GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Thursday 19 March 2009

The Guildhall,
Guildhall Square,
Portsmouth,
PO1 2AJ

BEFORE:

Mr Anthony Bradley
Coroner for North Hampshire
Assistant Deputy Coroner for South East Hampshire

In the matter of Mr Leslie Pittock & 9 Ors

(DAY TWO)

MR ALAN JENKINS QC, instructed by ??, appeared on behalf of Dr Jane Barton.
MR JAMES TOWNSEND, Counsel, instructed by the Royal College of Nursing, appeared on behalf of a number of nurse witnesses.
MS BRIONY BALLARD, Counsel, instructed by ??, appeared on behalf of the acute trust and the PCT.
MR TOM LEIPER, Counsel, instructed by Messrs Blake Lapthorn, Solicitors, appeared on behalf of the families of Brian Cunningham, Michael Packman, Elsie Devine and Sheila Gregory.
MR PATRICK SADD, Counsel, (instructed from 23/03/09) appeared on behalf of the Wilson family.

(Transcript of the Official Recording by T A Reed & Co Ltd
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(In the absence of the jury)

THE CORONER: Before the jury come in.

MR TOWNSEND: Sir, perhaps I might raise one matter in relation to the proposed amended timetable.

B THE CORONER: Yes.

MR TOWNSEND: Under your timetable the witness Beverley Turnbull has been brought forward to 20 March, tomorrow. Unfortunately, she is on leave at the moment and she was not in fact going to be attending until the end of next week. She is back from leave on Friday of next week I am instructed and so I would be asking ---

C THE CORONER: Friday of next week or tomorrow?

MR TOWNSEND: No, next week. It is tomorrow that, under your revised timetable, it was proposed that she should attend.

THE CORONER: Right, so she goes out for tomorrow?

D MR TOWNSEND: Sir, yes.

THE CORONER: She is not going to be available until?

MR TOWNSEND: Friday of next week, which is the 27th, which was the day she was originally scheduled to attend.

E THE CORONER: So if we put her in for then, that will restore the position. Right.

MR TOWNSEND: Sir, that is the only matter I have to raise in relation to the timetable, thank you.

THE CORONER: And we have got Lynn Barrett for tomorrow?

F MR TOWNSEND: Yes, for tomorrow.

THE CORONER: Thank you.

MR JENKINS: Sir, can I raise a concern about things that happened yesterday?

THE CORONER: Yes, certainly.

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MR JENKINS: On occasion there were people calling out and interrupting you and others who were speaking yesterday.

THE CORONER: I think I got a little bit short at one point.

MR JENKINS: If I may say you showed considerable restraint in allowing people to call out and I am concerned that should not continue, not your restraint, the people calling out. We

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are about to embark on a different stage of the inquest, plainly, where the witnesses are to give evidence, and I am concerned that there should be no repetition of people calling out if something is said with which they disagree. Everyone will have their say and you will ensure that that happens.

THE CORONER: I will, certainly.

MR JENKINS: But the price of that is that people must listen to the evidence. They will have the opportunity, be that individually or through lawyers, to ask questions but they must not, I would suggest, call out or express dissatisfaction in audible tones. It is not appropriate to do so. It is rude to you to do so and it is wholly outwith the investigation should be conducted and it distracts the jury.

THE CORONER: My concern is that it will interfere with witnesses and that is something that really must not happen.

MR JENKINS: It may also give rise to an atmosphere of intimidation of witnesses who are to give evidence.

THE CORONER: Yes.

MR JENKINS: I will be encouraging them to stamp down on any further calling out. I have raised these concerns in the absence of the jury and I do not identify anybody but if I have to raise concerns like this again I will do so in the presence of the jury and I will identify who it is that I am talking about.

THE CORONER: I do not think you will need to do that because I will make it quite clear to everybody in this court room that my powers are such that you could spend the rest of the day in prison or you could have 28 days in prison or you could pay a fine. This will be an orderly court. I understand that things are fairly heavily charged, but just sit on it and if you have got anything to say then there will be an opportunity to do that and I will afford you that opportunity. I said yesterday that I do not want to shut families out but it needs to be orderly.

MR JENKINS: Thank you very much. I hope I do not need to raise those concerns again.

THE CORONER: Yes.

FEMALE SPEAKER: Could I respond also about that because it was me that you told to be quiet.

THE CORONER: I actually did know who it was but thank you for that.

FEMALE SPEAKER: It was me and I am not in the habit of being rude, so I do apologise if it came across that way.

THE CORONER: Thank you.

FEMALE SPEAKER: At that time I had received a proforma which stated my grandmother was admitted to the Gosport War Memorial Hospital with cancer and she was never

diagnosed with cancer, nor did she have it when she died, so I was quite shocked. I am sorry if my shock came across as rudeness.

THE CORONER: It is all right, I got it wrong as well, did I not?

FEMALE SPEAKER: I will put my hand up in future.

B THE CORONER: If you would, thank you.

MR LEIPER: A matter of housekeeping as far as the jury document is concerned, we have printed the amendments that have been made. Unfortunately it still includes the issue we discussed yesterday, in relation to Elsie Devine, the entry where it says "Increased confusion" in the first column. It was our suggestion those words should come out.

C THE CORONER: Yes. (Requests usher to copy document) I am asking that it is done so it is not readable underneath.

MR LEIPER: I am grateful. In the column "Analgesics and other medication", where it sets out "Medication as required", that, as we understand it, is a reference to the prescription which was made rather than what was actually administered.

D THE CORONER: Yes, I am grateful. I think that will be dealt with by Dr Barton and Nurse ..(inaudible)..

MR LEIPER: Exactly so. So far as Mr Farthing is concerned, the timetable for witnesses, Mr Farthing cannot give evidence on 23 March. He was ---

THE CORONER: What day was he scheduled for?

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MR LEIPER: Originally he was due for 27 March and he would ask that that be kept to.

Two last matters: Yesterday we were able to get hold of the medical records and those were given to the families, and particularly Mrs Greaves last night. The bundle of medical records included a number of documents that she has not seen before and she has not had the opportunity to get to grips with that bundle yet and will not be able to do so before the weekend.

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THE CORONER: I do not know that that is going to affect us, is it?

MR LEIPER: I sincerely hope not.

THE CORONER: As long as it does not affect you.

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MR LEIPER: She will be listening to the evidence over the course of the next two days but she reserves her position in relation to having the right to ask those witnesses any questions after she has got to grips with the medical records.

THE CORONER: Okay.

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MR LEIPER: I am grateful for that, and the last matter is in relation to the witness statement of Dr Hamblin, and, I had said, it was not something which could be dealt with today. I understand from my learned friend for the Trust that she is not in a position to deal with it today in any event, but the position so far as the families are concerned is they are very strongly objected to and that the statement should not be read. I anticipate in the circumstances that it is something which will be subject to further argument and I would ask that in the circumstances it is something which is left until next week.

THE CORONER: Okay. I will bear that in mind.

MR LEIPER: I am grateful. Because of the nature of that the evidence of the witness who is going to be giving evidence will not be here today or tomorrow and so I would be grateful if it could be held over until next week.

THE CORONER: Right, so you want that particularly to go over until Monday?

MR LEIPER: Yes, please.

THE CORONER: Very well, I will do that.

MR LEIPER: I am grateful.

MS BALLARD: Sir, as has been indicated, I am not in a position to be able to deal with the matters that are raised in Gillian Hamblin's statement at this point in time. It is a little bit difficult with the successor organisation trying to delve back in archives of this long ago to see to what extent any of this is disputed and whether or not it is happy for it to be read out, so I am grateful for the indication that that will be dealt with on Monday.

With regard to the movement of Dr Reid giving evidence, we have not been able to check with him his availability on the 31st or the 1st because he was originally due to give evidence on the 3rd and the 9th.

THE CORONER: Yes, that is right.

MS BALLARD: So I will have to come back to you about that, sir, but I suspect I should be able to do that after the lunchtime adjournment today.

THE CORONER: Thank you. What I was going to do was to ask the Portsmouth Coroner's Administrator to re-warn the witnesses as were, just to re-formalise it, so if you could let me know this afternoon then I will get that note over to her this afternoon as well. Thank you.

Is there anything else? Mr Wilson?

MR WILSON: Good morning. I understand that there is a set of medical records that are going around that I still have not got copies of.

THE CORONER: They are not going around; they are available and if you ask me for them I will make sure you have sight of them.

MR WILSON: Can I have a copy of them then, please?

THE CORONER: I do not believe you can have a copy, but you can certainly have sight of them. Have we got a copy? We have got a copy you can have.

MR WILSON: Thank you very much. There is something I would like to say with regard the very first comments that came out and it is something I had brought up at both pre-inquest hearings. Unfortunately, some of us families aren't given the luxury, as Dr Barton is, of having barristers here to represent us. We do not understand the Coroner's laws. We are in deep water here that we do not understand fully so sometimes if we do make a mistake it is a genuine mistake and we probably will apologise. We do not need patronising from the learned friend over there.

THE CORONER: I understand what you say, and do tell me, have I at any stage shut you up or caused you difficulty?

MR WILSON: No but I have been very quiet so far.

THE CORONER: I am trying to facilitate things for the families, I really am and it is important that you derive as much benefit from this as you can. I am concerned when witnesses are giving evidence that they should not feel that they are at a disadvantage and so it is important that you afford them the courtesy that I will. Seriously, we have got to be civil with each other. That is what courts of law do. If you are in doubt signal to me and I will happily accommodate you.

MR WILSON: Okay, thank you. Again, I would like to reiterate about Dr Gill Hamblin's statement, I am not at all happy with that 13 page – it is not a statement, so I am not happy with it at all.

THE CORONER: Tell me what you feel about the other statements that she made.

MR WILSON: What, the police statements?

THE CORONER: Yes.

MR WILSON: I have got 74 pages of statements she made. I do not know whether that is complete. We are not sure whether we have got complete statements. 74 pages are broken down over eight different patients. 13 pages are spent praising Dr Barton and saying how difficult it was and how overworked they were. That is looking back with hindsight with the benefit of looking over those statements. I do not think they are any different in ---

THE CORONER: Is the answer to my question no?

MR WILSON: Yes.

THE CORONER: Thank you. Okay, thank you very much. Right, the timeline is now agreed. Hamblin is not. The timetable, is subject to those two changes, yes? There is a matter I need to take up with a member of the jury and I will do that when the jury comes in and I will then explain to them the procedure under rule 37 because we will get on to rule 37 statements today.

All right: jury please.

(The jury entered the hearing room)

THE CORONER: Ladies and gentlemen, good morning. Mr Jolliffe?

MR JOLLIFFE: Yes.

THE CORONER: Would you stand for a moment? Your wife is the ..(inaudible).. can you just hold on a second because Mr Leiper is here and he is instructed by her firm and I think it is fairly important he hears what I am just about to say. Which office does your wife work in?

MR JOLLIFFE: Cosham.

THE CORONER: She is in the accounts department?

MR JOLLIFFE: Yes.

THE CORONER: So she is not dealing with any active legal work?

MR JOLLIFFE: No.

THE CORONER: You were not aware of this connection until yesterday?

MR JOLLIFFE: no.

THE CORONER: That is what we have got, Mr Leiper, that one of the jurors is married to a member of staff of your instructing solicitors. I just thought you ought to hear that. I personally do not have any problem with that, if you do not feel compromised in any way.

MR LEIPER: I am happy with that.

THE CORONER: You have not discussed this matter with her?

MR JOLLIFFE: No.

THE CORONER: So much so that you did not know that is what you were doing?

MR JOLLIFFE: Only the fact that she stated yesterday, as I said in my note, that ---

THE CORONER: It was something she said to you rather than you said to her?

MR JOLLIFFE: Yes and I thought it prudent to mention it this morning.

THE CORONER: You will be quite comfortable not discussing matters with her so far as these proceedings are concerned?

MR JOLLIFFE: Yes.

THE CORONER: The difficulty we have got, ladies and gentleman, is that I have only nine jurors and if I lose one I am eight and that is the minimum. If I lose another through ill-health we will have to start from the beginning again, and I really do not want to do that.

MS BALLARD: I thought seven was the minimum, sir?

THE CORONER: Eight to eleven.. Do sit down. I can go to seven if one falls out, but a jury of eight to eleven.

MR TOWNSEND: It is Section 8(2).

THE CORONER: Not less than seven or more than 11.

MS BALLARD: Yes.

THE CORONER: I have been erring on the safe side for 13 years.

MS BALLARD: I sat with a jury last week that was seven and that was why I wondered why it should be eight.

THE CORONER: Good Lord, my visit has been worthwhile. Obviously we do things differently in the North. I am grateful, thank you. Any objections?

MR TOWNSEND: I am troubled, not by the gentleman himself, it is obviously right that it has been raised but I am troubled that there should be such a connection, that someone is employed by a firm of solicitors acting for some of the interest parties, in the same way that if a member of the jury was married to someone who worked for my instructing solicitors.

MR JENKINS: Sir, I would endorse that. No disrespect is meant to the juror at all; it is the appearance of complete impartiality.

MS BALLARD: I agree with that comment, sir.

THE CORONER: Presumably you are neutral?

MR LEIPER: Yes.

THE CORONER: I think you are on your way, Mr Jolliffe.

MR JOLLIFFE: All right.

THE CORONER: The jury bailiff will be in touch with you in due course.

(The juror stood down)

THE CORONER: Ladies and gentlemen, a timeline is now agreed. What we are going to do today is to take Alan Lavender, Mrs Lavender's son, and he will be followed by Mrs Joines. We will then deal with certain statements in writing. You may or not have picked references to ..(inaudible).. which is one of the Coroner's rulings, which enables us to admit evidence in

writing. That is done by me reading a statement to you and you then accepting that as evidence in the same way as if you had had a life witness in front of you.

That is where your pro formas are going to come in because you will find that we start bouncing around and that there may be reference to more than once of the deceased in a statement, and as that comes in, if you think the evidence is relevant for your purposes, because, again, it is your decision-making decision, if you note it on the relevant sheet in front of you, and if there is anything you want to add on there and any additional pages. If you need us to stop or you need any clarification say so because when we come to the end of the inquests you will have your 10 sheets of paper with your notes on and from those I hope you will be able to go into your decision-making mode; that is why it will be helpful if we do not get confused, because if you make notes on the wrong sheet of paper you are going to have the wrong person dying of the wrong thing, which is what I have already done once myself.

Right, Mr Lavender, please.

ALAN LAVENDER, Sworn
Examined by THE CORONER

THE CORONER: What are your full names, please?
A My name is Alan William Lavender.

Q Are you Mrs Lavender's son?
A I am indeed.

Q You made a statement to the police on 19 May 2004, you will find it helpful to read that through and we will ask you questions when you have done that, so if you would like to read that through to us?
A We have already decided who I am.

