GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Friday 20 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 Code A & 9 Ors

(DAY THREE)

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 waiting jury)

THE CORONER: Do I understand that Mrs Wiles is not present yet? I was going to start with her this morning because chronologically that would be the sensible thing to do, but let us get the jury in and see what happens. I may take her in writing if she does not want to be here. But let us see what happens.

B

Are there any observations on my taking her in writing if she does not want to be here, but let us see what happens? Any observations on my taking her in writing if she does not attend?

MR JENKINS(?): I would be reluctant.

THE CORONER: If she is going to come then I will sit and wait for her and do other things.

C

MR JENKINS: I would like to know whether she is going to come before you decide to read her. It seems to me that you could certainly read some of the background statements.

THE CORONER: Yes I can do that.

MR JENKINS: Then the jury will have some background and then we can reassess the situation.

D

THE CORONER: The other thing I was going to do was to defer the jury on Monday until 11 o'clock, to enable us to deal with the Hamblin point. Is that reasonable? Sorry, you wanted to say something?

MR TOWNSEND: I was simply saying, just to indicate that Lynne Barrett is here and is available to give evidence.

E

THE CORONER: I just wanted to do Mrs Wiles before I did Mrs Barrett that was all, because chronologically that seemed to be a sensible way to do it, to give the family the opportunity speak before Mrs Barrett spoke. Let us wheel the jury in.

COUNSEL: I will do a final check.

F

THE CORONER: Thank you. I will do some reading and we will take it from there.

MS BALLARD: Just to confirm that Dr Reid is available to attend on 31st or 1st.

THE CORONER: Thank you very much; I am grateful. Sorry about this, Mrs Barrett; we will get to you.

G

(After a short time the jury entered the courtroom)

THE CORONER: Good morning, ladies and gentlemen. Today we are looking at Mr Pittock, despite my attempts to try to get to him yesterday afternoon, out of order. The situation is that I was hoping that his daughter would be here to talk to us first thing this morning. As I understand it she is not here so we may just start off reading what I started reading yesterday afternoon in error, and that is really the background.

H

We then have Mrs Barrett, who is a lady who was nursing at Gosport and she will be able to tell you about her involvement. If by then Mrs Wiles is not with us we will have to think about it again. I will not go through the beginning of Dr Bayly again because we did that to a certain degree yesterday. Do you want to refresh your memories about her involvement with Gosport?

JUROR: Refresh.

THE CORONER: She said:

> "The late Mr Pittock, dob Code A had previously been admitted to Mulberry A ward in September 1995. Following Mr Pittock's discharge from Mulberry A ward on the 24th October I wrote a discharge letter on the 08/11/95 (08/11/1995) to his GP Dr Asbridge. This letter details his diagnosis, treatment and progress whilst a patient on the ward. The letter is as follows:
>
> *'Dear Dr Asbridge,*
>
> *Re: Leslie Pittock; Hazeldene Rest Home, Bury Road, Gosport.*
> *Date of Admission 14.9.95*
> *Date of Discharge 24.10.95*
> *Diagnosis Depression*
>
> *This 71 year old gentleman was admitted informally by Dr Banks ..."*

– the "informally" means that it was not an order under the Mental Health Act, that he voluntarily went in for treatment:

> *"... complaining of an exacerbation of his chronically depressed mood. He also complained of continuing problems with constipation. He felt his mood had deteriorated over the preceding few months as a result of deterioration in his physical capabilities and condition. He described early morning waking and a poor appetite, exacerbated by the embarrassment he felt at eating in public in the Rest Home where he was living as he tends to spill a lot of food down his front due to his frail physical condition. He also had a lack of energy and motivation and found that he was unable to enjoy anything. He also had a nasty taste in his mouth all the time.*
>
> *Past Psychiatric History*
>
> *Leslie has had problems with depression since his 50s when he attempted suicide by overdose on several occasions. He has had several courses of ECT, the last one requiring 30 treatments before there was any improvement.*
>
> *Past Medical History*
>
> *Hypothyroidism."*

That is an underactive thyroid.

> *"Drug History*
>
> *Diazepam; Thyroxine; Temazepam; Thioridazine ..."*

What is that?

COUNSEL: It is a tranquiliser.

THE CORONER: *"Lustral; Lithium; Co-danthramer ..."*

Do you know what that is?

COUNSEL: Laxatives.

THE CORONER: *"Locoid Scalp Lotion and Alphaderm Cream.*

Family History

There is no psychiatric illness in Leslie's family. His father died at 79, the cause is unknown. His mother died of cancer in her 50s. Leslie has a son aged 60 but he lost his daughter when she had her first baby. He has another daughter who is fit and well.

Background

Leslie grew up in Hemel Hempstead and joined the Navy at 14, when he moved to Portsmouth. He married at 35 years of age and had a happy marriage. He had moved to the Rest Home about 7 months before admission as his wife could no longer cope with his deteriorating mobility. Leslie describes himself as shy, tending to be a loner and to bottle up his feelings. He socialises badly because he is ashamed of his physical condition.

Mental State Examination

On admission Leslie was very flat in affect with little movement or eye contact. His concentration was poor. He was fairly well groomed. His speech was slow with nothing produced spontaneously, long pauses, and he had a tendency to lose his thread. The content was appropriate to questions asked. Leslie's mood was objectively and subjectively low though he was not tearful and he denied suicidal intent, but said if the opportunity to die came along he would be glad to accept it. He expressed feelings of guilt and shame and was quite pre-occupied with his poor oral intake, although staff from the Rest Home informed us that he had been eating quite well in fact. Leslie scored 8 out of 10 on a mental test score which seemed to be mostly due to lack of concentration.

Physical Examination

His mobility was very poor with a shuffling gait but otherwise there was little abnormality.

Treatment and Progress

Leslie's current medications were continued. Full blood count, U & E, LFT, bone profile and thyroid function tests were within the normal range. His lithium level was in the therapeutic range, and he had a PSA of 2. Leslie's food intake was monitored closely and appeared to be very good, so he was encouraged to mix with the other patients and to eat in the same room as them. Leslie developed a urinary tract infection which was treated with two weeks of Trimethoprim for an assumed prostatitis. ECT was offered to Leslie

but in view of his last experience of it being not very effective despite a protracted course he turned the offer down. Leslie's mood did in fact improve quite a bit during admission, and he seemed to have more energy and to become more sociable with both patients and visitors. Therefore he was discharged back to his Rest Home and will be followed up as a day patient attending the ward on Thursdays."

Then it gives his drugs regime on discharge. Then:

"Yours sincerely, Dr Rosie Bayly."

"There are a number of points within this letter that I can clarify.

Where I have written: '*Early morning* waking' – this is a common symptom of a significant depression involving waking up in the very early hours of the morning and being unable to get back to sleep.

'*Past Psychiatric History*' – the content of this section of the letter is self-explanatory.

'*Past medical History – Hypothyroidism*' – this condition means having an underactive thyroid gland which is treated by thyroid hormone replacement tablets.

Where I have written in the '*Drug History*' section: "*Diazepam 10 mg bd*"

– she tells you what the dosages were, which I do not think will help you a great deal, unless you want me to do that.

"The '*Family History*' and '*Background*' sections are self explanatory, however I cannot recollect exactly what it was that Mr Pittock was embarrassed about.

In the '*Mental State Examination*' section, where I have written '*Leslie was very flat in affect*', this means that Mr Pittock was subdued and quiet, showing very little emotion.

