph in the absence of documented pain or distress.

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Metoclopramide 10 mg, oral or intra-muscular. This was prescribed by Dr BARTON on 11/10/1999. This was recorded as a verbal order given by Dr BARTON. This was administered once only at 1615 on 01/11/1999. The entry written on the medical notes on page 69 by me indicates that Mrs GREGORY had an episode of vomiting that day. This is an appropriate dose.

Loperamide 2 mgs 2 tablets QDS (= 4 times daily). Loperamide is an anti diarrhoeal tablet and was prescribed on 18/10/1999, and was administered on two occasions. On the 20/10/1999 @ 1150 and then on 01/11/1999 @ 0715. This is an appropriate dose for a patient with diarrhoea.

The following drugs have been prescribed in the daily review prescription sheet on page 152 of the medical records (P5): I note at the top of the page "regular" has been crossed off and PRN has been written in its place. I do not know who crossed this out.

Diamorphine 20-80 mg S/C in 24 hours. This was prescribed by Dr BARTON on 11/11/1999.

Hyoscine 200-800 mcgs S/C in 24 hours. This was prescribed by Dr BARTON on 11/11/1999.

Midazolam 20-80 mg S/C in 24 hours. This was prescribed by Dr BARTON on 11/11/1999.

Cyclazine 50-100 ? or 200 mg S/C in 24 hours. This was prescribed by Dr BARTON on 11/11/1999.

This is not an appropriate prescription in the absence of any note in the medical records demonstrating an indication for the prescription of these drugs.

There is no record that Dr BARTON conducted a ward round or made a record in the clinical records.

On page 186 of the medical records on the 18/11/1999 Dr BARTON prescribed the following drugs on a regular basis. The page is headed "Regular Prescription".

Thyroxine 100 mcgs once daily. This was administered from 15/11/1999 until 21/11/1999. This prescription has been crossed out; there is no record in the medical notes as to why this was done.

Fluoxetine elixir 20 mg per 5 mls (one teaspoon daily). This was administered from 18/11/1999 to 21/11/1999. The prescription has been crossed out and there is no record in the clinical notes to explain why.

Oramorph 10 mgs per 5 mls, 2.5 mls four hourly. (However the administration times record four times daily). This commenced on 18/11/1999. No further doses were given after 1000 on 20/11/1999.

There is a further prescription of *Oramorph 10 mgs in 5 mls*, 5 mls to be given at night. This was given on 18/11/1999 and the 19/11/1999. These are appropriate doses for a patient in pain and/or distress.

Both Oramorph prescriptions were crossed out (i.e. ceased to be given at the same time). There is no record in the notes as to why this was done.

Magnesium hydroxide 10 mls twice daily. This was given from 18/11/1999 to 21/11/1999. This prescription has also been crossed out.

Frusemide 40 mgs daily. This was prescribed on 20/11/1999 and was given on 20/11/1999 and 21/11/1999. I also note that this drug in the same dose was given on 19/11/1999 by intra muscular injection at 1530. This was a verbal message recorded by Sister HAMBLIN and has been countersigned by Dr BARTON. Frusemide is a diuretic which is used in the treatment of heart failure. This is appropriate management for a patient in heart failure. However it is not normally given intra muscularly but in the absence of a doctor on site (i.e. within the hospital) this could be appropriate to relieve shortness of breath due to heart failure, if a patient were very distressed.

On page 184 of the medical records the following entries have been recorded by Dr BARTON:

Diamorphine 20-80 mgs S/C (= subcutaneously) in 24 hours. This was prescribed by Dr BARTON on 18/11/1999 and 20 mgs was administered from 1700 on 20/11/1999. This was repeated at 1705 hours on 21/11/1999. I feel that it may well have been appropriate to prescribe this subcutaneously as Mrs GREGORY had been requiring regular Oramorph over the previous 48 hours. The starting dose administered was appropriate but the range prescribed was unusually large.

Hyoscine 200-800 mcgs S/C in 24 hours. This was prescribed by Dr BARTON on 18/11/1999 but was never administered.

It is often common in the terminal stages of life for secretions to gather in the upper airways and for patients to become distressed by being unable to clear these secretions.

I feel to prescribe this on an as required basis was acceptable medical practice. It would be more usual practice to prescribe a slightly more limited dosage range. However I must point out I am not an expert in palliative care.

Midazolam 20-80 mgs S/C in 24 hours. This was prescribed by Dr BARTON on 18/11/1999. It was not administered. Midazolam is a sedative which is commonly used in the treatment of distress and anxiety in patients who are terminally ill. The prescription of a single as required (PRN) dose of Midazolam would have been more appropriate to assess its effect before writing up a dosage range.