Q Yes, we have done that.
A "My mother was diagnosed as suffering from diabetes in 1942. She was insulin dependent right from the start. I am making this statement about the care that my mother received in Gosport War Memorial Hospital and her subsequent death. My mother was Elsie Hester Lavender, nee Bryan, and was born on 4 November 1912. Elsie had a younger brother, Thomas William Henry Bryan, who unfortunately died in 1993 or 1994. My mother married George William Albert Lavender on 23 December 1934 and I am her only ..."

It says "son" there; I'm her only child.

THE CORONER: All right.

A "My father died in 1989 and my mother continued to live alone in the family home, which was 8 Rivers Close, Gosport. I took early retirement in 1990 and moved to Walls Ash to be closer to her.

Mum was more than capable of managing her diabetes other than diabetes mum had slight rheumatism and was slightly blind in her later years due to diabetes. Other than this she was fairly healthy and strong and an independent woman and remained so

right up to the day she was admitted to hospital in February 1996. She had coped with her housework and washing and was a family oriented person. She did have a home help and a nurse would attend from her surgery twice a day to assist mum with her insulin regime.

My mother belonged to Fortnum Road Surgery since she was first married and in later years Dr Jane Barton became her GP. Mum had been taken to hospital on a couple of occasions because she had become hypo. They would stabilise her diabetes and send her home. Early in 1996 I received a telephone call from Frances Domini who was my mother's home help. She informed me that mother had fallen and was taken to the Royal Naval Hospital Haslar. Mum was in Haslar for several days and we were told that she suffered a brain stem(?) stroke, which apparently is a very painful type of stroke. However, she was sat up in bed almost from the start. She was in obvious pain, but not from the stroke but from the fall as well. She had not fractured any bones but had cut her head open. I was shocked to find that she had had a stroke and had assumed that the incident was due to her diabetes.

Mum remained in Haslar for two or three weeks and underwent physiotherapy. Her progress was excellent, so much so that the occupational therapist spoke to me about preparing her home ready for her to return. Mum was now talking to others coherently and understanding what was being said to her. She had also learned to walk with the assistance of a frame. The physiotherapist was trying to arrange for an adjustable walking stick that mum could take with her when she was discharged. He returned shortly and said there would be no need to because she was going to Gosport War Memorial for rehabilitation.

Mum was very coherent at that time and was always checking had we fed her cat. The cat was a problem to us but she had had it for many years and it would let nobody go near it except for mum. We had wanted to sell mum's house and move her into a warden controlled flat. Dr Barton also wanted this to happen and she was having to find a nurse to visit the home twice a day.

THE CORONER: That was for your mum's insulin injections? Mum could not manage her own insulin?

A Because of her poor sight she could not manage, but if we were there we would do it, myself, I would give mum her injections. I gave her injections from when I was young, round about seven or eight. I knew how to draw up her insulin.

THE CORONER: You had had got to "Mum would not move".

A "Mum would not move because of the cat and the cat could not be re-homed because it had a bad temperament and used to bit us a lot. My mother was admitted to Daedalus Ward of Gosport War Memorial Hospital and was immediately placed in a room on her own. Just after she arrived a nurse came in and conducted a test, I believed was for Alzheimer's. It involved answering a lot of questions, like what was her mother's maiden name, and having to remember a word that she was told at the start of the test and recall it at the end. Mum passed this test with ease. The Stamford Royal Naval Hospital Haslar had told me that mum was going to Gosport War Memorial for rehabilitation and my wife and I visited daily, as well as to feed the cat.

Within two or three days of being in the War Memorial I had an appointment to see Dr Barton. I asked when she would be going home and she said that we needed to know because we had to get rid of the cat if we were going to get her into a warden-controlled flat. Dr Barton replied, 'You can get rid of the cat'. I was stunned at the way she said this. Dr Barton said, 'You know your mother's come here to die?' I did not know that to be the case. I believed my mother had gone into hospital for rehabilitation" – into the War Memorial Hospital that is: "I could not believe the cold, callous way that Dr Barton had broken this news to me, as if her death was predetermined. I was shocked. I did not ask any questions, even though I had a number that required answers. On reflection, I should have seen this coming and asked the questions of the Sister on Douglas Ward and I was told I had better speak to Dr Barton. I cannot remember the Sister's name but she was at Northcote House previously and my mother knew her and trusted her. On one occasion soon after my meeting with Dr Barton I noted that mum had been placed on a syringe driver. Mum had actually said to me, 'I don't like that thing' and pointed to the driver. I assumed the syringe driver was for pain relief but I did not know what drug was being administered by it.

My mother's health deteriorated quite quickly. On one occasion we visited she appeared to be unconscious and smelt awful. It really was difficult to sit near her because of the smell. I noted from the medical notes an entry stating 'leaking faeces'. Mum was always very proud of her appearance and spotless and she would have hated to be in this state.

About two or three days after the visit, on 6 March, I received a telephone call from Gosport War Memorial stating that she had died. The death certificate had been certified by JA Barton, BM, and gave the cause of death as cerebrovascular accident and diabetes mellitus. We buried mother in Aidensfield Cemetery, plot 150.

I am concerned about the rapid deterioration of my mother. When she initially went to the Gosport War Memorial Hospital for rehabilitation. I am also concerned about the callous way that Dr Jane Barton and ..(inaudible).. mum's death was partly down to her refusal to go into a nursing home, which placed financial burdens on Dr Barton's surgery and she had to supply a nurse twice a day. I am a realistic person and I accept that my mother was an elderly lady and at that time was one of the longest standing insulin dependent people. However, she appeared to be making a full recovery from the stroke, was lucid and other than a little pain from her shoulder was not complaining of the pain. It was not until her final day that I realised what was being administered through the syringe driver. I was not informed of this by the staff, despite visiting nearly every day."

THE CORONER: The suggestion that will be put forward is that before syringe drivers were used the matters were discussed with relatives: you are saying that did not happen in your case?

A We were – if you look at the notes that came, it looks as though that did happen but chronologically, I don't remember a discussion with Dr Barton until we saw the syringe driver there.

Q Did you not have a discussion with anyone else, any of the nursing staff?

A I did speak to Sister Jones, Janes, Jones

Q Joines?
A Because she was the lady that actually knew my mother because she was in Northcote House and my mother, my great aunt was in Northcote House in Gosport, which is an old people's home and she got very friendly with mother because mother was always visiting, so she did know mother, even though it says she didn't, but nobody would talk to me and referred me to Dr Barton, and that's when we discussed the issue of the syringe driver.

Q So it wasn't until you spoke to Dr Barton that there was any mention of a syringe driver?
A Yes, that is correct.

Q So you did not discuss it with any of the members of staff?
A Both my wife and myself knew what it was, basically, because my wife had had an operation and she had to manage her own pain control through an adjustment control on the driver.

Q You were also suggesting that Dr Barton may have had reservations about your mother going home because of nursing care and having to supply a nurse twice a day, but that had been your mother's situation before her admission had it not?
A Oh yes. There was a lot of money being spent on mother because the nurses were going there – they were going there while we were ... We moved away for a while, the family, and we came back. I was working in North London and they were looking after mother then, after dad's death. There was a lot of financial burden on the surgery, supplying her continued, you know, supply of nurses. We always assumed that that was the case.

Q Is there anything you want to add to that? Anything else that has cropped up over the years?
A Since ... It's been a very long time, it's 13 years, so – I'm on the other side of 20 so my memory's failing slightly as well but there is one thing if I could mention at this point, if you refer to mother's notes, page 97/228, there's an entry there:

> "Pain ..." on 6/3/1996, "Pain well controlled. Syringe driver renewed at 9.45. This is not my writing but an entry was made, it bears my name, but not my signature, along with that Nurse Pat Wilkins. I assume the entry was Pat's writing and would have been written at the time or shortly after. It was not usual to have two signatures as I was with a qualified nurse. We both had contact with the patient."

It would appear to me that that entry has actually got a forged signature on it.

THE CORONER: Let me have a look at it, please? (Same handed) What are you saying is not your signature?
A That is what the nurse is saying, not me. I'm not ..(inaudible).. that piece in the margin, it's been typed by – that's been written there by the hospital.

Q Yes.
A Yes, but she is saying that she did not write that note in there, that is what she is actually saying, yet somebody has signed it in her name so my point being, if that can happen with a small thing like that how do we know the chronological order of that record is correct? Do you take my point?

Q Two nurses would have signed – you are saying just one of them has signed it and the other ---
A No, what I am saying is that that nurse, when she's gone through those notes to explain them for the purposes of this hearing, or whatever this has been prepared for, it says there that "I didn't write it but somebody has signed my signature." If that is the case, sir ---

B Q That is Edgar, is it? Could I have a look at the original of page 97 of 228 for Elsie Lavender? (Same handed)
A I didn't know if this was the time to bring this up.

Q She has annotated that, okay. We might check that with her. Thank you for that. Is there anything else you want to say?
A No, I don't think so.

C THE CORONER: Please sit down. Right, Ms Ballard first.

MS BALLARD: I have no questions, sir, thank you.

THE CORONER: Mr Townsend?

D MR TOWNSEND: No questions, thank you.

THE CORONER: Mr Leiper?

MR LEIPER: I have got some but if you would give me a moment. Sir, if I could give you this. It is on the second page she deals with that.

E THE CORONER: I think that is what Mr Lavender is saying, that the entry has not actually been signed by Ann Edgar. She is saying she has not signed it, yet her signature appears on it.

MR LEIPER: There is reference to another nurse, Nurse Wilkins. (Pause) It is on the third page of Ms Wilkins' statement. (Pause)

F THE CORONER: What has been handed to me is a statement from Patricia Wilkins – I do not think she is on my list, is she?

MR LEIPER: No.

THE CORONER: That statement is dated 3 February 2005 and in it she says:

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> "I can also confirm that on page 105 of the notes is written 'bed-bathed'. This entry is written and signed by myself. I have also included the name of Wendy Edgar, who was with me and who at that time was a healthcare support worker. I also confirm that on page 109 of the notes, which is the nursing care plan dated 6 March 1996, is dittoed from an entry above date 29/2/96, 'Dressing remains in place'. This dittoed entry is signed by me and again I have included the name of Wendy Edgar who was with me at the time. I also confirm that on page 113 of the notes ---"

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So basically, what she is saying is that she has written her name in and it is not purported to be a copy of her signature?

MR LEIPER: I think the bottom line of the third page talks about the practice of dittoing, it is not done any more.

THE CORONER: "In 1996 it was common practice for the nursing notes to be dittoed if they were identical to the entry before. This is not the practice now, however."

MR LEIPER: The thrust of that appears to be she would write in the name of another nurse who was with her.

THE CORONER: Yes, and not purported to be a signature.

Cross-examined by MR JENKINS

Q Mr Lavender, I want to ask you about the position of Dr Barton, but before I do can I just go through your mother's treatment at the Haslar Hospital. What you told us was that in February 1996 your mother had a fall, yes?
A Uh-huh.

Q And she was treated at the Haslar Hospital.
A Uh-huh.

Q Do you remember how long she was there, approximately?
A It's difficult, we were talking about this ... It was something like two, one – more than one week but not two. There are no records here from Haslar to refer back to anyway.

Q No, I am just asking about your recollection.
A Yes, my recollection is she had more than a week there but probably not quite a fortnight.

Q Did you go and see her regularly at Haslar?
A Oh yes.

THE CORONER: Is it important, because we have got the Haslar records?

MR JENKINS: I do not think it is important, I am just dealing with recollection. (To the witness) Did you go on your own or did you go with your wife?
A My wife came with me on all visits; all visits my wife came with me.

Q Would your wife have gone alone, gone ahead of you to see your mother?
A No.

Q Whenever you went your wife was with you?
A My wife was there.

Q Did you go on a daily basis to the Haslar or less frequently?
A I had retired at that time so, yes, we used to go as often as we could. We used to go and feed the cat and then go down to Haslar to visit mother.

Q Would you speak to the doctors at the Haslar as well?
A We spoke to the doctors and they said she was doing quite well, basically. Can I just stretch that a little bit? When the physiotherapist was there and the person that was going to look at mum's house and put handles and things in ---

THE CORONER: The occupational therapist?
A The occupational therapist. I walked away from the bed for a while and mother actually walked down to the toilets with my wife, and that's the only time they were on their own together. She walked down and she took her to the toilets, aided, but she took her to the toilets.

MR JENKINS: I understand, and were there several doctors at the Haslar you were able to speak to about your mother?
A There was a Dr Tangy, which appears on a letter that was sent to the War Memorial Hospital, but of all the others, they were all of naval or military rank and we didn't get to see them too often.

Q All right, but they were there?
A There were lots of them.

Q There were lots of doctors, I understand. When your mother was transferred over to the Gosport War Memorial Hospital, how many doctors were there, do you know?
A What, the War Memorial?

Q Yes.
A We followed the ambulance down to the hospital.

Q Forgive me, I will ask the question again: how many doctors were there at the War Memorial Hospital looking after the patients, so far s you understood it?
A Dr Barton, one.

Q She was your mother's GP.
A That is right.

Q So you knew that at least some of them working there, she was working as a general practitioner. What did you understand was her role at the War Memorial Hospital?
A I understood that her role there was to look after her patients from her surgery.

Q Is that right?
A Mmm.

Q Who was looking after the other patients on the ward your mother was on?
A It must have been other doctors that we weren't involved with. One assumes that there was more than one doctor in the War Memorial at the time.

THE CORONER: I think that is the question Mr Jenkins asked you at the beginning. You were asked how many doctors there were at Gosport and you said the only doctor there was Dr Barton.
A The only doctor that we saw.

THE CORONER: The only doctor that you saw, and you presumed that there were other doctors seeing to their own patients in Gosport?
A Yes.

MR JENKINS: The truth, Mr Lavender, just so you know, is that Dr Barton was the clinical assistant for Dryad and Daedalus Wards, she was the doctor looking after all the patients, not just her GP patients, right?
A Okay.

Q There was a consultant for each of the wards.
A Can I just say one thing at this point?

Q Of course you can.
A Mother was in a room on her own.

Q Yes, but she was one of the wards?
A Yes.

Q She was in a side ward?
A Yes. So the only person I saw in there with mother was Dr Barton.

Q Are you able to tell us how many times you had the chance to speak to Dr Barton during the time your mother was at the War Memorial?
A Several.

Q Several times?
A Had a chance.

Q Did your mother's condition change during the period of time she was there?
A She was – yes, it went down, it went down.

Q I understand.
A At the time of entering she was very much alert, and she was ---

THE CORONER: You say "alert"?
A Very alert. When this series of questions that the reception nurse, whatever she was, fired at mother, she answered the immediately: "Where are you?" "Gosport War Memorial". The War Memorial was dear to mother's heart because she was there the day it opened. She knew she was at the War Memorial. She knew who the prime minister was. She knew who her member of parliament was; where she lived; where she had been; very fast and she also remembered a word, which I can't remember now because I'm also losing my memory.

MR JENKINS: What we know is that when your mother was transferred she had ---
A She was going in for rehabilitation.

Q I understand but she had a whole series of medical problems.
A Diabetes being one of them.