Where I have written '*little movement or eye contact*', this further indicates that Mr Pittock was quite subdued, and lacking in confidence, and unable to hold eye contact."

I think we all know what that means, do we not; it means he cannot look at you, is not engaging?

"Where I have written '*objectively low*', this relates to my observation that he appeared to be low in mood, and '*subjectively*' refers to Mr Pittock's opinion of his mood.

Where I have written '*pre-occupied with his poor oral intake*', this means that he was very focused on his perceived inadequate food intake. It will be noted that staff at the rest home had informed the hospital that he had been eating quite well.

In relation to the mental test score, this is a test designed to obtain information about the patient's memory and concentration. 8 out of 10 is a mildly reduced score which tells me that he did not have severe problems with his memory. His concentration seemed to be impaired and may have accounted for the reduced score.

In the *'Physical Examination'* section; where I have written *'shuffling gait'*, this means that when Mr Pittock walked, he shuffled.

In the *'Treatment and Progress'* section, to explain the content of this entry, there were no immediate changes made to Mr Pittock's medication. He had blood tests to check for anaemia, and to check his kidneys and liver were functioning normally, and that his thyroid problem was being adequately treated, and that his blood calcium levels were normal. The results were all normal. The amount of Lithium from his medication in his blood stream was checked and found to be at a good level.

The PSA is a test to check for prostate disease. This was found to be normal.

Mr Pittock's Urinary tract infection (UTI) was treated with a 2 week course of an antibiotic called Trimethoprim.

ECT stands for Electro Convulsive therapy.

To sum up Mr Pittock's condition, he had improved sufficiently to be discharged back to the rest home.

His medication on discharge remained the same except that his laxatives were changed ...

Sertraline is the same drug as Lustral.

A copy of this letter is kept on the patients medical notes.

Pages 59, 60 and 61 of exhibit BJC/71 are the carbonated spell summary form(s) for the admission and discharge of patients."

That is the carbon copy of the form.

"This form notes the details of the patient and a very brief summary of admission and discharge.

The form shows that Mr Pittock was admitted on the 13.12.1995, that Dr Banks was the Consultant. His diagnosis is recorded as depression. The form shows that Mr Pittock was transferred to Dryad ward on the 5 January 1996.

His condition had deteriorated and therefore he had to be re-admitted on 13 December 1995, which was a voluntary admission. Mulberry A ward was at that time a psychogeriatric ward for acute admissions. This was a secondary care ward run by psychogeriatric consultants. The medical records show my next involvement with Mr Pittock was on the 13 December 1995.

I can confirm that I wrote the following entries commencing on page 62 of exhibit BJC/71:

'Informal Admission 13 December 1995 PC "Everything's Horrible". From RH"

Verbally aggressive to wife and staff.

Staying in bed all day.

Not mobilising

Constipated

Not eating well

Sleep 'all right'

No DVM - feels bad all the time.

Hopeless and suicidal

PPH Chronic depression

Prev ECT courses

PMH Hypothyroid

Constipation

DH Mag hydrox, codanthrusate."

What is that?

MR JENKINS: Laxatives; they are both laxatives.

THE CORONER: Thank you.

"*Sertraline; Lithium; Diazepam; Thioridazine; Temazepam; Thyroxine.*

Background - see previous notes. MSE A+B withdrawn, monosyllabic;

Unwilling to move or mobilise. Seems a little agitated and irritable.

Speech indistinct, quiet nil spontaneous except one statement.

Mood 'I might as well tell you I just want to be dead'.

Has thought about overdosing.

Thoughts no hallu/delu."

Presumably hallucinations or delusions.

"*Insight 'I'm a wreck, I might as well be dead'.*"

Then it goes into the physical examination.

"*Chest clear; slight tremor on moving;Δ depressed; ECT discussed - no decision; Bisocodyl suppositories.*"

I can clarify a number of points within the entry above as follows:

'PC' – means Presenting Complaint.

In Mr Pittock's own words the reason for his admittance to Mulberry A ward was *'Everything's horrible'*.

'From RH' means the rest of the information in the PC section was reported by the staff at the Hazeldene Rest Home, the majority of which is self explanatory.

'No DVM' means no Diurnal Variation Mood, indicating that he was consistently low in mood all the time.

'Hopeless and suicidal' is self explanatory.

'PPH' means Past Psychiatric History.

'Previous ECT' means Mr Pittock had had Electro Convulsive Therapy in the past. This entails a patient having a brief general anaesthetic, and whilst anaesthetised the patient receives an electric shock to the head through electrodes.

'PMH' means Past Medical History.

'Hypothyroid' means an under active thyroid gland.

'DH' means Drug History, referring to the medication he was already taking prior to admission onto the ward.

In the *'Physical'* section, *'Full rectum'* means that on examination

Mr Pittock's rectum was full of faeces, signifying constipation.

'P80 regular' means he had a pulse rate of 80 beats per minute and the rhythm was regular.

'HS I –II' means the heart sounds were normal.

'Shuffling gait' means Mr Pittock shuffled when walking.

'2 to mobilise' means he required the help of two people to get up from a chair and move about.

'Slight tremor on moving' means Mr Pittock had shaking hands on initiating movement.

'Δ depressed' stands for diagnosis depressed.

'ECT discussed - no decision' probably means that I discussed with Mr Pittock whether he would want to try more ECT but that no decision was reached at this stage.

I prescribed biscodyl suppositories for his constipation.

'Check [Li] U&E √' means check his Lithium concentration and kidney function with a blood test, the tick indicating that those arrangements have been made. The results of these tests were normal.

'Recent TFT + FBC normal' means that a thyroid function test and full blood count have been done recently and the results were normal.

'D/W Dr BANKS and further info from RH' means discuss with Dr Banks and get more information from Mr Pittock's rest home.

I can confirm that I have written the following entry on page 64:

'20/12/95 Bowels loose stool 5 days

? diarrhoea

? overflow

Abdo soft, non tender BS normal

PR empty

→ plain AXR → empty →for reporting."

STOP APERIENTS.'

Where I have written *'Bowels loose stool 5 days'*, this means that Mr Pittock had had loose stools for the past 5 days.

'? Diarrhoea ? overflow' means that it's not clear whether his loose stools are due to too many laxatives or not enough, as extreme constipation can lead to liquid faeces being passed, which is termed overflow.

MS BALLARD: If I could just identify the question mark – it is query overflow, not diarrhoea and overflow. It makes sense with the transcription comment.

THE CORONER: It is a query about it, not a diagnosis.

"'*Abdo soft'* means an examination of his abdomen did not show abnormal tensing.

'→ *plain AXR'* means I have requested an X-ray of his abdomen to help with the diagnosis.

'→*empty'* means that the X-ray has now been done and I have looked at it, and it showed that his gut was empty.

'→ *reporting'* means that I have sent the X-ray off to the radiologists for their written opinion on them, which is standard procedure.

I can confirm that I have written the entry below following or during a ward round with Dr Daoud and myself.

'20/12/95 WR Dr Daoud

Mobility ↓↓ V Parkinsonion features

Low +++

↓Thioridazine to 25mg Qds + PRN

Procyclidine 5mg bd. Review Fri.

? sertraline next week'

'*WR Dr DAOUD*' means ward round conducted by Dr Daoud and myself.

'*Mobility ↓↓*' means his mobility has deteriorated.

'*V. Parkinsonion features*' means he is showing signs of Parkinson's disease.