Cyclizine 50-200 mgs S/C in 24 hours. This was prescribed by Dr BARTON on 18/11/1999. Cyclizine is used to prevent nausea and vomiting which can be associated with the administration of Diamorphine. I am not an expert in palliative care but I feel that the starting dose was appropriate and the dosage range was probably reasonable. Cyclizine was first administered in a dose of 50 mgs over 24 hours at 1315 hours on 20/11/1999. It appears that

another dose of 50 mgs over 24 hours was started at 1700 hours the same day. I would suspect that this is because the Diamorphine infusion was changed at the same time i.e. 1700. A further infusion of Cyclizine was started at 1705 on 21/11/1999.

It is worth clarifying in respect of elderly patients, particularly confused elderly patients, that it can be extremely difficult to determine whether their distress is due to physical pain or mental stress or a combination of both. In this situation the prescription of opiates and a sedative can be entirely appropriate.

I have been asked to comment on the Wessex Guidelines For Palliative Care. To the best of my recollection I was unaware of the existence of the Wessex Guidelines until approximately 2001. I would like to stress again that I am not an expert in palliative care.

When I took over as consultant for Dryad Ward at the Gosport War Memorial Hospital in February 1999 there were no guidelines/protocols that I was aware of for the use of opiates and sedatives. At this time in 1999 Dr BARTON had been working as a clinical assistant for some eleven years and almost certainly had more hands on experience in palliative care, than I had. I was pleased to be able to rely on her considerable experience.

In 1999 the Wessex Guidelines, I believe, was a yellow book, which I first became aware of in 2001.

On page 165 of the prescription sheet I have prescribed Ipratropium Nebuliser (Atrovent is the trade name for Ipratropium), which commenced on the 13/09/1999. I also prescribed Budesonide to be administered by nebuliser and this started on 13/09/1999. This was prescribed because Mrs GREGORY had difficulty in using an inhaler.

I have checked the prescription sheets and to the best of my knowledge none of the drugs prescribed is penicillin based although I believe that the pharmacology of Cefaclor is similar. However I am not an expert in this field.

I am not able to state why the allergy to penicillin was not recorded in the 'drugs sensitivities' box. This is normally written up by the doctor completing the first prescription chart.

I can recall one instance where I discontinued the prescription of Diamorphine to an elderly lady on Dryad Ward. This patient had developed heart failure several days before I saw her on my ward round. As I remember this patient was prescribed it appropriately as she had been acutely short of breath. I discontinued it as she had improved and no longer required it.

As far as I can recollect this patient had had a stroke and had been visiting her daughter locally. I believe she originated from Kent. I do not remember any other instances where I have stopped or changed the prescription of Diamorphine.

The initial objective relating to Sheila GREGORY, who had suffered a fracture to her hip prior to being admitted to Dryad Ward of Gosport War Memorial Hospital on 03/09/1999, was to assess her physical and mental state and her rehabilitation potential.

It would appear from referring to the medical records that our initial aim was to remobilise this patient with a view to her returning home. From the records I think it is clear, after a period of attempting to remobilise her, that she would not be capable of returning home and would require placement in a nursing home.

It would appear that this was still the aim, at least until 01/11/1999, when it is recorded by me that the patient had an episode of vomiting. I have also recorded that the patient seemed well when I saw her on my ward round. It is possible that the episode of vomiting was related to a presumed urinary tract infection for which Cefaclor was prescribe that day.

On page 151 of the medical records Cefaclor, which is an antibiotic, was prescribed by Dr BARTON to this patient.

I next saw Mrs GREGORY on 15/11/1999. I have recorded that *(she was less well and that she had a chest infection, was frailer and was having occasional bouts of nausea).* I examined the

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patient on 15/11/1999 and noted she had a normal pulse rate, that she had no ankle oedema and that she had a heart murmur. I also recorded that her chest was clear on using a stethoscope to listen to the chest (Auscultation). I have also recorded *legs* √√. This means that I have examined her legs for evidence of thrombosis and found none. I have recorded that her current treatment should be continued with the exception of changing Thioridazine to PRN (as required). I almost certainly did this because Mrs GREGORY was no longer agitated and was not in need of regular sedation.

I think that my note of her being frailer implies that there has been a significant deterioration in Mrs GREGORY's condition and that my examination confirmed that there was no obvious remediable cause for this.