Q Had she been blind for some time?

A Partially sighted, yes.

Q Had she been living alone, with her cat?
A Yes.

Q And she had had a fall, and she had fallen from the top of the stairs to the bottom of the stairs.
A That is right.

Q That is how she got admitted originally to hospital?
A Uh-huh.

Q There were discussions, I think, with Dr Barton about what might happen to your mother, whether it would be appropriate to transfer her to a rest home?
A Those were prior to her falling down the stairs that Dr Barton came round to see mother one day and there was a discussion. We went to several places to look to see where we could get mother in so that she could get some assistance but, yes, there had been discussions.

Q What I am suggesting is that there had been discussions when your mother was transferred to the War Memorial Hospital ---
A Sorry, can you speak up please?

Q What I am suggesting is, there were discussions after your mother had been transferred to the War Memorial Hospital about if she improved would it be possible to transfer her to a rest home.
A Mmm.

Q This was long after she had fallen down the stairs?
A This was after she had fallen down the stairs.

Q Yes, of course, she had fallen down the stairs ---
A Yes, yes.

Q --- gone to the Haslar, then gone to the War Memorial Hospital ---
A For rehabilitation.

Q Yes, and it was at that stage that discussions were being had about what would your mother's future be, what might it be?
A She wouldn't sell her house, basically.

THE CORONER: Say that again, please?

MR JENKINS: "She wouldn't sell her house, basically". (To the witness) I think your mother was very dependent on other people, nursing staff ---
A Uh-huh.

Q --- for her daily needs.
A Some of the time, yes. She had a home help and she had a nurse visiting twice a day because she had to have an insulin injection night and morning.

Q I understand.
A Except for the days when we went round there regularly, then I did her injection in the evenings.

Q I am grateful for that: what I was really asking about, and it is my fault for not being clear, is when your mother was at the War Memorial Hospital, I am suggesting that when she was there she was very heavily dependent on people for her daily needs?
A Yes, she was.

Q Yes? She needed a great deal of help from nursing staff.
A Yes.

Q That is why there were concerns about whether it would ever be appropriate to transfer her away from the hospital into a rest home?
A Yes, I – I am not quite sure when it came up but certainly the fact that mother had gone there to die cut that discussion down quite a bit.

Q At the start what was being discussed was your mother's mobility, what her needs were and whether she could be transferred away from the War Memorial Hospital: you agree with that, you are nodding?
A Yes.

Q There were concerns that your mother had about her cat? She was very attached to a feral cat; she got on with it but nobody else did I think?
A That is right.

Q I think there were concerns about your mother relinquishing the cat; she did not want to let it go, yes?
A Yes.

Q You discussed that with Dr Barton.
A Dr Barton said, "You can get rid of the cat".

Q It was affecting what could happen to your mother, is that right?
A Mmm.

Q As her GP and as well as the doctor treating your mother at War Memorial Hospital, Dr Barton knew your mother's circumstances very well, did she not?
A Uh-huh.

Q You have told us that you had several conversations with Dr Barton over the time your mother was at the War Memorial Hospital. Did you have a number of conversations with nursing staff as well when you went to see her?
A We spoke.

Q You knew that your mother was in pain.
A Yes.

Q You knew that your mother was deteriorating whilst she was in the War Memorial Hospital, that is what you have told us.
A Yes.

Q The impression, and I am raising this for you to consider, is that your mother was a rather proud woman about her own appearance and about how she presented.
A (No audible reply).

Q You have told us you read some notes at the end of the bed about your mother leaking faeces.
A Uh-huh.

Q Did she tell you that?
A Did she tell me?

Q Yes.
A Mother was unconscious at that time.

THE CORONER: Can you explore that a little more?

MR JENKINS: Are you able to tell us when it was you learned, in relation to your mother's death, that she was leaking faeces?
A When I learnt?

Q Yes.
A The day it said on the papers. I looked at the chart at the foot of her bed and it said – I forget what date it was, it is on there somewhere because I've read it.

Q You suggested that the medical records may not be entirely reliable, so that is why I asked about your memory.
A I saw it – it was fairly soon, maybe the day before she passed away or along that period, when she was really deteriorating.

Q I am not going to go into the detail of the medical records.
A Okay, but that is the only thing we've got.

THE CORONER: Sorry, the fact that that came up at a point when mum was unconscious, so it was fairly near the end?
A Yes, it was.

MR JENKINS: (To the witness) Did you know that there had been problems with your mother's bottom for many days by the time she died?
A No.

Q You told us there was a conversation with Dr Barton when you were told that your mother was dying.
A She didn't say it like that: "Your mother's come here to die".

Q What you have told us is you had several conversations with Dr Barton.
A Yes.

Q And the words you have put in her mouth are, one, "You can get rid of the cat", and, two, "Your mother's come here to die". I am suggesting that the conversations were a bit fuller than that. It was not just one line from Dr Barton ---
A No, there was ---

Q --- on several occasions.
A There were ---

Q I am exploring what it was that Dr Barton said, if you can recall it.
A I cannot recall exactly what she said. All I have done is told the truth as I saw it from that ... I can't remember how many times, and, crumbs, you know you are going back 13 years. She died 13 years ago. It is very difficult to be precise.

Q I agree with that.
A There's been a lot of water under the bridge since then. However, we have often spoken, my wife and I, about that occasion because my wife, although it does not say so there, was actually with us. She never saw Dr Barton on her own at any time, because I used to take her to the hospital with me. We only had the one car at that time so I drove my wife everywhere.

Q All right, I am just trying to explore what else you recall of the conversations, the several conversations you say you had with Dr Barton, and you are not able to help us?
A No, not really.

Q Do you remember being told that your mother was being given medication for her pain?
A Yes.

Q Do you remember being told that she was being give the use of a syringe driver and that being explained to you?
A I knew she was having treatment for pain but the syringe driver was not there at that time, when we were talking about pain control.

Q You spoke to the nursing staff about this?
A They referred me to Dr Barton. There was Nurse Joines, Sister Joines referred me to Dr Barton. She would not discuss it.

Q Did you indicate that you were keen that your mother should be pain-free?
A Uh-huh.

Q Anyone would in your circumstances.
A Uh-huh. I didn't want her to have unnecessary pain.

Q Of course, and did you say that?
A We didn't want to accelerate her death either.

Q No, of course not, but was that something you said because your mother appeared to be complaining of pain?

A She wasn't complaining to us a great deal. Mother was – by the notes, she was complaining to the nurses but she didn't actually complain to us a lot at all. We were aware she had a bad shoulder, but she's had a bad shoulder for years, she used to call it her "screws".

THE CORONER: Rheumatism.
A Maybe that was aggravated when she fell over as well.

MR JENKINS: Thank you very much Mr Lavender, that is all.

THE CORONER: One thing I am not clear about: you say that you do not recall any conversation about the syringe driver. Are you saying that that did not take place or that you do not recall it?
A The conversation about the syringe driver was after it was installed; that is what I am trying to say. I don't recall we had discussed it previously, but I knew they were going to try and manage her pain. I mean, you can do that with tablets, you can do it with aspirins when you have got a headache.

Q They can only do that if people can swallow though, can they not?
A She was being fed at that time.

THE CORONER: Ladies and gentlemen, is there anything you want to ask? (Nothing). Thank you very much. I propose to release witnesses as they go through. If there is any objection to that would someone say so? Thank you very much, Mr Lavender, I am grateful to you. I release you, you can go if you want.

THE WITNESS: I will stay for a short time.

(The witness withdrew)

THE CORONER: Do you want a break before we go on to the next witness? (Not required) Mrs Shelagh Joines, please.

SHELAGH JOINES, sworn.
Examined by THE CORONER

Q You are Shelagh Joines.
A Yes, I am.

Q Do sit down, please. You know what we are here for?
A Yes.

Q Do you want to read me your statement?
A No, I am quite happy for you just to ask me questions.

Q Tell me about your working at Gosport War Memorial Hospital.
A I first started working at Gosport War Memorial in 1973, when I came home from South Africa. I started off as a staff nurse on the male ward. I was then transferred down to Northcote annexe, which was what I would have called a geriatric unit, a 12-bedded geriatric unit. I was there for about 18 months. I came back up to the main hospital, and I worked as a

Sister on the children's ward for 18 months. I went back down to Northcote for about a year; then back up again to the children's ward, where I was Sister of the children's ward and I was sister of the relief team. Sister Wynn retired from the male ward. Then I applied for Sister of the male ward, and at that time there was a mixture of patients, medical, surgical, geriatric, and we also did the care of terminally ill patients. I was there on the ward until we transferred into the new hospital in I think it was 1993, and I was Sister of Daedalus Ward which was an eight bedded stroke rehabilitation ward and 14 long-stay beds.

Q Would you say the numbers again?
A Eight stroke rehabilitation beds and 14 long-stay – I don't know what the term is they use these days, and Dr Barton was a clinical assistant for all the patients, and Dr Lord was the consultant. I stayed on that ward until I retired in 1997.

Q You worked closely with Dr Barton?
A Yes.

Q Daily?
A Yes, she did a ward round every morning between 8.00 and 9.00 before she did morning surgery.

Q What other doctors were there on the ward?
A There was only Dr Lord, the consultant who used to do a ward round every other Monday, and if Dr Barton was not on call and we needed her we used to have to get one of her partners from the surgery.

Q Did you have telephone contact with her?
A Yes, always.

Q Was that an easy contact or did you have any difficulty?
A No, I did not have any problems.

Q You managed to avoid the receptionist?
A No, the receptionists were very good. They got to know me and often nine times out of 10 I did speak to Dr Barton even if she was doing surgery.

Q Your duties would have been as nurse in charge, effectively?
A Yes.

Q What would it have involved?
A It would involve both administrative and nursing. We had two teams on the ward, we just named them red and blue team. There would be a senior staff nurse in charge, and all the teams knew what the other were doing. Mine was overall running of the ward and the general wellbeing of the patients; seeing the relatives; keeping them up-to-date with what was going on, and also the administrative side of running the ward as well, and obviously escorting Dr Lord on ward rounds, and Dr Barton in the mornings.

Q Was Dr Barton's ward round a formal ward round or was it a walk through?
A No, it was more informal. We would discuss the patients. She would discuss the patients if it was absolutely necessary. It wasn't a formal occasion, no.

Q Would you be responsible for note-taking for that ward round or not?
A Yes, most of the time.

Q Just for the sake of clarity: do you have any recollection of Elsie Lavender?
A I am afraid I don't, no I really don't.

Q Nobody is going to criticise you in any way.
A It is 13 years ago.

Q How many people pass through the ward?
A Precisely.

Q Let us talk about standard practice rather than what actually happened with Mrs Lavender. In the event that a patient's condition was deteriorating, what pain control measures did you have?
A They would first off be written up for, in tablet form, paracetamol or ---

Q "Written up for" meaning they would have a prescription for?
A On their treatment charts, yes, tablet form, anything from paracetamol up to morphine tablets.

Q Things going downhill; patient still in pain?
A Obviously the amount dosage of any analgesia was always checked but if a patient came to a point where they could not swallow analgesia we obviously had to find other forms and basically it was the use of a syringe driver rather than giving them injections all the time.

Q You were familiar with the syringe driver?
A Yes.

Q It had been used ...
A Many times, yes.

Q Had you used it before you went to Gosport?
A Yes.

Q So it was something with which you were quite familiar?
A Oh yes, very.

Q Any prescription would be written up by Dr Barton?
A Yes.

Q Or a consultant, Dr Lord?
A Dr Lord didn't usually, no, most of the prescribing was done by Dr Barton.

Q How would that be done?
A It would be done when the patient's condition deteriorated, but can I just say that sometimes with the type of patient we got the deterioration could be quite rapid and the patients might be in pain and agitated and if Dr Barton wasn't on call it meant calling in one of her partners who, understandably so because they did not now the patients, were reluctant to write them up for any analgesia, so it was decided, I think on a ward round of Dr Barton,

Dr Lord and myself that where necessary patients could be written up for analgesia prior to it being given so there was no delay in relieving their pain. But it wasn't done on a regular basis and I don't think it was done on other wards, I don't know but whenever it was used it was for the patient's good.

Q At whose discretion would it be to decide to employ the analgesic at that point?
A What, you mean in setting up the syringe driver?

Q Yes.
A That would be... Dr Barton would.

Q And in Dr Barton's absence?
A Basically, because it was written up we were able to but I would always get a message to the surgery informing Dr Barton that we were going to increase the dosage, but, inevitably, sometimes one dose was enough, one certain dose, you know, without increasing it.

Q So you would set it up but you would always agree that with Dr Barton.
A Yes.

Q Maybe even retrospectively?
A Yes, because it was written on the chart we were well within our rights to give it.

Q I was not talking about rights. It is a question of what your practice was, and it was quite normal for that to happen. Dr Barton would then be consulted, on what terms? She was just informed that is what you had done?
A Yes. We always tried to discuss it first.

Q What about families? Did you discuss syringe drivers with families?
A Yes, always. If a patient's condition was deteriorating and maybe they would have to have a syringe driver put it, Dr Barton always saw the relatives, or if she didn't I would speak to them, and at that time they were always told why the syringe driver was being put up, what would be in the syringe driver and the consequences of putting a syringe driver up. We never ever put a syringe driver up without the relatives agreeing to it.

Q Mr Lavender says that he does not recall that conversation taking place. You are saying that in each case it would have happened, either with you or with Dr Barton?
A Yes.

Q Was anyone else every going to have that conversation?
A Maybe my senior staff nurse might have done but as far – I think as far as – I don't know, I haven't got the notes but if I had seen – and I think I was there at the time of that conversation, I would have written it in the Kardex that Mr & Mrs Lavender were seen by Dr Barton; syringe driver was discussed and agreeable, but I haven't got the notes so I don't know.

Q Would you have a look at that (pages 97 and 98) and look at the entry for 30 March? It is not your entry, it is the entry of Mrs Couchman. Does that mean anything to you?
A Other than the fact that she put the syringe driver up, no, sir, I am afraid it does not.

Q But it is written up, it is in the notes and it is there?
A Yes.

Q The conversation that you or Dr Barton would have had before that about the syringe driver with Mr Lavender, that would have been before the 5th?
A Yes, it would have been.

B

Q There is nothing on that card that seems to give that impression.
A Nothing on here but I do remember when I gave my statement, my second statement re Mrs Lavender, I actually saw a piece of Kardex where I had written, "Mr & Mrs Lavender seen by Dr Barton". I actually ---

THE CORONER: 26 February. I am not going to get the same document that you are. What is the date, again?

C

MR JENKINS: 26 February.

THE CORONER: I cannot see it in the notes?

THE WITNESS: I have actually found it in my statement.

D

THE CORONER: Is that your first or your second statement?
A My second statement, the one re Mrs Lavender. It has just got here, "14.30: son's wife seen by Dr Barton. Prognosis discussed. Son is happy for us just to make Mrs Lavender comfortable and pain free. Syringe driver explained." But I have gone into more detail on the Kardex.