Parkinson's disease is a disorder causing problems with mobility and shaking. Similar symptoms can be due to some types of medication, or it can occur spontaneously.

'*Low +++*' means that he Mr Pittock was very low in mood.

'*↓ Thioridazine to 25 mg Qds + PRN*' means reduce the dose of Thioridazine to 25mg to be given 4 x daily plus additional (but only if required).

'*Procyclidine 5mg bd. Review Fri*' means add in 5mg Procyclidine tablets twice daily (probably to see if it will reduce the Parkinsonion symptoms)

'*? sertraline next week*' means questioning a possible increase in dose of sertraline next week.

I can confirm that I have written the following entry.

27/12/95 WR Dr Banks

Chesty

Poorly, abusive, not himself at all.

→ chest physio

Sputum sample

Erythromycin finished →for cefaclor

Stop Procyclidine until well

Reassess mood once medically better

Also ? further inx of bowels

Catheterised end of last week by on call GP as in urinary retention

Geriatrician review may be helpful

CXR √

Where I have written '*Chesty*' this probably means that Mr Pittock had a rattly chest with a cough.

'*Poorly, abusive, not himself at all*' is self explanatory.

'*→ chest physio*' means refer Mr Pittock to a physiotherapist for treatment to clear phlegm off the patient's chest.

'Sputum sample' means collecting some phlegm from the patient to send to the microbiology laboratory for testing. This is to see what bacteria are growing in it to help choose the most effective antibiotic treatment.

The result of this examination is recorded on page 112 of the medical notes, and indicates the presence of bacteria called Pseudomonas.

B

I cannot tell from the notes what date the result of this test came back to the ward.

'Erythromycin'" is the name of an antibiotic that was prescribed on the 22 December 1995 for a chest infection.

'Cefaclor' is a the name of a different antibiotic which was then prescribed for the chest infection after the Erythromycin had failed to clear his chest.

C

'Stop Procyclidine until well' means the new drug was stopped as Mr Pittock was poorly in himself. I do not know why this made it necessary to stop the Procyclidine.

'Also ? further inx of bowels' means do further investigation of the bowels need to be done?

'Catheterised end of last week by an on call GP as urinary retention" means that Mr Pittock needed to have a plastic tube inserted into his bladder ... because he was unable to pass urine due to a blockage.

D

'Geriatrician review may be helpful' this raises the possibility of asking a geriatrician to see Mr Pittock to advise on the management of his physical illness (our specialty was psychiatric illness, so if patients became physically ill as well it was usual practice to ask a geriatrician to give advice on any additional treatment or investigations that would help the patient).

E

'CXR√' means Chest X-ray has been arranged.

The next entry in the medical notes dated 27/12/95 relates to the treatment given by the hospital physiotherapist."

That is the same day, is it not? Yes.

F

"I can confirm that I wrote the following entry.

2/1/96 Remaining poorly and lethargic.

Reports of him saying 'Why don't you let me die'?

Skin breaking down - Pegasus bed - v poorly

G

FBC√ U + E√ [Li] + TFT √

Geriatrician review to make sure not medical problem.

'Why don't you let me die' is a quote from Mr Pittock demonstrating how extremely depressed he was.

'Skin breaking down' means Mr Pittock was developing pressure sores.

H

'Pegasus bed' is a bed with a special mattress designed to be more gentle on the patient's pressure areas.

'V. poorly' indicates that Mr Pittock had now become very physically weak and unwell as well as suffering from psychiatric illness.

'FBC√' means a full blood count has been arranged.

'U&E√' stands for urea and electrolyte tests (kidney function tests) have also been arranged.

'[LI] +TFT √' Lithium levels and thyroid function tests have been arranged.

I note that these tests were completed. The results are recorded on page 86 of exhibit BJC/71

The U&E results of the patient were shown to be normal.

The liver test results showed some abnormal readings suggesting that the patient was not taking in enough food. This is highlighted in the low protein result of +57 and the Albumin level of +27

Recorded on page 85 of exhibit BJC/71 is the result of the lithium test 0.57 which is within the therapeutic range (i.e. it is not at toxic levels).

The Full Blood Count (FBC) is recorded on page 114 of exhibit BJC/71 which appears to be normal.

On page 89 of the medical records I note that the patient's glucose levels are normal.

'Geriatrician review to make sure not medical problem' means that we have now made the decision to ask the advice of a geriatrician.

A request was made for a geriatrician to assess the patient as above. I then wrote a brief letter into the medical notes summarising the patient's problems. I outlined what we would like the geriatrician to assess as shown in the entry dated on the 2 January 1996 on page 66 of the medical records.

I can confirm that I have written the below entry as recorded on page 66 of the medical records.

"2/1/96 Dear Dr Lord,

Thank you for seeing Les who has been treated for many years for resistant depression.

On this admission his mobility initially deteriorated drastically and then he developed a chest infection. His chest is now clearing but he remains bed bound, expressing the wish to just die.

This may well be secondary to his depression but we would be grateful for any suggestions as to how to improve his physical health.

Thanks Rosie.

(PS He also complains of some abdo pain intermittently which I thought may have been constipation, but an AXR showed his bowels to be very empty, so his aperients were stopped. Unfortunately he still has pain intermittently)."

This brief letter to Dr Lord (consultant geriatrician) makes it clear that Mr Pittock is already very poorly. This could well have all been due to his depression, but we are asking Dr Lord to double check that there are no treatable physical illnesses that are contributing to his deterioration.

Where I have written *'abdo'* this means abdominal.

'AXR' means abdominal X ray.

'Aperients' means laxatives.

I can confirm that I have written the following entry on 3 January ..."

So the following day:

"WR Dr Banks,

Poor food intake, fluid ok. Deteriorating. Some breaks in skin now.

? fit for ECT - may not agree to it ?would work.

→ fortisips and high protein diet.

Await EC review.

Needs more time to convalesce.

Diazepam.

Stop Thioridazine therapy.

Watch for benzodiazepine withdrawal.

Probably will need NH"

With reference to this entry dated 3/1/96 it basically shows that we have run out of any other treatment options as Mr Pittock was by this stage too frail to have ECT treatment, and it would probably be ineffective anyway even if he agreed to try it.

'→ Fortisips and high protein diet' means a high nutrient dietary supplement was to be started.

'EC' refers to Elderly Care (the geriatricians).

The below results were highlighted in the hand written section of the notes for the benefit of Dr Lord to assist her in her assessment of the patient."

Then various entries are given there.

"Mr Pittock was subsequently moved to the elderly care ward and I had no further dealings with him."

That builds a picture of Dr Pittock and his deterioration.

Victoria Ann Banks made a statement on 4 February 2005.

> "I am employed by the Hampshire Partnership Trust as a consultant in old age psychiatry at the Mulberry Hospital ... West End, Southampton. I have held this position since November 2002."

Do you want me to go through the qualifications? Do you need to know the qualifications?

A SPEAKER: No.

THE CORONER: " I am a consultant at Mulberry A Ward at the Gosport War Memorial Hospital and I also ran the Phoenix Day Centre Unit at the hospital. This was for assessment in treatment for mental illness for patients living in the community of Gosport and Lee-on-Solent. Mulberry A ward was a strong term functional assessment treatment ward for elderly patients over 65 suffering primarily with depression. Mulberry A Ward consisted on average of 12 beds.