I have recorded that Mrs GREGORY had a chest infection. The fact that I also recorded her chest to be clear means that this was likely to have been a minor infection of the upper airways, for which I judged antibiotics not to be necessary.

My next entry of the 22/11/1999 records that the patient has *further declined but was comfortable.*

I have also recorded that the patient was opening her eyes to speech and making a short verbal response.

The notes also record that I had found her to be in uncontrolled atrial fibrillation and that her respiratory rate was 24 per minute which is higher than normal.

I have also recorded that her chest was clear at the time.

This could be consistent with early broncho pneumonia to which elderly patients can rapidly, within a few hours, succumb.

I have been shown a copy of the death certificate which records the cause of death as la bronco

pneumonia, which is the primary cause of death. The death was certified by Dr BARTON.

Only one doctor is required to complete a death certificate for patients who are buried. No further medical certificates are required.

In the case of cremation, a second medical certificate has to be completed by one doctor (often the doctor who has signed the death certificate) and countersigned by a second doctor.

There is no specific record within the medical notes referring to broncho pneumonia; however these findings could be consistent with the onset of early broncho pneumonia, to which elderly patients can rapidly succumb, i.e. within a few hours.

I have been asked to comment about the lack of entries made by Dr BARTON.

I did not speak to Dr BARTON with reference to the lack of entries by her in the medical records.

The first reason is that by the time, i.e., in November 1999, I was aware that Dr BARTON was under considerable pressure because of her general workload with her GP practice commitments, her chairmanship of the Gosport Primary Care Group and her clinical assistant role on the wards at Gosport War Memorial Hospital.

I did not want to add to her burden of work by insisting that every contact with the patient to be recorded.

It was my impression until this time, that when a significant change had occurred in the patient's treatment or management, Dr BARTON made a record, as she did on the 18/11/1999 in the notes. I was also aware that Dr BARTON was assiduous in attending to the patients at the request of the nursing staff. This was told to me by various members of the nursing staff, although I cannot remember any particular conversation.

Therefore while her note keeping may have been poor, I felt that the patients were being appropriately medically managed by Dr BARTON. Also the nursing staff were always well informed as to changes in patients' condition and as to how Dr BARTON had managed these.

With the benefit of hindsight I should have spoken to Dr BARTON about her lack of entries in the medical records. I was undoubtedly influenced by the fact that she was under pressure and she was a very experienced GP and highly regarded by the nursing staff who raised no complaints with me about Dr BARTON.

I have been asked whether I would expect an entry from Dr BARTON in the medical records when Diamorphine is prescribed and administered. I can confirm that an entry should always be made when prescribing controlled drugs.

I would add that at this time in 1999, I was working between 12-14 hours a day. I had responsibility for an acute 19 bed ward at the Queen Alexandra Hospital (QAH), which was shared with Dr TANDY who worked on a part time basis. I conducted full formal ward rounds there twice a week and would also visit the ward on an almost daily basis. My team at QAH comprised of a House Officer (a newly qualified doctor) and a Senior House Officer. I shared a Senior/Specialist Registrar with another team.

I also had responsibility for the 24 beds on Dryad Ward at the Gosport War Memorial Hospital where I conducted a weekly ward round. In addition I had responsibility for seeing patients in Dolphin Day Hospital, at Gosport War Memorial Hospital, every Tuesday morning.

I also conducted an outpatient clinic on alternate Tuesday afternoons at the Gosport War Memorial Hospital.

Dr LORD and I also had responsibility for undertaking ward referrals at Haslar Hospital. These referrals were invariably undertaken in the evenings and when Dr LORD was away I would spend up to three evenings a week up to 9 pm (2100) or 10 pm (2200) at Haslar Hospital.

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I was appointed as Medical Director of Portsmouth HealthCare Trust (the organisational predecessor of East Hampshire Primary Care Trust) in 1998, when I took up my Consultant appointment in Portsmouth. Portsmouth HealthCare Trust ran all the community hospitals in the district - Gosport War Memorial Hospital, St Christopher's Hospital in Fareham, Havant War Memorial Hospital , Emsworth Cottage Hospital and Pertersfield Hospital , as well as all the elderly medicine wards at Queen Alexandra Hospital and St Mary's Hospital. Portsmouth HealthCare Trust also managed all the mental health services in the district, all community paediatrics and all community and health visiting services in the district.

Although nominally my time was split 50/50 between clinical and managerial duties, the reality was that the Medical Director's role involved a huge range of responsibilities which took up far more than the nominally allotted time.

In these circumstances I relied heavily on experienced colleagues, such as Dr BARTON.