THE CORONER: Have you got the Kardex?

E

MR JENKINS: Sir, it is in your big files, halfway through the files. For those who followed my index it is page 13.

THE WITNESS: The only other thing, it sounds rather trivial, is the only time I knew of Mrs Lavender was when I was walking my dog round a cemetery and I came across her gravestone and her name just rang a bell but I have no recollection of her whatsoever.

F

THE CORONER: The procedure that was taken with Mrs Lavender was fairly standard from your point of view. There was nothing exceptional about it? And even going back to the records at this stage, there is nothing that you thought was untoward about it?
A No, definitely not.

G

Q The practice of proactive prescribing, was that something that happened regularly or was it done in exceptional cases?
A More in exceptional cases than regularly. As I said, because there could have been a delay in the patient getting any pain relief, this is why it was set up, that if it was deemed necessary then Dr Barton would write up the prescription beforehand.

Q How would it be written up, as a fixed dosage or ...
A No, it was on what we call the PRN side of the treatment chart and basically what was usual was 100 to 200mg of diamorphine, 40 to 80mgs of Midazolam and 400 to 800

H

micrograms so you had the minimal to the maximum dosage and all the patients were set up on a minimal dose to start off with.

Q And if that was not sorting the pain threshold you would then ...
A It would be increased, yes.

Q Whose decision would that be?
A Basically it would be Dr Barton's, but, as I say, if Dr Barton was not there it was up to us to decide whether the patient needed extra but obviously we let Dr Barton know, or it would have been discussed if she came round in the morning and say perhaps the patient had had a bad night, I would report that to Dr Barton and we would say, "Right, when the syringe driver ran through, when we set up the next syringe driver it would be a higher dose to try and control the pain".

Q How would you know to increase the dose?
A From observing the patient to see if they were in pain on movement or whatever, or stated that they were in pain.

Q What about the patients that were unconscious?
A Again, on movement you could tell by expression if you were hurting them when they were moved; if they were restless, even though they were unconscious, or if they were agitated, there are ways, even when they're unconscious that you can tell if they are in pain.

Q That would be the sole reason for increasing the dosage at that point?
A Yes, we would never increase it unless it was absolutely necessary.

Q Were any patients a management problem?
A No, not really that I can say. I would just like to say that although we were supposed to be a stroke rehabilitation ward, a lot of the patients that were transferred to Daedalus Ward were not suitable candidates for rehabilitation because of age, frailty, other medical things that they might have wrong with them, and also they were blocking acute beds in either Haslar, Queen Alexandra or St Mary's, so not all the patients that were transferred into rehabilitation beds were suitable for rehabilitation.

Q I think the pressure at QA and other hospitals was quite considerable.
A Yes.

Q What was your way of dealing with that? How did you cope with demands for beds at Gosport?
A Really it was a case of we just had to. In other words, a lot of the patients, if we knew they weren't going to be rehabilitated and the patients were not going to be able to cope at home they would sometimes be transferred into one of our long stay beds, but Dr Lord could only make that decision, so sometimes they went from a stroke rehabilitation bed into a long stay bed, but the dependency did get quite high at times. I think this was more after I had retired actually than prior to that.

Q A busy ward?
A Yes.

Q How many staff?

A Off the top my head I genuinely can't remember but I always had sufficient staff and I had a very good team. They really were excellent to work with, everybody knew what they were doing, and all the patients were given the highest possible care that we could give. I am afraid I am a bit old school. We took pride in looking after our patients.

THE CORONER: Batting order?

B MS BALLARD: I have no questions, thank you, sir.

MR TOWNSEND: I have no questions, thank you.

MR JENKINS: I have one or two questions.

Cross-examined by MR JENKINS

C Q I am asking you questions on behalf of Dr Jane Barton. What you have told us is she was a GP.
A Yes.

Q Working as a clinical assistant?
A Yes.

D Q At Daedalus Ward. I think she had been there since 1998, working as a clinical assistant.
A Yes.

Q Had you been there throughout that time?
A Yes, I was.

E Q So you worked alongside Dr Barton for, would it be, nine years, from 1988 to 1997 when you retired?
A Yes.

Q What we know is that Dr Barton would do a walk through ward round of the ward in the morning.
F A Yes.

Q I think she was contracted to be there for just a limited portion of each working week?
A Very limited, yes.

Q So in the morning she would do a ward round of Daedalus Ward and, to your knowledge, was she also doing a ward round of another ward, Dryad, in the same hospital?
G A Yes.

Q She would leave before 9 o'clock I think to go off to work in her general practice?
A Yes.

Q Just remind us, how many beds were on Daedalus Ward?
A Eight stroke rehabilitation beds and 14 long stay beds.

H

Q So more than 20?
A Yes.

Q Were you often at maximum occupancy?
A Very often, yes. We also did respite care so some of the empty beds could be used for patients who came in for respite care so it gave their relatives a chance to have a rest.

B

Q And so far as you understood, was there a similar number, 20 or may be more, beds on Dryad Ward?
A As far as I know, yes.

Q So every weekday morning before leaving at 9.00 Dr Barton would be doing a walkthrough of 40 or more patients?
A Yes, and can I also add that sometimes if Dr Barton had been on call the night before, like at a weekend, she would often come in in the morning to see if everything was all right with the patients.

C

Q For the rest of the morning on a weekday, was there any doctor on the ward at all?
A (No audible reply)

THE CORONER: Was that a no?

D

MR JENKINS: It was a no. (To the witness) Would it happen perhaps several times a week that Dr Barton would come in at lunchtimes?
A Yes.

Q Would she also come in several times a week, or regularly, during the evenings on a weekday?
A If it was necessary, yes.

E

Q What about the weekends? Was there any doctor there on the premises at the weekends?
A No. If I needed a doctor I had to phone through to the surgery.

Q There was a consultant, Dr Lord, and you have told us that she would conduct a ward round ---
A Yes, every other Monday.

F

Q Every second week?
A Yes.

Q I think a ward round would take several hours on Daedalus Ward?
A Yes.

G

Q You would go round as Sister for the ward round?
A Yes.

Q A consultant would be there, and Dr Barton would be there?
A Yes.

H

Q If the patients needed any treatment or adjustment in medication during the times when Dr Barton was not there and that was, from what you have told us, 22 or 23 hours in every weekday, and she was not there all weekend, what would happen?
A We would have to phone the surgery and one of her partners would come in.

Q I think what you have suggested is that there might be some reluctance on the part of her partners because these were patients they did not know?
A Yes, precisely. They didn't know the history and maybe had never seen the patients, so quite rightly they were reluctant to prescribe.

Q You told us that Dr Lord might on occasion prescribe but normally it would be Dr Barton?
A Yes.

Q At a ward round, when Dr Lord the consultant was there, would that involve a full review of the patient's condition, their treatment and any medication they were receiving?
A Yes.

Q So the consultant would be well aware at every ward round of the treatment that was being provided to her patients?
A Yes, definitely.

Q So far as you recall, were any concerns ever expressed by Dr Lord as to the care that was being provided for her patients?
A Never.

Q What you have told us is that not all the patients who were transferred to Daedalus Ward were suitable for rehabilitation, although that was the reason why they were being transferred.
A Yes.

Q What we have heard is there was great pressure on beds from other hospitals, Haslar, Queen Alexandra ...
A Yes.

Q And patients were transferred from those hospitals to the War Memorial?
A Yes.

Q There were problems with bed blocking in the major hospitals and the War Memorial was used to take patients from post-surgical units or other units of those hospitals?
A Well on my ward it would have been stroke units.

THE CORONER: The expression that has been used is that Mr Jenkins has put to you is that of bed blocking. Is that the expression that you used at that time?
A We had done, yes.

THE CORONER: So you would recognise it as you being a channel to avoid bed blocking at QA or Haslar?
A Yes, sir.

THE CORONER: Sorry, Mr Jenkins.

MR JENKINS: That is all right, sir. (To the witness) Did the pressure on you at the War Memorial, did that increase over the time that you were there?
A It was starting to increase just before I retired. I seem to remember that when we first got the stroke patients into the ward they were rather low dependency but that seemed to increase as time went on, and some of them that came to us were very high dependency and really not fit for rehabilitation.

Q Again, you retired in 1997.
A Yes.

Q You cannot take the picture on from there ---
A Not really, no.

Q --- but up to 1997 the situation was getting worse?
A Yes. May I just say something?

Q Of course.
A When we had these patients over, obviously, as Mr Lavender has said, he was told his mother was being sent to my ward for rehabilitation. This sometimes caused problems because we would know that the patients weren't suitable for rehabilitation, therefore I think – this is only my opinion – the relatives sometimes were expecting their relatives to be rehabilitated, and this is why I think when their condition deteriorated, like Mrs Lavender, and she eventually died, I think sometimes this could cause a problem of what the relatives were told and what we were actually seeing.

THE CORONER: There would be a reasonable expectation?
A Yes.

MR JENKINS: What I take from that, and from the learned Coroner's comment, is that relatives, perhaps patients, might have been given unrealistic expectations ---
A Yes, definitely.

Q --- of what the future may hold. Does that also cover unrealistic expectations of what could be provided at the War Memorial Hospital?
A I think to a certain extent, yes.

Q Again, your ward was one where you had a doctor present for an hour a day?
A Yes.

Q On a weekday?
A Yes.

Q No more?
A No.

MR JENKINS: We have heard Dr Barton described as "callous" this morning, and I think you are entitled to give your experience of knowing her over nine years, working alongside her.

THE CORONER: Bearing in mind Dr Barton is not on trial: I understand what you are saying and I have no problem with you pursuing that but this is not a trial of Dr Barton. It is right that you should answer but that your answer goes to your understanding of Dr Barton.
A I would like to answer that if I may. In working with Dr Barton I have always found her very compassionate; very open with patients and patients' relatives. She was a very caring doctor. Her patients concern and welfare, that was all she strove to achieve really, and I had no objections to working with her. I admire her as a doctor and I have certainly not had any reservations in any treatment that she has ordered me to give over the years, and also I have never ever heard her speak to a patient's relatives as Mr Lavender says she spoke to him. It just wasn't her way, I am afraid, I am sorry. She was always very professional.

MR JENKINS: So far as explaining matters to relatives were concerned, would the nursing staff have a role to play in explaining what was happening to the patients and what the expectation for the future might be?
A Yes. We always prided ourselves on trying to keeping the patient's relatives up-to-date to everyday occurrences, whether it was the fact that they had improved slightly or they might have deteriorated, how they were getting on with physiotherapy or occupational therapy. I like to think we had a good rapport with their patients and their relatives as to what was going on, and that applies to all staff, mainly trained staff, obviously.

Q And from your observation, what was Dr Barton's approach to speaking to relatives and explaining what treatment options there were and what may lie in store for the patient?
A If the patient's relative wanted to speak to Dr Barton she always made herself available. She would always go into great details, as I have said, as to the patient's condition, the prognosis, if there was going to be a syringe driver she would go through all of it, why it was being put up, what was being used and the outcome of it. She was always very open and honest with the relatives.

Q You say she would make herself available, that means she would come back to the hospital.
A Yes.

Q Just to see the relatives of a particular patient?
A Yes.

Q Later on in the case we will be dealing with medical records, and the amount of detail that was put into medical records by Dr Barton.
A Yes.

Q I just want to have from you your understanding of how busy Dr Barton was when she was at the War Memorial Hospital?
A She was extremely busy.

Q When Dr Barton came in in the morning, and you told us you would do a walk through ward round ---
A Yes.

Q What information would she be given about how the patients had been getting on since she had last seen them?

A Obviously, we would go by what the night nurses had reported, if there was any deterioration or any change that would have been passed on. Also the fact, like if the patient was in pain whether we should increase the dose of analgesia, say, in the syringe driver, or even just tablet form of analgesia, this would be discussed. Basically, it was just a carry on of what happened the day before, or she might say, "What happened?" if I had said on Tuesday about a patient, on Wednesday she would perhaps have said, "What happened?" or if she was put on medication, "What were the results of that?" It was an ongoing thing.

Q So you are providing as one of the nursing staff feedback to Dr Barton?
A Yes.

Q To assist the decisions as to what treatment the patient should be receiving?
A Of course, yes.

Q Again, since there are not doctors on the ward all the time it is essential the nurses are that conduit for that information?
A Yes.

Q You have told us that if Dr Barton was not there and you wanted to change the treatment or increase the medication you would phone up Dr Barton?
A Yes.

Q Would that be any time of day or night?
A Mostly during surgery hours and into the evening, yes. The surgery would always be able to get a message to her.

Q What you have told us is that it was agreed with the consultant, Dr Lord, and Dr Barton, that there would be cases where it was appropriate to prescribe medication in advance of the patient needing it, yes?
A Yes, and I was also asked was I happy with that regime, and I said yes, I was.

Q On a ward with no resident doctor, can nurses give diamorphine or morphine on their own and without any prescription?
A Not without prescription, no.

THE CORONER: (To the witness) The question was put to you, could you do it on your own ---

MR JENKINS: Without prescription. Sorry.

THE CORONER: Could you do it on your own or did you need to have a counter-signatory?
A I am sorry, I thought he said "without prescription", I was saying ---

THE CORONER: He said first of all "on your own, without prescription". You cannot do it without prescription ---
A No.

THE CORONER: Can you do it on your own?
A Yes, if it was written up we were able to give it – but we would always try and let Dr Barton of an increase.

THE CORONER: I go back to the question, would it be just one of you that would do it, or would there be more than one that would be attending the patient?
A There would be two of us would have to check it. Sorry, I didn't realise what you meant, no, two trained staff would have to check it.

THE CORONER: Thank you.

MR JENKINS: Again, coming back to giving medication: if the patient was to be given tablets for pain relief, or a syringe driver was set up, would it be nursing staff who were doing that?
A Two trained staff would have to check.

Q Not the doctor, the doctor prescribes.
A Yes.

Q But it is the nursing staff that administer the medication or give the patients the tablets if they are able to swallow?
A Yes, it is.

Q Perhaps it is obvious, but if you were dealing with a patient and what was prescribed for them you felt was inappropriate what would you do?
A Never have given it.

Q Would you contact the doctor?
A Yes, I would, yes.

Q Or the consultant?
A Yes.

THE CORONER: I am not sure ..(inaudible).. there does not seem to have been much contact with the consultant at all, apart from a fortnightly ward round.

MR JENKINS: Indeed. (To the witness) But if you had concerns that the prescribing was inappropriate by the clinical assistant Dr Barton you would not have given the medication?
A No.

Q If she had said, "Well I want it given" what would you have done?
A I'm afraid I would have refused.

Q Did the situation ever arise?
A No, never.

Q You have told us I think that you never had any concern about the medication that was provided for patients on your ward.
A No, never. None of my staff ever expressed any concern and can I add also that none of the relatives ever refused their relatives to have the ... I have never had any complaints at all from relatives.