I was one of three consultant psychiatrists who had responsibility for the patients on this ward. I was responsible for patients from the catchment area of Gosport and Lee-on-Solent. At that time working on the ward would be one or possibly two psychiatrists, Senior House Officers working on rotation as part of the Solent SHO training scheme in psychiatry. Mulberry Ward was also covered by a part-time clinical assistant, Dr W Munroe.

There would normally be two trained Registered Mental Nurses who were not necessarily RGN qualified. Nursing staff would be supported by auxiliary nurses and there would be a senior RNN on duty on most occasions. I would only physically attend Mulberry A Ward approximately twice a week. Also attached to the ward would be an occupational therapist. Their role was primarily assisting in the assessment and management plan of the patients. I normally worked between 9 a.m. and 5 p.m. during this period. I was on call to manage psychiatrist patients. In 1996 I would conduct a ward round at Mulberry A ward accompanied by the clinical team, which comprised a junior doctor, trained nursing staff, community psychiatrist nurse, social worker, occupational therapist and physiotherapist. The clinical team would discuss each patient's care case in the staff room on the ward.

At this time there was a local GP practice who covered out of hour calls for patients with physically problems on Mulberry A Ward.
Psychiatric problems for the patients were managed by the on-call psychiatry service between 5 p.m. and 9 a.m. at weekends. I have been shown a photocopy of a microfiche ..."

That is the medical nursing notes relating to Leslie Pittock.

> "I do remember Mr Pittock. He was a very chronically depressed man, mentally frail and with a disability to cope with life. I do recollect visiting Mr Pittock at his home address. However, I do not have the records relating to these home visits to refer to.
>
> I have been shown page 10 of an exhibit, which is a copy of a letter written by

Dr Lord, which is a referral initiated by myself relating to Mr Pittock. I have been shown a photocopy of a microfiche and medical notes for Mulberry Ward A detailing the admission of the patient Leslie Pittock and they are as follows.

> 'Admission on 13 December. Admitted by Dr Bayly, my Registrar at this time.'"

B And she then confirms the entries. What I am looking at now is really confirmation of Dr Bayly's statement.

I will move on from there. 20 December 1995, ward round with Dr Dowd, again you have heard from. 27 December the ward by Dr Banks – chesty sounds noisy, coughing sputum, unwell, abusive to staff and family, not himself at all. Then the physiotherapist attending again on 27 December.

C

There is a 2 January entry which confirms Dr Bayly's findings. A letter to Dr Lord.

COUNSEL: Could you read the bottom of page 9?

THE CORONER: "2 January 1996, remaining poorly and lethargic. Reports of him saying,

D

> 'Why don't you let me die?' Pegasus bed, specially designed very expensive bed designed to alleviate pressure on the skin. Very poorly. Mr Pittock was very frail and very unwell. Chances of recovery are becoming increasingly unlikely. *FBC√ U + E√ [Li] + TFT √*. All tests to be arranged again. Geriatrician review to make sure not a medical problem, which translated into an examination by a geriatrician had been requested."

Entry signed by Dr Bayly.

E

> "The following entry is also written by Dr Bayly, 2 January 1996.
>
> *'Dear Dr Lord,*
>
> *Thank you for seeing Les who has been treated for many years for resistant depression.*
>
> *On this admission his mobility initially deteriorated drastically and then he developed a chest infection. His chest infection is now clearing but he remains bed bound, expressing the wish to just die.*
>
> *This may well be secondary to his depression but we would be grateful for any suggestions as to how to improve his physical health.*
>
> *Thanks, Rosie.*
>
> *(PS He also complains of some abdo pain intermittently which I thought may have been constipation, but an AXR showed his bowels to be very empty, so his aperients were stopped. Unfortunately he still has pain intermittently)."*
>
> *"3 January 1996.*
>
> *WR Dr Banks,*

F G H

Poor food intake, fluid ok. Deteriorating. Some breaks in skin now.

? fit for ECT - may not agree to it ?would work.

→ fortisips and high calorie drink + high protein diet.

Await EC review.

Needs more time to convalesce.

Decrease Diazepam.

Stop Thioridazine therapy.

Watch for benzodiazepine withdrawal. This means that Mr Pittock had been on both these drugs for some considerable time and stopping them could cause some unpleasant distressing withdrawal symptoms.

Probably will need NH – a nursing home."

This entry had been written and signed by Dr Bayly. The following entry relates to blood test results, GLU 4.3 a normal reading. U = urea, 7.2; PO4 1.05, AST 127.

I am unable to state who wrote this entry. These readings obtained from the blood test results are indicated as a bodily function. Noticeably the albium scored at 27 is low and this is a reflection of his poor dietary intake.

Next entry dated 4 January 1996 is the examination and assessment of Leslie Pittock by the consultant geriatrician, Dr Lord, which reflects the entries as previously shown in the patient's medical notes.

4 January 1996, Elderly Medicine.

> *'Thank you. Frail 82 year old with chronic resistant depression, completely dependent, ... zero; catheter bypassing; ulceration superficial of left buttock and hip. I pro protein anaemic, suggesting (1) high protein drinks; (2) bladder washouts twice a week; (3) catheter bypassing, the urine is going down the inside and outside of the tube from the bladder; (4) I would be happy to take him over to a long stay bed at Gosport War Memorial Hospital. I feel his rest home place can be given up as he is unlikely to return there.'*

This is signed by Dr Lord.

In this letter by Dr Lord I believe she summarised Mr Pittock's severe mental illness and has recognised that he had been physically unwell with a chest infection. Dr Lord has identified that Mr Pittock is entirely dependent on nursing staff for his activities of daily living. She summarised his poor physical condition which outweighs the mental condition; therefore she has suggested that Mr Pittock should be transferred to Dryad Ward, which could manage his physical state more appropriately. She has given guidelines as to his management.

The letter also notes that Mrs Pittock had been made aware of her husband's frailty and poor outlook, i.e. that he may not survive to leave the hospital.

Mr Pittock was transferred to Dryad Ward on 5 January 1996 and I had no further dealings with him.

At this time in 1996 the policy and procedure in respect of entries in the clinical notes written by doctors were completed recorded when the patient was reviewed on or shortly after a ward round. There would be timely entries detailing the review of the relevant problems which had been noted and discussed by the clinical team in relation to each patient. These entries would summarise current medical, physical and psychiatric problems. Other entries would be initiated as part of the planned review by medical staff, including physiotherapists or at the request of other members of the clinical team, i.e. nursing staff, or at the request of patients or relatives. Entries into the clinical notes are only made where necessary and relevant. There is no set format for entries written into clinical notes. There are no entries in the clinical notes over the weekends as there were no resident doctors at that time.

I had previously been a consultant in the treatment of Mr Leslie Pittock's mental illness and health illness since I started as a consultant in 1992. I was aware that Mr Pittock had suffered from a chronic resistive depressive depression since the early 1960s."

MR TOWNSEND: Can I suggest that you do not need to read the early 1990s and his mental health issues. Can I invite you to take it up at the bottom of page 13.

THE CORONER: Any observations? (No observations)

"On 5 January 1996 Mr Pittock was transferred to Dryad Ward, as previously mentioned. Where it is written on Mr Pittock's notes that a geriatrician's advice would be helpful it had been agreed by the team review that his physical state was very poor. It was therefore decided to request examination of Mr Pittock by a geriatrician in order that his physical state could be reviewed. This was done promptly by Dr Lord. In the event that a patient on Mulberry Ward was expected to die then the process that was undertaken at that time, as far as I can recall, was as follows. If there were concerns about someone's physical health and there was a possibility of the patient dying then a member of the medical team would meet with the family or discuss over the phone with the family the patient's poor prognosis. Once it had been established with the family that the patient was expected to die the next step would be a formal sick noting of the patient. This was a form written by a nurse or a ward doctor giving a brief outline of the patient's very poor physical state or poor prognosis. A copy was given to the relatives and a copy was pinned to the front of the patient's notes. If the patient subsequently died then it was the procedure of the qualified nursing staff to verify the death."