Q I was asking you about prescribing in advance of the patient requiring that medication.
A Yes.

Q And you told it was agreed with Dr Lord and Dr Barton and you were content that that should happen.
A Yes.

Q Would that be usual in a hospital, for patients to be prescribed medication which they did not need?
A I have not come across it before, no.

Q Was it happening in this case because there was no doctor resident in the hospital, on the ward?
A Yes, that was the only reason.

THE CORONER: Can you just rationalise that slightly? You have not encountered it before.
A No.

Q It was done because of the staffing problems: had you had a discussion with Dr Barton as to why it was happening, why it was happening, or was it just a practice that you went into?
A I think it was – it was discussed and if I can remember rightly, on the ward round it was discussed with Dr Barton, Dr Lord and myself and that was the only way we could see round keeping the patients pain free on a regular basis.

Q But it was something that had been explored; it was the subject of discussion? It was not just one of those things that happened?
A No, no, definitely no. Sorry, I didn't quite understand what you ... No, definitely not. It was very fully discussed actually, if I can remember rightly.

MR JENKINS: If that had not happened and a patient for whom there was no prescription in advance was experiencing severe pain, how would they be treated?
A I would just have to rely on one of the partners being able to be, for want of a better word, talked round into relieving the patient of pain. You just couldn't have your patients in pain all the time.

Q Do you need a doctor to come into the hospital?
A Yes.

Q So you would need, one, to wait for a doctor to come in if they agreed to do so.
A Yes.

Q It may be some time before Dr Barton could get in?
A Yes.

Q What is it like to have a patient in pain, severe pain, which is not treated?
A It's not very nice and it's even worse for the relatives.

Q If there was, let us say, a syringe driver with a particular range of medication prescribed, would it always be that the syringe driver was instituted, it was used there and then?
A Not always there and then, no. It was just that if was there if we needed it.

Q Let us come back to patients who were admitted to the ward. Let us say it is a patient where the relatives have been told that the patient has come from the Haslar for rehabilitation.
A Yes.

Q And the patient is not suitable for rehabilitation: in your experience, could the process of moving an elderly or unwell patient lead to a deterioration in their condition?
A Very much so.

Q Very much so?
A Yes.

Q By deterioration in their condition what do we mean?
A Just – I do not know quite how to describe that – they could be in pain; they could be agitated; they could be frightened, and that is what a lot of it was, it was fear.

Q So might it be occasionally, or even regularly, the case that patients would be transferred into the Daedalus Ward who did not have sufficient pain relief ---
A Yes.

Q --- for the symptoms of the condition they were then presenting with?
A Yes, that did happen, yes.

Q Is it right that on occasions patients would be transferred to you and you did not have any medical records?
A Occasionally, yes, we didn't always get a follow-up for patients.

THE CORONER: Did you not get a discharge summary from QA or Haslar or wherever they had come from?
A Sometimes we didn't, sometimes – not very often but sometimes – it did happen, or if we did it wasn't a very large one so to speak, very basic.

MR JENKINS: Did you sometimes get the patient first and the notes some time later?
A Occasionally that has happened, yes.

Q Did it happen occasionally that there would be more than one family member, relative of a patient, who wanted to be involved in the decisions about a patient?
A Yes.

Q Did it happen on occasion that there might be different views amongst the relatives as to what should happen to the patient?
A Yes.

Q Did that sometimes cause difficulties?
A I have come across it, yes.

Q Perhaps in one case where one relative was named as the contact and another relative was named as the next of kin?
A Yes.

Q Was that the sort of thing that might happen?
A Yes.

Q And where both of those individuals wanted to have input as to the decisions for their relative?
A Yes.

THE CORONER: In this case are we talking about patients who are not able to speak for themselves or are you looking at patients who are part of the consultation process?
A Both, yes.

Q So it may well be that you have got relatives arguing over a patient that is with us and compos mentis?
A Yes.

MR JENKINS: Was that easy for the patient themselves to deal with?
A No.

Q Two relatives perhaps expressing different views as to where their best interests lay?
A It could be very upsetting for the patients at times, yes.

Q Let us come back to changes in the regime of treatment for a patient: if the treatment had been prescribed by Dr Barton but not yet instituted, and the patient was not doing well on the treatment that was presently being provided and you had a view about changing the treatment you would contact Dr Barton, is what you have told us?
A Yes, definitely.

Q Again, if it was a syringe driver and what had been prescribed was a very wide range of diamorphine, say, if the syringe driver was instituted, would it normally be instituted at the lowest level of the prescription?
A Yes, we always started with the minimal dose.

Q If the patient's pain was not being controlled on that would the nurses increase the dose without further recourse to Dr Barton or would they speak to her?
A If it was necessary we always used to try and go through and let Dr Barton know but it was not just one trained nurse's opinion, it would be discussed, like me and my senior staff nurse we would discuss it, and because it was written up on the treatment chart we were legally able to give it, but we always tried to let Dr Barton know, if it had not been discussed at the ward round in the morning.

Q Of course. I want to ask you about Mrs Lavender now, and I want you to have a document you refer to in your statement, and you have read a passage for us. For those who have it, it is page 153 of 228. I do not know if you have that?
A I have got my statement.

Q I will give you a copy of the page, if I may. (Same handed) This is a nursing document I think, it is a summary and it is said to be a "Summary of Significant Events", do you have that?
A Yes. Is it the one dated 25 February?

Q That is the first date, 25 February.
A Yes, that's my writing.

Q I think the jury have this on their large A3 sheet, and what I am going to suggest, Mrs Joines, is that this patient had been admitted to the War Memorial Hospital a few days before, on 22 February, all right?
A Yes.

Q So here we are on 25 February some way into Mrs Lavender's stay at the War Memorial Hospital. I think there is an entry in your writing for the evening of 25 February, which reads as follows: "Appears to be in more pain, screaming 'my back' when moved but uncomplaining when not"?
A Yes.

Q "Son would like to see Dr Barton".
A Yes.

Q If the son said he wanted to see Dr Barton she would have to be notified so that, effectively, an appointment could be made for her to come back into the hospital so that they could have a discussion?
A Yes.

Q On 26 February, the next day, and this is your entry: "Seen by Dr Barton. MST" – meaning morphine sulphate tablets ...
A Yes.

Q "... increased to 20mgs" is that?
A Written up for 20mg BD, twice a day.

Q Thank you. "She will see Mr Lavender at 14.00 hours this afternoon."
A Yes.

THE CORONER: (Phone interruption) Sorry, can we stop there.

MALE VOICE: Sorry.

THE CORONER: If you have got a bucket of water, would you toss it into it, please?

MALE VOICE: Sorry.

THE CORONER: Sorry Mr Jenkins, do go on. It normally costs you £20 in this court, do you know that?

MALE VOICE: Sorry, I was given this today and I've no idea how it works. My apologies for my ignorance.

MR JENKINS: Can I suggest it is given back? (To the witness) So, 26 February, seen by Dr Barton, morphine sulphate tablets, 20 mgs: "She will see Mr Lavender at 14.00 hours this afternoon". Have you written, "I did phone him"?
A Yes.

Q Meaning the son to tell him ---
A To tell him that Dr Barton would see him at 2 o'clock that afternoon, yes.

Q There is reference to blood sugars and the level those were at, "Insulin dosage increased", yes?
A Yes.

Q "14.30 hours" – in other words, after the discussion with Dr Barton, Mr Lavender and his wife ...
A Yes.

Q "Son and wife seen by Dr Barton: prognosis discussed."
A Yes.

Q "Son is happy for us to just make Mrs Lavender comfortable and pain free. Syringe driver explained".
A Yes.

Q We know that the syringe driver was not brought into use for another week ---
A No.

Q --- 5 March. There are then other entries that day and following days. There is reference on 29 February to Mrs Lavender's blood sugars and Dr Barton contacted, I think that is by a different nurse, Nurse Couchman?
A Yes, she was one of my trained nurses. Mrs Lavender was a rather unstable diabetic and we used to have to do blood sugars regularly and according to what they were would be what dosage of insulin was given.

Q I think there is an entry for 4 March 1996, "Patient complaining of pain and having extra analgesia", that is pain relieving drugs, "PRN", meaning as required.
A Yes.

Q "Oramorph sustained release tablets dose increased to 30mg twice a day by Dr Barton."
A Yes.

Q Oramorph is oral morphine.
A Yes.

Q "Sustained release" means that the drug takes effect gradually, it is not just one dose?
A No, you would give them BD and therefore the effect would last until the second dose.

Q I think "BD" is Latin and means twice a day.

A Yes, sorry.

Q That is all right, you are telling us what the note says. So Dr Barton there on 4 March was increasing the dose of oral morphine tablets?
A Yes.

Q I think the next entry, again from one of your nurses, the next day, 5 March 1996: "Patient's pain uncontrolled: very poor night. Syringe driver commenced" and there is an indication of the levels of medication that were being provided.
A Yes.

Q "Son contacted by telephone; situation explained".
A Yes. We would always inform the relatives when we were about to set up a syringe driver. We never did it without the relatives knowing.

Q Again, perhaps it is obvious, Mrs Joines, but if a syringe driver was started, in your view, was it appropriate for that patient to receive medication by syringe driver?
A Yes.

Q And the medication that was being provided was appropriate?
A Yes.

MR JENKINS: Thank you very much, Mrs Joines.

THE CORONER: Could you let the jury have a look at that, so the jury can see what the notes look like and to see what we are talking about.

MR JENKINS: I have one with yellow highlights but if there is no objection to that I will hand it in. (Same handed).

THE CORONER: (To the jury) Just so you know what it looks like to see if you have any questions about that.

Mr Lavender, is there anything from that that you want to comment on, what Mrs Joines has told us?

MR LAVENDER: Not really, just to say what I said when I was in the witness box that my point is valid, that there are alternative ways to a syringe driver to relieve pain and the point was made that only if the patient was able to eat or to swallow tablets, and it's been established then exactly what was going on, therefore the syringe driver came in a lot later than when the first drugs were administered. Making the patient comfortable doesn't necessarily mean with the syringe.

THE WITNESS: Am I allowed to answer?

THE CORONER: Yes, of course you are, that is the point of this.

THE WITNESS: Mr Lavender, I was there a lot of times when Dr Barton saw relatives and discussed and if ever a syringe driver was discussed she would always explain why the syringe driver was being put up.

MR LAVENDER: But it wasn't put up then, was it?

THE WITNESS: No, but she would always explain – I am trying to say, when it was going to be used at a later date, she would always explain why it was being used or why it would be used, what medication was put in it and also she would let you know what would happen when the patients were put on a syringe driver, so as far as I'm concerned all the patients that were seen by Dr Barton were fully aware of the why, whens and – you know, I don't understand, I am sorry, because I was there, and ---

THE CORONER: I think the point is the one Mr Jenkins took last or almost last, that the discussion took place on 26 February but the syringe driver was not actually implemented until 5 March.

THE WITNESS: Yes.

THE CORONER: So to say the conversation happened on 5 March is not right, it happened on 26 February, according to the notes.

THE WITNESS: Yes, but what I'm saying is it was always explained fully, that the patient's relatives were never left in any doubt as to why and what for: I'm sorry.

THE CORONER: Do not apologise. Is there anything arising from that? (No replies) So no question for Mrs Joines. Right, thank you very much, I am grateful to you. You are now released.

(The witness withdrew)

MR WILSON: Excuse me sir.

THE CORONER: Yes.

MR WILSON: Do I get a chance to ...

THE CORONER: Is Mrs Lavender anything to do with you?

MR WILSON: It is to do with the nursing staff.

THE CORONER: What is your question?

MR WILSON: I have got a few actually, to do with syringe drivers and this lady's dealings with them.

THE CORONER: Mrs Joines is dealing with Mrs Lavender, and she was giving evidence with regard to Mrs Lavender. If you have an interest with regard to Mrs Lavender then that is a point I will listen to. What I do not want to do is to get our deaths confused.

MR WILSON: Mr Jenkins spent a good 20 minutes/25 minutes talking about general hospital dealings and then he actually went on and said, "Now I'm going to talk to you about Mrs Lavender", surely the rest of us can ---

THE CORONER: If you want to deal with general hospital dealings ... I do not want you to pick up Mrs Lavender, that is what I do not want you to do.

MR WILSON: No, I want ask some ---

THE CORONER: (To the jury) This gentleman is Mr Wilson, and he is the son of Mr Wilson who appears on your sheet. The point that he is making is that he has got general questions he wants to put to Mrs Joines. Are you happy to do that?

THE WITNESS: If I have to.

THE CORONER: Yes.

THE WITNESS: I am not entirely happy but I will.

THE CORONER: Come and talk to us again.

(Witness recalled)

THE CORONER: (To Mr Wilson) If I think any of your questions are irrelevant I will stop them, okay?

MR WILSON: Yes, sure.

THE CORONER: It has got to be general hospital practice we are dealing with.

MR WILSON: (To the witness) First of all, you talked about rehabilitation and long term beds on the ward you were in.
A Yes.

Q Can you explain the term "long term beds" to us?
A I am not quite sure what term they use now but when I was doing it it was what they called "geriatric nursing", I don't know what they ...

THE CORONER: It is still geriatrics as far as I know.
A It is but it was deemed to not be very appropriate so it was long stay beds, so these would be patients who were unable to be looked after at home so they would come into us, sometimes if the relatives couldn't cope they would come into us, and we also did respite care, which was when patients' relatives needed a break, so we would sometimes admit them to the beds on the ward for maybe a week or two weeks, just to give the relatives ... but that is basically what it was.

MR WILSON: So they were not palliative care beds?
A Some of them could be termed "palliative care".

Q Either they are rehabilitation or long term ---
A Well, we would get patients who came in whose condition deteriorated, therefore they were terminally ill.

MR JENKINS: Forgive me for interrupting: I do not mean to interrupt Mr Wilson, but Mr Wilson senior was a patient on Dryad Ward and I think there may be distinctions to be drawn between the two.

MR WILSON: That is one of the reasons I wanted to ask about that particular point.

MR JENKINS: Of course but I wanted us not to misunderstand.

MR WILSON: (To the witness) Can you explain the difference between rehabilitation and palliative care?
A Well rehabilitation would be to try and get the patient to a degree that they could either go home or be transferred into a nursing home/rest home. Palliative care was basically when the patients were brought into us, they were dying and therefore we would treat them appropriately and we did a lot ... In the old hospital, on the male ward, we did a lot of palliative care, terminal nursing of cancer patients, and sometimes medical patients and we took a lot of pride in our care of those patients too.

Q You stated in a previous police statement and earlier on this morning that it was yourself, Dr Lord and Dr Barton that decided that pre-prescribing drugs ..(inaudible).. would happen, yes?
A Yes.

Q I think you said it was agreed while you were with Dr Lord and Dr Barton?
A Yes, on a ward round.

Q On a ward round?
A Yes.

Q Prior to this you are saying this was not the hospital practice?
A No.

Q You are also saying that the prescriptions were written up immediately the patients were admitted?
A No.