The next statement is Alicia Lord, dated 28 September 2004. Employed by the East Hants. Primary Care Trust as a Community Geriatrician for Fareham and Gosport Primary Care Trust. Held this position since 21 January 2004. Then it goes on to the qualifications; do you want me to deal with those?

MR TOWNSEND: Can I suggest that the jury should hear when she qualified, 1978; you can then take it to over the page and her position as a consultant geriatrician, when she started.

THE CORONER. 31 March 1992.

MR TOWNSEND: So the second paragraph on page 1, the rest can be skipped; and then go to the top of the second page.

THE CORONER: "In 1978 I graduated ... at the University of Sri Lanka, Colombo. I obtained an MB, which is a Bachelor of Medicine and a BS, which is a Bachelor of Surgery.

On 31 March 1992 until June 2004 I was employed as a consultant geriatrician for the Department of Medicine for older people in Portsmouth. During this period I worked in the Queen Alexandra, St. Mary's and Gosport War Memorial Hospitals.

In 1997 I obtained an FRCP, which is a Fellowship of the Royal College of Physicians. My General Medical Council registration number is that. I have been asked to detail my involvement in the care and treatment of Leslie Pittock.

I have been shown a photocopy of the microfiche, pages 5 and 10, and I can confirm that I was the author of the typed letter dated 8 January 1996.

In 1996 I was a consultant geriatrician and my responsibilities included inpatients at Queen Alexandra Hospital, Douglas(?) Ward at Gosport War Memorial Hospital, King's (?) Rehabilitation Ward at St. Mary's Hospital. I also conducted a day hospital session at the (?) Day Hospital located at St Mary's Hospital and Dolphin Day Hospital at the Gosport War Memorial. The sessions alternated every week.

I also held an outpatient session weekly at St. Mary's Hospital on first, third and fifth weeks and a session at Gosport War Memorial Hospital.

I was a consultant for all these patients who required specialist care for their physical health. All these patients would have been over the age of 65. At that time in 1996 I believe it was Martin Sethers(?) who was the clinical director of the department.

Firstly I must explain that where other departments require an assessment and believe the patient's physical condition requires specialist geriatric assessment a referral is made to the Department of Medicine for older people. It was in this context that I was asked to see the patient, Mr Pittock. I do not recollect the patient or indeed the assessment of Mr Pittock on 4 January 1996. I am therefore reliant on my assessment letter. My usual practice includes examining the patient, reviewing the available medical and psychiatric notes, liaising with the medical and nursing staff as appropriate. This assessment was undertaken by myself in response to a referral from Dr Banks, consultant in old age psychiatry or a member of her team.

It was an overall assessment to determine whether the patient's best interests would be served by him remaining on the psychiatric ward or by his transfer to the Department of Medicine for older people. I can confirm that I wrote the following within the letter referred to as page 5.

> *'Thank you for referring Mr Pittock, whom I visited on Mulberry A on 4 January. He has had chronic resistant depression and long courses of ECT (electric convulsive therapy) in the past, that had not been effective.*

He had recovered from a recent chest infection but is completely dependent with a Barthel of O. He was catheterised ...'"

MR JENKINS(?): I think you have read it twice before but it can be summarised, I am sure.

THE CORONER: "With reference to this letter I have written I have the following comments to make which will clarify the points.

Recovered from chest infection; the Barthel score is the functional assessment of activities for daily living – an assessment of how much you can and cannot do for yourself."

Is there anything else you want me to read?

MR TOWNSEND: Might I suggest starting "The letter continues with"?

THE CORONER: "The letter continues with the following.

'My overall feel is that his prognosis is poor and will be happy to arrange transfer to Dryad Ward on 5 January. I gather that Mrs Pittock is also aware of the poor prognosis. As he is unlikely to return to Hazeldene Rest Home I feel that his place there could be given up.

My conclusion that his prognosis was poor was based on the following factors: his extreme functional dependency in the absence of an acute medical problem, such as a stroke; his pure nutritional state; pressure sores, together with the background of longstanding depression. It is therefore my original impression that his physical needs outweigh the psychiatric problem and the transfer to Dryad Ward is appropriate. I would have found out whether a bed was available on Dryad Ward to be in a position to arrange a transfer on the following day, 5 January.

With regards to Hazeldene Rest Home, I have stated that Mr Pittock's bed should be given up. This I would only do when I was satisfied that the patient's condition and prognosis was so poor that he was not able to return to the rest home.

The transfer to Dryad Ward was in order to assess the patient's physical needs as well as his psychiatric needs.

The letter relating to the patient Leslie Pittock is a summary of my assessment of the patient. It is intended to provide interim guidance for the staff on Mulberry Ward pending transfer and initial guidance to staff on Dryad Ward after transfer.'"

So that covers the transition.

"Finally, it is intended to inform any other teams involved in the patient's care, in this case the GP Dr Asbridge. I should make it clear that it is not intended to be a

comprehensive care plan. The care plan would be devised by the medical and nursing staff after transfer to Dryad Ward.

There were five copies of this letter. The top copy went to Dr Banks, the referring psychiatrist. The other copies would have gone to Dr Asbridge, Sister Hamblin, a copy placed with the patient's medical notes on Dryad Ward and a further copied filled in at the elderly medicine office at the Queen Alexandra Hospital.

I reviewed the clinical notes of the patient Leslie Pittock and there are no other entries by me. I can see no references on the nursing notes to indicate any further involvement by me in this patient's clinical management.

Where I refer to a 'poor prognosis' this was indicating that the patient's chances of survival were slim. Mr Pittock was unlikely to survive for a very long time."

We then move on to Dr Jane(?) Tandy. 1983 graduated with an MBChb from the University of Edinburgh and RCP in 1986. She details the various posts that she had.

"Between November 1991 and May 1994 I held the post of Senior Registrar in geriatric medicine at hospitals in Portsmouth and at Southampton General Hospital. My current responsibilities as at 20 December 2004, consultant geriatrician, include working on Mary Ward, an acute ward at the QA Hospital. Patients admitted to this ward are in the main patients over the age of 65 who have suffered from a stroke.

I also hold an outpatient session once a week at St. Mary's Hospital. I see general medical patients as well as stroke patients. I cover ward rounds on a rotational basis with other colleagues from the medical admissions unit at QA.

If there are patients on the medical admissions unit or on the Accident & Emergency Department whose likely diagnosis is a stroke, then subject to availability of a bed the patient will be transferred to the Mary Ward at the QA. The Mary Ward is currently the responsibility of Dr Jarrett and myself. Patients admitted to this ward are seen on the consultant ward round. Dr Jarrett and myself conduct two ward rounds per week. Day to day medical care is provided by junior hospital doctors.

With regards to the one outpatient session held at St. Mary's Hospital Portsmouth, GPs and occasionally hospital doctors refer their patients to this outpatient session. I also conduct ward visits where patients are referred by other departments within the hospital to give advice re. elderly care.

On occasions I conduct domiciliary visits at the request of elderly patients' GPs.