Q If I take you back to your statement ---
A I might have said in my statement that – I am afraid I have made several amendments to that police statement.

MR WILSON: Yes, but this is the evidence that has been given ..(inaudible).. and in this statement it says ---

THE CORONER: Sorry, this is what?

MR WILSON: As the patients were admitted.

THE CORONER: What did you say, I did not hear?

MR WILSON: I am saying that in the statement that has been given to us as part of the evidence ---

THE CORONER: No, the evidence is what Mrs Joines has told us this morning.

MR WILSON: Why have I been given this as evidence then?

THE CORONER: Because it is advanced disclosure. It was given to you to inform you of what evidence was likely to be given at the hearing. Those statements do not form any part of the evidence that is given to the jury, and it is they who will make the decision. They will make their decision on the oral evidence that they have heard, unless the statements are admitted under rule 37.

MR WILSON: Okay.

THE CORONER: It goes to not having a chap on the front row. It is not criticism but that is what it is, that is how it is organised. The documents that were given to you in the three lever arch files were to make sure you were informed for this hearing.

MR WILSON: (To the witness) So when were these prescriptions written up then?
A If it was deemed feasible they would be written up on admission, but this was not a regular case: that is what I am trying to say. It was only after discussion. If they thought the patients might be needing them, yes, they were written up beforehand, and that could be on admission; not always but could be.

Q It could be on admission?
A Yes.

Q Thank you. You also stated that the reason for pre-prescribing was that as a patient became more in pain, distressed, and I think you said "agitated", if Dr Barton was not available then you would go to one of Dr Barton's partners?
A Yes.

Q And I think your words were you tried to "talk them into" ...
A No, that is what I said after, but basically we would ask one of the partners to come in but sometimes they were reluctant, not having known the patient or the history, to prescribe analgesia.

MR WILSON: It would not have been that the reason they were unwilling was because the notes ---

THE CORONER: No, she definitely cannot answer that question.

MR WILSON: Okay, sorry about that, I will take that one back. (To the witness) You stated that pre-prescribing was the exception and not the general rule.
A Yes.

Q How many patients were the exception?
A I do not think I could comment on that, I'm sorry.

Q A rough guess, one to five? In the last, say, three years that you were at the War Memorial Hospital?

A I don't think I could, I'm sorry, I don't think I could quite honestly say.

MR WILSON: Okay. Dr Barton's partners you said weren't happy with the pre-prescribing?

THE CORONER: That is not what she said at all, what she said was they may not be happy to prescribe if they were brought into the hospital because they don't know the patient; they are not aware of the history. There was no question of her partners pre-prescribing or prior to this prescribing. (To the witness) You were quite specific about that: I have not misunderstood that have I?
A No.

THE CORONER: If the partners were called in in place of Dr Barton they would not be happy to prescribe because they didn't know the patient or have the history.

MR WILSON: Well that takes me back to the bit you just stopped me from: if the notes had been up together then I am wondering whether the doctors would be more happy to have given the patients ---

THE CORONER: The difficulty is ---

MR WILSON: ..(inaudible).. they need and then there would not have been the need ---

THE CORONER: --- question, that is the difficulty: "Tell me what the doctor was thinking", no she can't do that.

MR WILSON: No? Okay, fine. Can you recall if any of the partners were actually against it?
A No.

Q What was Dr Peters' view?
A I don't think I've ever asked Dr Peters his view. I've never asked any of the doctors their view. I am just saying that some of the doctors were not keen to write up for the stronger of any analgesic without knowing the patient's history: that was understandable as far as I am concerned.

Q You said if Dr Barton was not available, i.e. on leave or away on holiday or anything, you would then ring her partners at the practice.
A Yes.

Q Were there any doctors you would avoid ringing ---
A No.

MR WILSON: --- or any doctors that you would prefer to speak to?

THE CORONER: I am not even going to ask the purpose of that question.

MR WILSON: I would have thought it was fairly obvious. I wanted to know whether there were any doctors who were actually against ---

THE CORONER: Do you feel that is helpful to the jury, because let me tell you it isn't.

MR WILSON: Okay.

THE WITNESS: Can I just answer? Mr Wilson, what drugs is he now talking about that the doctors won't prescribe? I'm talking about analgesia. I am not talking about syringe drivers, Oramorph or morphine.

B MR WILSON: No, I am talking about analgesics. I am talking about pain killers.

THE WITNESS: Yes, that is all I wanted to know.

MR WILSON: You said that sometimes patients were transferred and the relatives had unrealistic views as to what they were going ... and previous medical records quite often didn't turn up.

C A It did happen, it wasn't ---

THE CORONER: The word she used with me was "occasionally".

MR WILSON: All right, occasionally did not turn up: how many occasions would you say?

A Very few.

D Q Very, very few?

A Very few, but it did happen, yes.

Q What grade nurse were you?

A I think I was G.

Q Grade G?

E A Yes.

Q That was when you left in 1997?

A Yes.

MR WILSON: Thank you very much.

F THE CORONER: Are there any more questions?

MISS REEVES: I have a few questions with regards the general points.

THE CORONER: Yes.

G Code A Just with regards to the writing up of the analgesics, whether it be on admission or prior to the actual requirement of them you mentioned that usually what would be written up as a tablet form and then if patients were not able to swallow then it would be moved on to the use of a syringe driver, is that correct?

A Yes.

Q So if a patient was able to swallow, that would not happen?

H A No, they would be given tablet form.

Q They would be given tablet form?
A Yes.

Code A I think that was one of the points, sir, that Mr Lavender was trying to make, this his mother could actually swallow and was taking food but was placed on a syringe driver. I am not sure if that ---

B THE CORONER: You want to make this address to Mr Lavender, do you?

Code A I was personally confused and I did not want the jury also to be.

THE CORONER: I took the point.

Code A (To the witness) With regards to prescribing the analgesia you mentioned
C that if it hadn't been written up prior to its need then a patient may suffer, should they fall into chronic pain, a period of time whilst we waited, or a patient waited for either Dr Barton or one of her partners to return to the Gosport War Memorial Hospital?
A Yes.

Q So, Dr Barton or her partners were unable to prescribe over the telephone, is that correct?
D A They could, unless it was more of the controlled drugs.

Q So in fact if a patient was in pain the prescription could be given over the telephone or, say, a tablet form of Oramorph?
A No.

Q No? So what form of pain relief could be prescribed over the telephone, just so we
E understand?
A Anything like paracetamol.

Q Co-codeine?
A No.

Q You mentioned also that any dosages that you felt were of a high level you would
F have questioned.
A If I thought that, yes.

THE CORONER: This lady would have questioned.

Code A Yes, I know.

G THE CORONER: It would not generally have been questioned without putting it to each person.

Code A Yes, I understand. (To the witness) So you would have, certainly in any case you had been involved with or witnessed at the hospital, that if the prescriptions were inside the Wessex guidelines, which were, as I understand it, the palliative care programme that was being followed, if they fell outside that they would have been questioned?
H A Yes.

Q You personally would have questioned them at least?
A Yes.

Q Also you mentioned that the prescriptions which were written up by Dr Barton for the analgesics would have always been started on the most minimal dose?
A Yes.

Q That is correct, so in your opinion if a minimal dose starting had been written up that is the dose that the nurses would have taken?
A Yes.

Q Lastly, with regards the transfer for rehabilitation and the moving of the patients from a rehabilitation bed to a long stay bed: at the point that decision was made would it have been practice to have informed the families that their relatives were no longer in the Gosport War Memorial for rehabilitation but rather had been moved to one of these long stay ---
A Oh yes because it would have been discussed with the family, whether they were suitable to go into a long stay bed or maybe be transferred into a rest home/nursing home, the families would have known about it, yes.

Code A Thank you very much.

MR JENKINS: Can I just clarify one thing out of that?

THE CORONER: Yes.

MR JENKINS: (To the witness) With regards to Mrs Lavender, we know that at one time she was prescribed morphine sulphate tablets.
A Yes.

Q Which is a kind of morphine, quite plainly?
A Yes, it is.

Q We know that at a different time Mrs Lavender was given Oramorph, oral morphine.
A Yes.

Q Which is a different formulation ---
A It is a derivative, yes.

Q A week after the syringe driver was prescribed she was administered diamorphine by syringe driver.
A Yes.

Q Which is a different formulation of morphine.
A Yes.

Q If someone has been on one form of morphine and is changed to another form of morphine, and then a third type of morphine, diamorphine was given, have they built up a tolerance to morphine?
A They could do.

Q So in the case of Mrs Lavender, if a range for the syringe driver was prescribed a week before it was used, and within that week Mrs Lavender was given different types of morphine at different and increasing strengths to deal with her pain ---
A Yes.

Q --- and finally the syringe driver is brought in because it is needed, might the level of diamorphine being given fall above the bottom of the range that had been prescribed a week before? You are saying yes?
A Yes.

MR JENKINS: Thank you very much.

THE CORONER: Mr Farthing.

MR FARTHNG: One general question. I would just like to ask the Sister, what would you expect the effect to be on a normal person of receiving 10mg of Oramorph?
A In what way do you mean?

Q How would it affect their behaviour?
A Well basically it would hopefully relieve the pain; it might make the patient drowsy, but other than that a small dose of morphine, in my opinion, and I do not think it ..(inaudible).. it all depends what their condition was ---

Q For the first time.
A --- when they were given it.

MR FARTHING: How long would it take to have an effect?

THE CORONER: Are you asking the right person? (To the witness) Can you answer that?

MR FARTHING: I am asking an experienced nurse, I hope she could answer?
A I would say within half an hour to an hour.

Q And it would last for whatever?
A Usually it would last for up to four hours.

MR FARTHING: Thank you.

THE CORONER: That was Mr Farthing, who was Mr Cunningham's step-son and Code A
Code A

Code A

THE CORONER: Code A of Mrs Devine.

THE CORONER: Mr Wilson is at the back and – I should know who you are.

MRS LAKE: Ruby Lake.

THE CORONER: Ruby Lake is the daughter.

MR JENKINS: And my name is Jenkins.

THE CORONER: Thank you very much indeed. I am very grateful to you, and I can now release you.

(The witness withdrew)

THE CORONER: I am now going on to some rule 37 statements but I think we will do that after lunch. On the grounds we have not had a break, do you want to finish now and start again at 2.00?

MR JENKINS: Yes, please.

THE CORONER: Okay, we will go straight into the rule 37s after lunch.

(Luncheon adjournment)

THE CORONER: Good afternoon. Would you look at the witness schedule, which the usher is going to copy, and let me have any comments you have on that before we finish.

MR JENKINS: Thank you, sir.

(The jury entered hearing room)

THE CORONER: You will remember I spoke about rule 37? Our entire afternoon will be spent with me talking to you. I am sorry about that.

The first witness is Rosemary Alison Bailey. Her statement is dated 3 June 2005. She says she is a practising general practitioner at the Fleet Medical Centre, Fleet, and she has been so employed since April 2004.

I should tell you, this is as much evidence as anything else you hear so if there is anything you want to write down please do:

> "As a GP I qualified as a BM, Bachelor of Medicine. I obtained this qualification in 1992. In 1995 I obtained a Diploma in Obstetrics and Gynaecology. In 1996 I obtained a Diploma in Family Planning, and in 1997 I obtained Membership of the Royal College of General Practice."

She then tells me what her registration number is with the General Medical Council:

> "From January 2000 until April 2004 I was employed as a half-time GP partner at Ravenbrook Surgery, Shirley, Southampton. I have been a part-time GP locum at various other surgeries. In May 2001 I was employed as a part-time honorary clinical research Fellow by Southampton University, working on a study called Southampton Women's Survey. From March 1997 until December 1999 I was employed as a full-time locum GP in the Southampton area. From March 1996 until March 1997 I was a GP registrar in Milford on Sea, Lymington. Between February 1996 and March 1996

I undertook a six week elective in dermatology, ENT (ear, nose and throat) ophthalmology and community paediatrics in Portsmouth. From September 1995 until February 1996 I was employed as a locum registrar in psycho-geriatrics at Gosport War Memorial Hospital under Dr V Banks. Between February 1995 and August 1995 I was a senior house officer in elderly medicine at Southampton General Hospital under Professor Briggs, Dr Eastwood and Dr Turner. From August 1994 until February 1995, I was employed as a senior house officer in obstetrics and gynaecology at the Princess Anne Hospital, Southampton under Mr G Massingham and Mr N Saunders.

Between February 1994 and August 1994, I was a senior house officer in the accident and emergency department in North Hampshire Hospital, Basingstoke under Dr Elgin. For a six months period between August 1993 and February 1994, I spent travelling and locuming as a house officer. From February 1993 until August 1993 I was employed as a house officer in general surgery and orthopaedic surgery at the Royal Hampshire County Hospital Winchester under Mr Gartel and Mr Trivett.

Between August 1992 and February 1993 I was a house officer in elderly medicine and general and chest medicine at St Mary's Hospital, Portsmouth, under Dr Lord and Dr Grunstein and then Dr Neville.

I have been asked to detail my involvement with a patient, Leslie Pittock. In 1995, I was a locum registrar to Dr Banks. I was in effect a senior house officer because I had no previous experience of working in psychiatry, so was supervised very closely.

Mulberry A Ward was at that time a psycho-geriatric ward for elderly people with psychiatric problems. The late Mr Pittock, born on Code A had previously been admitted to Mulberry A Ward in September 1995. Following Mr Pittock's discharge from Mulberry A Ward on 24 October, I wrote a discharge letter on 8 November 1995 to his GP Dr Ashbridge. This letter detailed his diagnosis, treatment and progress whilst a patient on the ward:

> 'Dear Dr Ashbridge,
>
> Re Leslie Pittock: born Code A, Haseldene Rest Home, Bury Road, Gosport, date of admission 14 September 1995, date of discharge 24 October 1995, diagnosis depression'."

MR JENKINS: Sir, forgive me, you are reading a statement and I think from your list you are going to read a lot of other statements this afternoon about Mr Pittock.

THE CORONER: Yes.

MR JENKINS: I know that when you originally wrote your list the first witness you were going to deal with was a relative of Mr Pittock, and you then had to re-jig your list to deal with the availability of that witness.

THE CORONER: That is what has done it, is it not?

MR JENKINS: What you were anticipating was that you would read a number of statements dealing with Mrs Lavender, and you have those on the list that we were given yesterday and you were scheduled to read them tomorrow afternoon, but it might be ---

THE CORONER: More sensible to read them this afternoon.

MR JENKINS: I am sure that was your intention but you did not re-jig the list once you had crossed out the name of Marion Wiles.

THE CORONER: Can I look at mine again, because I will need to put that together. That is Peters and Taylor?

MR TOWNSEND: Yes, it is on the wrong day, yes.

THE CORONER: I am sorry about this.

MR JENKINS: Again you have started off with Pittock and were clearly planning to read statements to be read dealing with Mr Pittock and things have had to be rejigged. You might prefer to read the four statements dealing with Elsie Lavender.