I have been shown a photocopy of a microfiche, which is a provide a spell summary, which every patient admitted to hospital should be provided with.

I can confirm that I was a consultant for the patient Leslie Pittock, born 11 December Code A I have checked the spell summary. I am able to establish what the diagnosis was in relation to this patient as it is illegible.

I can state that I have no recollection of Leslie Pittock or subsequent examination. On examination of this form I note that there are codes relating to a specific diagnosis of the patient. These codes are inputted by the coding department within the hospital. I am unable to decipher the codes.

On 10 January 1996 I was the consultant for Dryad Ward, Gosport War Memorial Hospital. I had overall medical responsibility for the ward. Dryad Ward largely contained frail and elderly patients who would be difficult to manage in a nursing home because of their medical and/or nursing needs. These patients would have been assessed prior to transfer to Dryad Ward by a consultant geriatrician.

Dryad Ward was a long term care ward and generally patients were transferred from other wards within the Portsmouth Hospital.

At this time in 1996 there was not a resident doctor for these patients on Dryad Ward. Day to day cover was provided by the local GP. In the case of Dryad Ward this was Dr Barton and possibly others from her practice.

My responsibilities included a ward round on Dryad Ward once a fortnight. I would normally be accompanied by a senior member of the nursing staff and Dr Jane Barton.

My usual routine when conducting a ward round would be to see all the patients. I would discuss the care of the patients with the ward team. I would talk to the patients and examine them if appropriate. I would review drug regimes where relevant with the ward team. I would also review any blood test results, X-rays or other test results relating to the patient. I would check the medical notes thoroughly, especially if the patient was new to me.

One of my responsibilities was to review the prescription of drugs on Dryad Ward at Gosport War Memorial Hospital. The majority of drugs can only be prescribed by a doctor. The day to day administration of drugs would be by qualified nursing staff.

As a consultant geriatrician I covered Dryad Ward from 1994 to the end of 1996. Drugs can only be prescribed by a doctor; drug doses can be modified, current drugs stopped or new drugs added depending on the patient's condition. The drug regime would be reviewed by the consultant on the ward round as appropriate during the week by the general practitioner where necessary.

There was no requirement to notify me of every change to the drugs prescribed to a patient by the GP during his or her ward round, unless the GP sought my advice.

From my experience it was very infrequent that a doctor would phone me for advice. I have examined the drug chart, page 16, a photocopy of the exhibit, in relation to Leslie Pittock. On the drug chart there is recorded the following entries, as I understand them, commencing on 5 January 1996."

Do you want me to go through all that?

COUNSEL: No, sir.

THE CORONER: There was a skin treatment and the skin was beginning to break down.

"Arthrotec was commenced on 8 January 1996 – a pain killer, non-steroidal anti-inflammatory drug; and sepostratol (?) which helps protect the stomach against ulceration, in the form of a tablet given twice a day, and that was initiated by Dr Barton.

B

On 10 January 1996 I conducted a ward round together with Dr Barton and Sister Hamblin on the Dryad Ward. Oramorph 5 mgs commenced at 22.00 hours on 10 January 1996. 5 mgs at five times a day. This is an opiate drug which is given orally, primarily used to kill pain. Oramorph was given as a result of the patient stating that he was in pain. It was given to alleviate the pain and also help alleviate any distress.

C

On 11 January 1996 the drug chart was re-written by Dr Barton. The diazepam has been increased to 5 mgs to be given three times a day. Oramorph had been maintained at 5 mgs four times a day. The dose at night had been increased to 10 mgs. This would be to try and render the patient pain free at night. This dosage being given orally is maintained until the morning drug round conducted by Dr Barton on 15 January.

D

On 12 January the sertraline and lithium carbonate had been stopped by Dr Barton and on 15 January it appears that a syringe driver was commenced containing diamorphine, an opiate drug. The dosage was recorded at 8 mgs over 24 hours.

Diamorphine is used as a pain killer and to alleviate distress by making the patient more comfortable. Also contained within the syringe driver was hyoscine and the quantity of 400 micrograms. This is used to dry up secretions on the patient's chest.

E

Midazolam, 60 mgs over 24 hours was prescribed and put into the syringe driver and this drug is another antylitic drug, used to reduce anxiety and agitation.

On 16 January 1996 the mixture of drugs in the syringe driver continued at the same dosage rate. However, haloperidol at 5 mgs over 24 hours was added to the driver. It is an antipsychotic drug that can be used for acute confusion and agitation.

F

The above driver containing diamorphine, haloperidol, Midazolam and hyoscine were only given as the patient was distressed. These drugs administered subcutaneously are intended to alleviate the patient's symptoms.

On 17 January 1996 it is noted at 09:00 hours that the nurses' record shows that the patient remained tense, agitated and distressed on turning. The patient is seen by Dr Barton and a note recording the medication has been reviewed ...."

G

– "and altered" I believe.

"However, I am unable to read the entry for the prescribed dose of drugs for 17 January as they are illegible. However, it would appear that the dosage of diamorphine has been increased to 120 mgs. From 18 January 1996 the following dosage of drugs were administered in the syringe driver for Mr Pittock – haloperidol

H

20 mgs over 24 hours, diamorphine 120 mgs over 24 hours, hyoscine 12,000 micrograms over 24 hours, Midazolam 80 mgs over 24 hours.

At this stage there were two syringe drivers in operation delivering this dosage at a constant even rate. Also added, included in the syringe driver at the same time was nozidan, 50 mgs over 24 hours."

B What is that?

COUNSEL: Sedatives.

THE CORONER: "On page 27 of the nursing notes Nurse Douglas notes the fact that the patient's skin was marking easily, despite hourly turning.

C The patient remained distressed on being turned. The patient was on a special mattress to help prevent pressure sores. Mr Pittock at this stage was very poorly.

My observation with regard to the initial dosage of drugs used by the syringe driver was set up as follows. I would have used a lower dosage of the diamorphine and Midazolam. However, I must point out that I did not see the patient when this dosage was commenced. At that time there was no resident doctor at Gosport War Memorial D Hospital to review the medication and these dosages. Therefore, the prescribing doctor cannot always be present to change the dosage if and when required. I will add that I am not an expert in palliative care.

On 18 January 1996 the doses of Midazolam, diamorphine and hyoscine were not changed. The haloperidol was stopped from 20 January 1996. The nozidan was increased to 100 mgs over 24 hours and on 20 January as the patient's symptoms were E still not controlled.
On 20 January 1996 the dosage of diamorphine, Midazolam, hyoscine and nozidan remained the same and continued to be administered until the death of Mr Pittock.

On reviewing the nursing and medical notes it would appear that on 21 January 1996 that the patient was much more settled. Where I have stated that the patient Leslie Pittock was very poorly, from reading his notes it was likely that this patient was F dying.

I have been shown and reviewed a photocopy of the microfiche, an exhibit, page 13, and I can confirm that the entry dated 10 January 1996 was written by me during a ward round, Dryad Ward, Gosport War Memorial Hospital. The following is written 10 January 1996: *Depression; catheter, superficial illness, transfer from Mulberry; Barthel 0; will eat and drink; TLC. 1D/W (wife) agrees in view of very poor quality* G *TLC.'*

I would observe that the patient was seen by Dr Lord on the Mulberry Ward. There is a letter from the consultant, Dr Lord, outlining the psychiatric and medical history of the patient, which resulted in the transfer of Mr Pittock to Dryad Ward. This letter states that Mr Pittock's diagnosis is chronic resistant depression. He had also suffered from a recent chest infection. At the time of the transfer to Dryad Ward he was also

H

(Inaudible) which means that the proteins in his blood were low, which might be due to his poor nutritional state.