THE CORONER: Peters and Taylor. Thank you very much for that. I will now deal with these statements. Thank you very much, Mr Jenkins.

Yvonne Anne Astridge, Clinical Manager at Gosport War Memorial Hospital, had 25 years experience in the nursing profession:

> "I began my training in 1979 at the Nightingale School of Nursing at St Thomas's Hospital, London: qualified as a registered general nurse in 1981.
>
> In 1981 I was employed as a staff nurse at St Thomas's Hospital London, where I worked on a night pool for three months, and for the next three months on an elderly care ward.
>
> From 1985 to 1986 I worked at the Royal Free Hospital in London as a staff nurse on the medical ward; from 1982 to 1984 I worked at Abingdon Hospital as a staff nurse on the GP ward, the maternity annexe.
>
> From 1986 to 1987 I worked as a general nurse in a nursing home where, when on duty, I was in charge of the nursing home, its staff and the care given to the elderly clients. I was also responsible for the recruitment of staff.
>
> From 1997 to 1998 I was employed as a staff and senior staff nurse at Gosport War Memorial Hospital, where I assisted the clinical manager/ward sister in the administration of the department and took an active role in the development of nursing practice, where I was involved in the rehabilitation of stroke patients and I ran an NVQ group to help other nurses study for NVQ qualifications.
>
> From 1998 until 2004 I worked at St Christopher's Hospital in Fareham, on Rosborough Ward and latterly Shannon Ward, this was a hospital for the elderly.

I recently returned to Gosport War Memorial Hospital where I am currently employed as the Clinical Manager on Dryad Ward. I am an extremely experienced nurse, having kept up-to-date with all of my courses, including stroke handling and positioning, critical companionship, stroke rehabilitation, safe movement and handling of loads, care of the elderly and social services guidelines for the placement of patients. I am also the holder of a City & Guilds certificate in further and adult education, and a further City & Guilds qualification for assessing a candidate's performance and assessing candidates using diverse evidence. I also hold an English National Board qualification in the care of the elderly.

In 1996 I was the senior staff nurse on Daedalus Ward at Gosport War Memorial Hospital, where I would run the ward in the absence of the ward manager, although my primary role was that of patient care. At that time my line manager was Shelagh Joines" – from whom you heard this morning – "I had training in the use of IV drugs" – that is intravenous drugs – "but last used them in London in the 1980s. I have not given IV drugs in Hampshire.

The term 'Wessex protocol' refers to the palliative care book used for guidance in what drugs are to be used in that care. I believe these guidelines were used at the Gosport War Memorial Hospital.

Before 1996 I think it was I had training in the use of setting up syringe drivers. This driving would have been purely sessions on the ward. I believe the brand of syringe driver used at that time was Grasby, and in fact I am sure they are still used today. There was formal training in the use of syringe drivers but I am unsure if this was before 1996. I have also been on syringe drivers refresher courses at Queen Alexandra Hospital.

The named nurse is the nurse responsible for overseeing the care of the patients in broad terms. That named nurse does not actually need to do it."

Have you got that, there is a named nurse who is nominally responsible although she is not just the working with that patient; she is a general nurse on the ward.

"My working hours in 1996 were 37½ hours per week and my tour of duty would have been 07.30 to 16.15 for two days, 07.30 to 13.30 for one day and then 12.15 to 20.30 for two days.

I have been asked to detail my involvement in the care and treatment of Elsie Hester Lavender. I can say that I have no recollection of this patient but after reference to her medical notes I can confirm that on 27 February 1996 I was shown as the named nurse in the nursing care plan for Elsie Lavender, which states that the problem, 'The patient has painful shoulders and upper arms. The desired outcome is to relieve pain and make Elsie more comfortable. The desired action is, position patient for comfort. Elsie can lift her arms if given time, dependent on pain. Administer analgesia as prescribed and monitor effectiveness.' I have no recollection of this document. On looking at this care plan, however, I would say that the nursing action in relation to drugs is satisfactory.

I can confirm that on page 97 of the nursing care plan, dated 2 March, it is written, 'Slight pain in shoulders when moved'. This is signed Y Astridge and J Moss. This is neither my writing nor my signature. It was policy at that time that a healthcare support worker should have any entry counter signed or a trained member of staff could sign an entry. I rather feel that Jean Moss, the healthcare support worker, signed this entry. The account given should and would be in order.

I can confirm that on page 99 of the notes, dated 22 February, the following is written in the nursing care plan: 'The problem, restricted mobility. The desired outcome, to increase mobility and encourage independence. The nursing action, to assist Elsie to transfer from bed to chair with two nurses. Refer to physiotherapists.' I did not start this care plan. My name is at the top, which means that I am the named nurse, not that I wrote the entry. This is not my writing, nor do I recognise whose it is. I would add that if it is painful for the patient to get up then they remain in bed. The patient has the final say if they get up or not.

I can confirm pages 103 and 105 of the notes are the nursing care plan from 22 February 1996 and reads: 'The problem: unable to care for her hygiene needs unaided. The desired outcome: to promote an adequate level of hygiene. The nursing action: assist to wash and dress daily. Offer a bath regularly. Ensure hair, teeth and nails are care for. Encourage independence where possible.' This entry at page 103 is written by me but page 105, which is a continuation for page 103, is not. I would add that patients are asked if they can wash and clean their teeth, if not this should be done with assistance from a nurse.

A 'care plan' means a plan of how to address a problem which the patient has. If there is no problem them there is no care plan. In general, there is a specific care plan for every problem.

Page 107, dated the same day, is another nursing care plan, with the named nurse SSN Y Astridge. This is not in my writing and states: 'Problem: leg ulcer on right leg and dry skin. Desired outcome: to aid healing. Nursing action: dress alternate days with catastat soaked in N saline. Cover with NA dressing and 9x9 bandage. Apply emulsifying ointment to both legs'. Even though I am the named nurse I would not necessarily issue such instructions. 'N saline' means normal saline.

Page 109 dated the same day is a continuation of page107, regarding leg ulcers. Again this is not in my writing. Staff would interact with a patient by asking such questions as were necessary and recording such in the notes.

In 1996 it was common practice to 'ditto' entries if those were unchanged. It is not, however the practice now.

I can confirm that on pages 111 and 113 of the nursing care plan, dated 22 February, I am shown as the named nurse. It is not my writing. Following is written: 'Problem: indwelling urinary catheter', this means pertaining to a tube left within the organ for draining. 'Potential problems are, (a) trauma, (b) infection, (c) retention of urine. Desired outcome: to minimise the risk of trauma, infection and retention of urine. Nursing action: catheter care to be carried out daily. Monitor urine output and report. Test urine if infection suspected. Secure tube of catheter to leg to minimise trauma.'

This is what I would call a 'bog standard' care plan to assist the patient for the toilet. A catheter would be inserted if the patient had retention of urine in the main. The permission of the patient is required to pass a catheter or if that patient is incapable then a medical decision would be necessary. For the catheter to work correctly it should be clean and in working order. If the patient is in retention with a large amount of urine in the bladder then in turn it could cause back pressure on the kidneys. Of course, once the patient is better the catheter would be removed.

I can confirm that pages 115 and 117, dated 21 February 1996 are the nursing care plan for Elsie Lavender. Again I am shown as the named nurse; again it is not in my writing, and the following is written: 'Problem: red and broken sacrum. Desired outcome: to heal. Evaluate daily. Spray minute broken area with Betadine. Nursing action, 24 February 1996, Broken area sprayed with Betadine' and signed by a nurse. The other areas are signed by other medical staff and not by me. Betadine is an iodine spray which kills bacteria. It was a standard pressure sore treatment but it is not used in the same way now.

I have reviewed the rest of the entries and it would appear that apart from the spray iodine dressings were also used.

From viewing the notes I can see that on admission her sacrum was red. She was overweight, immobile and not able to get out of bed.

On 27 February the area was blackened and that is bad news for the sacrum. The sacrum is the triangular bone just below the lumbar vertebrae. I can confirm that on page 119 of the notes, dated 1 March 1996 to 6 March 1996, I am again shown as the named nurse. These entries are not in my writing, the following is written: 'Problem: Constipation due to medical problems. Desired outcome: monitor bowel action daily. Give a high fibre diet and plenty of fluids. Give suppositories or enemas as required. Nursing action: suppositories and enemas given, with little result and patient continues to leak faecal fluid'. These notes are written by other staff and not by me."

You may remember that that was referred to this morning, and I think Mr Jenkins referred to it specifically:

"From reviewing these notes I can see that the patient was not eating and drinking, therefore she was likely to be constipated. She was in pain and this would not encourage the bowels to open. The use of suppositories and enemas was a reasonable course of action. I can confirm that on page 121 of the notes, dated 22 February 1996, that a nursing care plan was started. These entries are not in my writing and I do not recognise whose it is. I can state that the following page 123 is linked to page 121. The following is written: 'Problem: requires assistance to settle for the night. Desired outcome: to ensure patient had adequate sleep. Nursing action: transfers to seat with assistance of two nurses'. On page 123 the entries range from 22 February to 3 March and appear to be a nightly record of her sleep pattern. It also shows analgesic given and records the medication was refused on 1 March. I also observe that there are blank spaces on 25 February, 27 February, 28 February and 29 February. It was the practice back then that if there was nothing to report then it would be left blank.

I can confirm that on page 137 of the notes, dated 5 and 6 March 1996, that this is a doctor's drug prescription written by Dr Barton. On 6 March, at 09.45 hours I gave the patient 100mg of diamorphine for pain relief and 400mg of Midazolam as a sedative. I can confirm that on page 151 of the notes, at 17.00 hours on 22 February this is an ambition summary and written by me. I am not sure though if I actually admitted the patient. The entry states: '83 year old lady; insulin dependent; registered blind, atrial fibulation' which is an irregular often rapid heartbeat, 'Had a probable brain stem CVA" – that is the stroke – "5 February. She now has problems with her grip in both hands and also experiences pain in arms and shoulders. She can transfer with two nurses" – I think that is from bed to chair, whatever – "Seen by Dr Barton; medication prescribed. Catheterised size selastic, trade mark for a substance similar to rubber, which drained 750 centilitres in the first hour. ? retention. General bath given and leg ulcer on right leg redressed. Area on left leg appears healed'. This entry is signed by me.

On 23 February 1996, I have written 'refer to physio'. FBC ESR Us and Es taken. This entry is signed by me. FBC means full blood count. ESR means check sedimentation speed of erythrocytes when spun."

We will not be doing that this afternoon.

" 'SB, Dr Barton, antibiotics prescribed for possible probable UTI'. This entry is signed by me. UTI means urinary tract infection. 'Transfer with two nurses' means the patient can be got out of bed and into a chair with a 90 degree turn with two nurses. SB means seen by a doctor and medication written up. Us and Es means urea creatinine and electrolytes and bloods taken. I can confirm that on page 153 of the notes of Elsie Lavender, dated 27 February 1996, I have written 'Bloods taken' which means blood samples were obtained from the patient. I have no idea why these were taken. It could be because of a spoiled previous sample or some other results were required or that the patient's condition had deteriorated. This would probably have been authorised by a doctor and a blood nurse would have taken the sample.

I can confirm that on page 167 of the notes, it is an abbreviated mental study dated 22 February, that I wrote the name 'Elsie Lavender' on the top of the page. This is a mental test score in which the patient scored 10 out of 10, which means this lady had all her marbles" – that is the technical term. "On page 169 of the notes, which is a Waterlow pressure sore prevention and treatment policy, dated 22 February 1996, I can confirm that I wrote the patient's name on the top of the page. This is what we call the Waterlow score, and details the patient's susceptibility to bed sores. This patient had a score of 21, which is very high and places that patient at a very high risk. A score of below 10 is okay. A score above 10 is a risk. A score above 15 is a high risk, and over 20 is, as I have said, a very high risk. If the patient's appetite is poor this just adds to the problem.

On page 171 of the notes, also dated 22 February 1996, which is the lifting, handling risk calculator, this patient scores 15, which means she was difficult to move. Any score above 10 means a specific care plan is needed.

On page 173 of the notes, which is a day bar basic nutritional assessment plan, the patient has scored a three, which is okay. A score above five means the patients

would need additional nutritional supplements. A score below five means that the patient would require reassessing regularly. This plan is no longer used.

I have been asked to comment if I had any issues regarding patient care at Gosport War Memorial Hospital. I would like to say that if I did have any concerns then I would not work at the hospital. It is a good hospital and the standard of care is excellent. The use of diamorphine was in my estimation an ideal way of making patients more comfortable and I had no problem with its use of syringe drivers in 1996."

Is there anything arising from that? (Nothing)

Next we have got Margaret Rose Couchman, and this is a statement she made on 15 December 2004:

"I have been in the nursing profession for over 25 years and am a fully trained registered general nurse. I trained at the Portsmouth School of Nursing in 1976. I worked at the Royal Hospital Portsmouth throughout the 1970s until it closed. My general experience is surgical, medical, children's nursing, private nursing and orthopaedic nursing. I then moved to the Queen Alexandra Hospital in Cosham, where I worked in the orthopaedic wards. I left the Queen Alexandra Hospital in 1980 when I went to work with autistic adolescents in Anglesey Lodge, Alvestoke.

In 1992 I started working at Gosport War Memorial Hospital. Initially I worked on the children's ward. At this time the hospital was carrying out minor ENT and orthopaedic operations. The NHS later closed down the children's ward and I moved on to the male ward dealing with the terminally ill, dermatology, GP unit, etc. A theatre was also closed down and changes were made to the wards. The male ward was turned into Daedalus Ward and we took on elderly services. I have been on this ward ever since.

I was at that time and still am an E grade nurse and I currently work two nights a week. As an E grade staff nurse I would mostly take charge of the ward. I would also often have the keys to the hospital, which means I am the person responsible at that time.

I have been asked about my knowledge of a patient named Elsie Lavender. I cannot remember this patient. I have been shown original documents relating to Elsie Lavender concerning her stay in Gosport War Memorial Hospital. I have been shown several pages of notes and make the following comments: on page 153 there is an entry dated 29 February 1996, which reads, 'Blood sugar at midday 20mmls. Dr Barton contacted, ordered 10 units Actrapid stat.' I can confirm that this is in my handwriting and that I have signed the entry. I have been asked to explain the entry. The patient was a diabetic and at midday her blood sugar levels were high. '20mmls' stands for 20 millimoles, which is a measure used for blood sugars. Because of this high level I contacted Dr Barton. I cannot remember exactly how I did this but it was probably by bleep. If Dr Barton was in the hospital and available she would have visited the patient as a result of my request, or as seems happened in this case, she may have authorised 10 units of Actrapid. Dr Barton would then have signed for the

Actrapid on the once only medication chart either at the time or post-administration of the drug.

Going by the available record, I am not sure if Dr Barton did attend or not but clearly her authority was given. I would normally have chased her up to complete the entry although I am unable to find one in this case.