The history of the patient has also been summarised by Dr Barton at the beginning of the medical notes on his admission to Dryad Ward on 5 January.

Where I have written 'catheter' I have reviewed the patient's notes and noted that due to his inability to pass urine a catheter was fitted on 23 December 1995 whilst he was on Mulberry Ward.

Where I have written 'superficial ulcers' these were noted to be on the patient's left buttock and left hip. This is a sign of immobility and general poor health. The nursing notes on page 12 state that the patient has broken skin on his scrotum.

Where it is written 'Barthel score 0' this means that the patient was completely dependent on nursing care. He had a catheter inserted and was incontinent.

It was also noted within Dr Lord's letter that the patient is eating very little and will drink moderate amounts with encouragement.

Where I have written 'will eat and drink' at this stage it is one of the few activities of daily living that Mr Pittock is able to manage. Where I have written 'transfer from Mulberry Ward' is self-explanatory.

TLC means the patient is to be kept comfortable, that he is not in pain or distress.

Where I have written DW wife agrees in view of pure quality of life, the scribble is not legible, TLC; this means that I have discussed Mr Pittock's very poor condition with his wife at the time of the review of Mr Pittock. I made her aware and she agrees with the care plan to be provided to her husband. TLC, I translate this to mean that the patient's prognosis was extremely poor.

I believe that the relief of suffering for the patient is paramount. This does not preclude active treatment if the intervention would improve the patient's symptoms. The overall prognosis that I have made has been reached as a result of reviewing the medical notes, discussions with members of the clinical team, discussion with Mr Pittock's wife and examination of the patient.

My role as a consultant geriatrician is to check that both current and planned care is appropriate to their needs and, where possible, to verify in accordance with the patient's and family's wishes.

I note from the nursing notes on 9 January that the patient had told the nursing staff that he had generalised pain. I also note that on 9 January from the clinical notes that Dr Barton recorded the fact that the patient had pain to his right hand. Dr Barton also reported the fact that the patient was becoming increasingly anxious and agitated.

With reference to page 15 of the exhibit, which relates to the final entries on the clinical notes, are as follows: 18 January 1996 further deterioration. The next two lines in this entry I am unable to read. The final entry is 'Try nozidan'.

It is my understanding that Mr Pittock's symptoms were not controlled by his current drug regime. He was commenced on nozidan, a drug used in palliative care to help control agitation and anxiety.

On 20 January 1996 'has been unsettled on haloperidol and syringe driver' and the next part of this entry is unreadable. The last line of the entry reads, 'increase nozidan 50 mgs to 100 mgs in 24 hours (Inaudible)'. I note that half the haloperidol has been stopped on this date 20 January and the following entry, dated 21 January, appears to be written by the author of the entry ... (Inaudible). 'Much more settled; quiet breathing; R rate 6 p minute. Not distressed. Continue' Entry signed by an unknown doctor.

R rate is the respiratory rate which is noted as 6 per minute, which is slow; the normal respiratory rate would be ten to 15. It would appear that as the patient's symptoms were finally alleviated that it was felt appropriate to continue with the current drug regime.

I have nothing to add with reference to the final entry on page 15 of that exhibit. The death of Mr Pittock is verified by two members of the nursing staff.

As regards my observations concerning the initial dosage of diamorphine and Midazolam given to Mr Pittock, administered by a subcutaneous syringe driver, I wish to clarify why I would have administered a lower dosage initially. My normal practice is to use the lowest dosage likely to achieve the desired outcome for the patient, thereby diminishing the possibility of adverse effects. This dosage would be reviewed and increased as necessary. I noted it proved necessary to increase the dose of diamorphine administered to Mr Pittock."

I go on to Michael Brigg. Employed as a general practitioner, working at the Forton Medical Centre, Whites Place, Gosport. He joined the practice in 1993; fully registered with the GMC since 22 August 1982. Final medical degree exams in 1981. Various diplomas.

"From October 1993 to date I hold the position as principal in general practice, Dr Beesley (?) and Partners, Whites Place, Forton Road. I have been asked to detail my involvement with the patient Leslie Pittock, born Code A

I have been shown the photocopy of the microfiche which are the medical notes on Leslie Pittock whilst a patient at Gosport War Memorial Hospital.

I can confirm on page 6 that I was the authorising doctor for the entry relating to nozidan, 100 mgs subcutaneous in 24 hours, dated 20 January 1996. Dose 100 mgs verbal order Dr Brigg, 17:20, which has been signed by Tina Douglas, a staff nurse and counter signed by PS Ring(?). This entry has then later on that day, 20 January, been signed by myself. I cannot recollect the time that I wrote this entry on 20 January.

The standard practice at the time when a sister/nurse in charge on the ward was concerned with a patient's clinical condition was to ring the duty doctor to discuss the patient's problems. The duty doctor could then make the decision based on the

information given by the nurse regarding the patient's management to change treatment and/or to visit the patient. If an immediate change in medication was necessary this might require a verbal order to be given in order to avoid delay in carrying out a change of treatment for the patient.

At a later stage this verbal order should be countersigned and confirmed by the ordering doctor. In this particular case the clinical problem arose when a syringe driver was due for recharging. The nurse's review of the patient raised a concern about his clinical response to some of the medication previously prescribed, in particular haloperidol. It was thought that the patient was developing side effects from haloperidol. These effects included agitation and movement disorder, both of which are recognised with higher doses of this drug. I was also concerned that several different drugs were being used in the syringe driver which might affect the pharmaceutical properties.

Since haloperidol and nozidan have broadly similar indications I felt it was appropriate to stop the dose of haloperidol and replace it by increasing the dose of nozidan. The higher dose of nozidan then has the added advantage of sedative properties which would be appropriate in this situation as the patient was agitated. I did not physically see the patient Leslie Pittock prior to the time that verbal order was carried out. However, I subsequently visited the ward, checked the patient to ascertain whether he had responded and settled to the treatment change that I had made. I have recorded my clinical decision on page 15 of the exhibit as follows:

> *'20 January 1996. Has been unsettled on haloperidol in syringe driver. Discontinue. Must change to higher dose of nozidan. Increase nozidan 50 mgs to 100 mgs in 24 hours (verbal order).'*

With regard to this entry I stopped haloperidol and ordered an increase in the dosage of nozidan. This entry confirms the verbal order that I had given at 17.30 on 20 January to the nurse. I have been shown page 7 of the microfiche which is the drug record for Leslie Pittock, and on 20 January at 15.30 hours it shows that the syringe driver was charged with diamorphine, Midazolam, hyoscine and haloperidol. The syringe driver was subsequently charged at 18:00 the same day as per my verbal order."

Do you think that means "charged" or "changed"? What expression would have been used.

COUNSEL: Either.

THE CORONER: "The fourth edition of the book of *Terminal Care* by (Inaudible) lists the dosage for haloperidol between 5 to 60 as an antiemetic."

Again, do we think that is 50 to 60 or 5 to 60? 5 to 60; thank you.

> "Nozidan has a dosage of 25 to 500 mgs in 24 hours. It is also noted, however, that extra (Inaudible) side effects are likely to occur with dosages above 20 mgs haloperidol.