I have been asked about another entry, dated 1 March 1996, on page 97 which reads, 'Complaining of pain in shoulders on movement'. I can confirm that this is my writing and my signature. This would have been recorded as the patient probably told me that she was in pain when she moved. She was not necessarily in pain at the time, only when she moved. She was not given anything for the pain at this time.

I have also been asked about an entry dated 5 March 1996, on page 97, which reads, 'Pain uncontrolled. Patient distressed. Syringe driver commenced 09.30. Son informed'. I confirm that this is my writing and that I have signed the entry.

On page 153, the summary page, there is a further entry dated 5 March 1996, which reads, 'Patient's pain uncontrolled. Very poor night. Syringe driver commenced 5.3.96 at 09.30 hours. Diamorphine 100mgs. Midazolam 40mgs. Son contacted by telephone: situation explained.' Again I can confirm this is my writing and I have signed the entry.

Regarding these last two entries I can explain them as follows: I would have been told by the night staff that the patient had had a very poor night. She was in uncontrolled pain and she was distressed. She had been seen by Dr Barton, who had authorised the commencement of a syringe driver. This was commenced at 09.30 and contained 100mg of diamorphine and 40mg of Midazolam. The patient's son was contacted by me on the telephone so that I could explain the situation.

I have been asked why Mrs Lavender was put on the syringe driver and if this was the start of the process. I can say that this was the start of the process and that it started on the instructions of Dr Barton, and on page 153 Sister Joines has written that the son had requested we keep his mother comfortable and pain free.

I have been shown an entry of the same set of notes, on page 85, dated 5 March 1996. This is Dr Barton's writing and is the instruction to commence the syringe driver application. I have also been asked whether another nurse was involved. In answer I will explain how we withdraw drugs. Drugs are kept in a locked CSSD room and within that room they are held in a locked cupboard. Within the locked cupboard is a further secure cabinet and it was from that that the diamorphine and Midazolam were withdrawn. The correct procedure to follow, and this would have been the case in this instance, was for two trained nurses to be present when the drug were withdrawn and administered. Entries were then made in the ward controlled drugs record book. These entries include the amount, date, time, patient's name, amount given, person administering and the witness. Unfortunately, I have not been shown the relevant book for the drugs previously mentioned. I have been told that it is no longer available. However I have been shown page 137. There is a prescription page and shows that Dr Barton has signed up a prescription of 100 to 200mg of diamorphine and 40 ? of Midazolam on 5 March 1996."

The query was unreadable, I believe.

> "It also shows that on 5 March I administered those drugs to Mrs Lavender, as has been previously stated. I administered 100mg of diamorphine and 40mg of Midazolam. The lowest amounts were given as it was considered that they would be appropriate to the pain level being suffered. In other words, it would keep her comfortable. These drugs were over 24 hours.
>
> I have been asked if I have had any training in the use of syringe drivers. I cannot be specific at this time but this would have been covered during our regular training sessions on site training from Countess Mountbatten staff during my time at QA Hospital, Gosport War Memorial Hospital training days at Countess Mountbatten hospital and there was also a large poster in the office which acted as an aide memoire."

Yolanda J Peters made a statement on 30 September, she is Dr Yolanda J Peters, employed as a general practitioner, at Portland Medical Centre, White Place, Gosport, Hampshire. She has full registration with the GMC, granted in 1978:

> "The date of my JCPTGP was my GP training qualification in 1982, and the date of my appointment is that of a general practitioner in Hampshire. I obtained my London College of Physicians... I am a member of the Royal College FRCS" – Royal College of Surgeons meaning I qualified to be a doctor in 1977. In that year I also qualified as a Bachelor of Medicine and Bachelor of Surgery. I also gained the DRCOG, London" – Diploma of the Royal College of Obstetricians and Gynaecologists – "another medical qualification in 1981. I became a member of the Royal College of Medical Practitioners London in 1987. I shared a practice, which I am still at along with other doctors, including Dr Jane Barton.
>
> During 1995 to 2000 I was employed as a clinical assistant at the Royal Hospital Haslar, Gosport, Hampshire. I started at my practice on 1 April 1982. I have been shown the GP medical records for Elsie Lavender, a patient at the practice. By referring to the notes, I can say that she was first seen at the Portland Medical Centre on 24 March 1982 with low blood sugar. The first record of her being diabetic was on 7 August 1946.
>
> Elsie Lavender was born on 4 December 1912. I first saw her on 4 April 1982. She had recently been in Haslar Hospital, on 26 March 1982, with a hypo attack, which meant that her blood sugar had gone low and she had fallen unconscious. I took her medical history and checked her urine and then gave her a repeat prescription for paracetamol and insulin for her diabetes. Diabetes is a disease that affects the whole body. It affects small blood vessels and this can affect every organ in the body. In Elsie's case it affected her eyes and heart.
>
> I saw her regularly until she was admitted to hospital prior to her death in 1996. Her medical condition was kept generally under control. However, as the years progressed she deteriorated with age. She was also very overweight, which did not help.

With regard to her heart, this went back to January 1985 when she had an irregular heart beat and mild heart failure. She was given Digoxin and a diuretic to combat it. In 1983 she was short of breath and had an irregular heartbeat. I gave her Frusemide at that time, which is a diuretic, which I changed to Frumil two weeks later, which balances potassium levels in the body.

In 1992 she had swelling of her ankles and I increased her Frumil from one to two a day, this again was due to her heart failure. This is a condition she had until she died, in combination of diabetes. Elsie suffered a haemorrhage in her left eye in 1968 as a result of diabetic eye disease and was followed up in the eye clinic after that.

She had a cataract extraction in 1985. Throughout this time she regularly attended the diabetes clinic. In 1988 her vision had deteriorated and she was put on the blind register. In 1991 she was admitted to Haslar Hospital with a chest infection. In 1995 she had chronic bronchitis. She was on strong steroid inhalers to combat that.

On 6 February 1996 she was admitted to Haslar Hospital with a stroke. She was immobile, diabetic, blind and had an irregular heart. She was transferred on 25 February 1996 ---

MR JENKINS: Sir, we think that is the wrong date, it should actually be 22nd. The jury have it on their schedule as 22 February.

THE CORONER: Is there any objection to my answering that?

MR JENKINS: You are about to confirm it with the last statement you read, that it was the 22nd.

THE CORONER: "... she was transferred on 22 February, to Daedalus Ward, Gosport War Memorial Hospital for long-term care. She had multiple bruises following a fall on 5 February 1996. She died on 6 March 1996 on Daedalus Ward.

Digoxin is drug which regulates irregular heart beat."

It is significant that her understanding of it was it was for long-term care and not for rehabilitation but that is what she says.

MR JENKINS: Yes.

THE CORONER: The last one for this afternoon I believe is Rodney Hemmingfield Taylor, consultant physician and gastroenterologist. Qualifications, BSc, MBBS, MRCS, MRCP, MRCPN, etc.

"I have held the following positions: 1972-1973, house physician and house surgeon University College Hospital, London, 1973-1975, senior house officer London Chest, Whittington and West Middlesex University Hospitals. 1976-1978 medical registrar, Central Middlesex Hospital. 1978-1980 DHSS Research Fellow and honorary senior registrar, Department of Gastroenterology and Nutrition, Central Middlesex Hospital, surgical unit UCH Medical School and University Laboratory of Physiology, Oxford. 1980-1994 honorary consultant physician Department of Gastroenterology and

Nutrition at the Central Middlesex Hospital. 1980-1984 Wellcome senior research Fellow in clinical science and honorary senior lecturer in medicine Middlesex Hospital Medical School. 1984-1986 Head of Human Pharmacology Research Division, Beecham Pharmaceuticals. 1986-2001 consultant physician and gastroenterologist, Royal Hospital Haslar, Gosport, Hants. Professor of Medicine RCP 1988-1994. Postgraduate clinical tutor, RCP college tutor, associate postgraduate dean Royal Defence Medical College, Medical Director, Royal Hospital Haslar, and Deputy Medical Director at Gosport Hospitals NHS Trust. 2001-2003 Medical Director, consultant physician and gastroenterologist Ealing Hospital NHS Trust. July 2003 to date consultant gastroenterologist Ealing Hospital NHS Trust.

I have been asked about my role at the Royal Hospital Haslar, and in particular whether I recall a patient named Elsie Lavender. I have no recollection of this lady. I have been shown a copy of her hospital notes. These notes show that Elsie Hester Lavender was admitted to Royal Naval Hospital Haslar on 5 February 1996.

As stated in my introduction, I was employed at the Royal Naval Hospital Haslar from 1986 to 2001. The hospital was called 'The Royal Naval Hospital' when I joined although it was during my time that it became the tri-service hospital and changed its name to 'The Royal Hospital Haslar'.

I held numerous positions of responsibility during my time at Haslar, although my principal role was on the medical wards as a consultant physician and gastroenterologist. There were four, sometimes three, medical teams each consisting of a consultant, a registrar, a senior house officer and a house physician. We would be on call every four days.

I have been asked how patients might be admitted to a medical ward. Typically, a patient would be admitted through the accident and emergency department, where they would be seen by a senior house officer. Following the SHO's assessment, they would discuss the case with the registrar and if it was deemed appropriate the patient would be transferred to a medical ward. Once on the medical ward the patient would be seen by the house physician.

After admission to the ward the house physician would normally see the patient every day, the SHO when needed and similarly the registrar. The consultant would normally see the patient for the first time during the next ward round or sooner if requested by one of the team. Obviously, the duty team would normally pick up such admissions. However, if a patient had been seen by a consultant on a previous occasion it would be quite normal for that patient to be referred back to allow for continuity of care.

Regarding the ward rounds: my normal procedure would be to hold them twice a week, on Monday and Thursday mornings, though this was subject to occasional change depending on circumstances. Those present would normally include the team as previously mentioned, plus a senior nurse from each ward visited. The house physician was normally responsible for writing the ward round up in the patient's notes.

As previously stated, I have no recollection of the patient Elsie Lavender. From the notes I see that she was admitted to A&E on 5 February 1996, after having had a fall at home. She had been found at the bottom of her stairs. She had bruising and lacerations but no evidence of any fractures. It would appear that Mrs Lavender came in on another consultant's take. His team would have handled the first two days of her admission. I note that on page 156 there is an entry dated 7 February 1996 referring Mrs Lavender back to my team. Presumably this was because I had previously seen her in my diabetic clinic.

Looking through her GP notes, there is a letter to Dr Peters, dated 3 July 1995, this relates to an occasion when Mrs Lavender visited my diabetic clinic on 23 June 1995. There is a further letter going back to 1991 when she was treated by my team.

On page 158 of her hospital notes there is an entry dated 9 February 1996. The entry relates to a review of Mrs Lavender by my SHO, though I cannot read the signature. The note states that her blood sugar was low and her insulin was reduced. She was feeling better but still complaining of pain in her arms and shoulders.

Also on page 158 of the notes is an entry dated 13 February 1996, signed by Simon Hamling, who is my SHO, and it states, 'SB, RHT. Needs referral to Dr Lord: has OT assessment tomorrow. Remains well.' This was saying that I had seen her on that ward round. Obviously I was referring her to Dr Lord and that she was due to be assessed by an occupational therapist the next day.

On pages 159 and 160 is a further note, written and signed by another of my SHOs. Unfortunately, I cannot read the signature. The note is written as a consequence of the ward round and it reads as follows, 'To consultant in elderly medicine: Thank you for seeing this 83 year old woman who was admitted on 5 February 1996 after she had fallen down the stairs in her house. According to her son, she has fallen at the top of her stairs, hit and cut her head and then fell down stairs. The cause of her collapse was ? hypoglycaemia as she is a poorly controlled IDDM. Mrs Lavender has no recollection of what happened.

On admission she complained of pains in both shoulder/upper arms and a cut to her forehead. X-rays showed no fractures. After the time she spent on the ward she has been slow to mobilise and needs help to walk. She can dress herself, feed and wash herself, Bartel(?) score five. Before her admission she lived alone but a district nurse visited her daily to give her her insulin injection. She sleeps downstairs and is visited by her son daily. Mrs Lavender is reluctant to go into her home but her son feels that she cannot go back home in her present condition. Her diabetes is now under control but we are not sure how mobile she normally is as she does not seem to be able to do anything for herself. I would be most grateful for your opinion'. The entry is then signed by Dr L but I cannot read the rest of the signature.

Hypoglycaemia is a condition in which the person's blood glucose level becomes abnormally low and is most likely to occur in diabetic patients as a consequence of taking more insulin or anti-diabetic tablets than they need or having missed or taken too small a meal. As the blood sugar falls consciousness is impaired and the patient can become totally unconscious.

IDDM is an acronym for insulin dependent diabetes mellitus. It is a serious form of diabetes in which the patient's blood glucose levels cannot be controlled by diet alone or with diet and anti-diabetic tablets. Most patients with this condition take between two and four injections of insulin a day.

Page 161 also shows an entry dated 15 February 1996, which reads, 'WR RHT. Remains well. BG controlled better today. Await elderly medicine opinion.' This is signed by I am unable to identify the author. This entry shows that her blood glucose control was better. The reason for seeking the opinion of an elderly medicine [presumably a consultant] when Mrs Lavender was living alone, nearly blind, she was registered blind, diabetic. She had had a fall and both the occupational therapist and physiotherapist felt that she was no longer able to live at home. Patients in these situations would normally be referred to elderly medicine for long-term care. The notes show that on page 162 Dr Jane Tandy, from elderly medicine, did in fact review Mrs Lavender on Ward A4 on 16 February 1996. Dr Tandy has written the visit up on pages 162, 163 and 164. Subsequently, Dr Tandy wrote a covering letter to me pertaining to this visit, which is dated 20 February 1996 and was dictated on 16 February 1996. Dr Tandy listed the following problems, 'Probable brain stem stroke, insulin dependent diabetes mellitus, registered blind, now immobile, AN'. She concluded by writing that she would arrange for Mrs Lavender to be transferred to Daedalus Ward at Gosport War Memorial Hospital for rehab as soon as possible.

The last entry in Mrs Lavender's clinical notes is dated 21 February 1996. It is from an SHO ward round and indicates that Mrs Lavender will be transferred to Gosport War Memorial Hospital the following day.

In conclusion I would say the following, Mrs Lavender was registered blind and was diabetic. She was admitted to Royal Naval Hospital Haslar following a fall at home. After examination it was believed that she had had a small brain stem stroke, which had caused her to collapse. She needed stitches as a result of her fall. We stabilised her medically and accepted that she would not be able to go home from us. She was referred to elderly medicine for continuing care and transferred from the care of my team to Daedalus Ward, Gosport War Memorial Hospital."

Right, have you got that: not a well lady?

Is there anything else we can achieve this afternoon? (No audible replies heard) 10 o'clock tomorrow morning then. Thank you very much.

Tomorrow we have got Marion Wiles, Lynne Barrett and the rule 37s that we did not take today but that I started on.

(The inquest was adjourned until 20 March 2009 at 10 am)