The entry for nozidan suggests the lowest effective dose to be used unless sedation is required. On this basis I felt that 100 mgs of nozidan in 24 hours was appropriate for the patient's needs. I was discontinuing haloperidol and anticipated a compensatory increase would be necessary in order to alleviate antiemetic tranquilliser.

To show that a change of drug regime has been made the original syringe dosing has been crossed out in a manner that does not obscure the previous dose record. This allows continuous retrospective analysis of administered drug dosage.

I presume this has been completed by a nurse at the time of changing the drug dosage and is entirely appropriate to the maintenance of an accurate record. My understanding is that the previous dose would have been disposed of according to the standard hospital protocol.

With regard to the haloperidol dosage recorded on page 7, this prescription has also been discontinued, marked by a double hatch line, which I recognise as my usual way of indicating this. It also looks like my handwriting style. In this case I have not signed the entry, which is my usual practice.

The entry relating to diamorphine, Midazolam, hyoscine have been written and recorded by a member of the nursing staff.

I note that on page 6 the original 50 mgs dose of nozidan appears to have been admitted when the driver was recharged at 15:30 on 20 January. Had I noted this error at the time when countersigning the verbal order to change the drug regime it is quite possible that I would have revised my decision to increase the dose of nozidan from 50 mgs to 100 mgs and in these circumstances I might have continued with the haloperidol. However, in general I tend to favour the nozidan over haloperidol and it is quite possible, therefore, that I may have let my decision stand as the patient appeared to be well settled on the dosage he was receiving.

I would also have brought the error to the attention of the nursing staff in order that the appropriate investigation and audit would be undertaken according to standard hospital procedure.

It is worth noting that the nozidan is written up as the 'as required' section as opposed to the regular prescription which is on page 7.

I can confirm that I wrote the following entry on page 15 of the clinical notes – 'much more settled, quiet breathing; R rate 6 per minute, not distressed. Continue.'

With regard to this entry, 'much more settled' is self-explanatory. 'Quiet breathing' means that he did not have any rattle; there was no excess labour in the breathing pattern. 'R rate' respiratory rate 6 a minute. I would have noted if the breathing was irregular or shallow. The rate of 6 per minute is slow but I would bear in mind that he was under the influence of diamorphine and therefore this would have been expected. I would also have noted whether his skin colour suggested excessive respiratory depression, i.e. cyanosis, pallor or sweating. Where I have written 'continue' I mean to continue with the current drug regime. Where I have reviewed the drug regime and stopped the haloperidol, this has been based on the report on the patient's clinical

condition, which I received from the nurse by phone. This includes a discussion with the nurse about possible causes. A senior nurse such as staff nurse Douglas has extensive personal experience of palliative care, including a knowledge of different drugs and their specific side effects. Staff nurse Douglas expressed the suspicion that haloperidol may be causing side effects.

I do not remember the patient Leslie Pittock; however, I clearly remember the clinical issues involved and the reasons for my decision. At this time in 1996 the medical cover for elderly patients of Dryad, Daedalus and a limited number of Sultan Ward beds at Gosport was undertaken by my partnership. This was a consequence of an agreement between one of our partners, Dr Barton, and the practice – at that time Dr Mappin and Partners – that the practice would undertake Dr Barton's responsibilities as a clinical assistant in elderly care. It is my understanding that in effect Dr Barton sub-contracted on call responsibilities for the hospital to the practice when she was not on cover to the practice.

I would undertake all of my on call commitments and did not make use of deputising services. I would therefore take responsibility for seeing any clinical problems arising in elderly care patients at Gosport whilst I was on call at the practice. When this occurred I was in effect acting as a clinical assistant on the ward."

Can I have a break?

(Short adjournment)

THE CORONER: The latest on Mrs Wiles is that we have no response to the witness summons; we have had no acknowledgement and have had reply to the telephone call, so I do not know how you want me to handle this? I am more than content to leave it out of account altogether or admit it under Section 37 I will do so, or I will leave it on file and we can review it at a later time after further attempts to contact her.

COUNSEL: I am happy that her statement is read for the moment. You were planning to call her. You clearly had had a positive response at an earlier stage which led you to say that you would be calling her and if there has been a change of heart it would be nice to know that.

THE CORONER: She is also from North Yorkshire and I do not say that in any kind of partisan view ---

COUNSEL: You are talking distance.

THE CORONER: I am talking distance. It may well be that she took the view not to come, but it seems odd that she has not answered the telephone.

COUNSEL: It wounds like she may be on her way.

THE CORONER: Shall we leave it?

COUNSEL: Again, I am content that you read the statement.

THE CORONER: Shall we deal with Mrs Barrett first, shortly, and then review it at that stage?

B COUNSEL: But rather than send the jury out again, if we reach that part, for my part I am content that the statement is read, but if she can come I would be very keen to ask her a few questions.

THE CORONER: Right. Jury in, please.

(The jury were brought into the court room)

C LYNNE JOYCE BARRETT, Affirmed
Examined by THE CORONER

THE CORONER: Mrs Barrett, thank you very much for being here; I am very grateful. Do sit down, please. You are Lynne Joyce Barrett?
A I am.

D Q Tell me about your work history and your qualifications.
A I began nursing in my training for qualifications in 1969 and ended them in 1972. I then became a staff nurse on an ear nose and throat ward in Hull Infirmary. I then got married and moved to Portsmouth and did a fairly short stint as a staff nurse on a young ward, which is primarily a children's ward. I then left to have my eldest son, went back to nursing in Plymouth and did bank work, which means I was only asked to work as and when E was necessary when they needed me, and that included various different areas of hospital units. I then left there when I was pregnant with my youngest son and came back down to Portsmouth. When my youngest son was nine months old, I believe, I went to work in the private sector at the Telasser(?) Nursing Homes Group and worked within that group for some years and then went back into the NHS, working at Redcliffe Annex, which was a long stay unit for elderly patients and then when that was closed we moved up to the new hospital, as it was then, into a ward that was specifically built for us, which was Dryad Ward. Then I F left there, took early retirement from there and I have actually now retired completely from nursing because of ill health.

Q So when did you actually engage with Gosport War Memorial Hospital full time?
A Full time, 1987 I think it was.

G Q And you worked what kind of shifts?
A Early and late shifts. At that time early shifts consisted of twice a week I would work from 7.30 to 4.15 and once a week I would work 7.30 to one and twice a week I would work 12.15, I think it was, until 8.30 and then two days off.

Q General nursing duties?
A Yes, because that is what my qualifications are, just general nursing.

H

Q Can I ask if you have any recollection of the patients we have been talking about, particularly Mr Pittock?
A I have not, no; I have to be honest, I do not have any at all.

Q I think you have referred to various notes?
A Yes, I have looked through my folder and I have listened to what has been said but I cannot remember the gentleman, I am afraid.

Q The notes that you have, where have they come from?
A I was given them by the solicitors when I went to a meeting some weeks ago. There were copies of statements that had been given to the police over a long period of time.

Q Hospital notes?
A The hospital notes were not actually in the folder but I have been shown hospital notes in the past, yes.

Q Tell me about the general practice at Gosport; who ran it, who was clinically in charge?
A On the ward or the whole hospital?

Q On the ward?
A On the ward we had a clinical manager, or sister as she was always known to people, and at the time that I was there that was Gill Hamblin. Under here was usually a senior staff nurse – we had two or three while I was there. Then it was the E grade staff nurse – I was one; D grade staff nurses and then untrained staff and we were all responsible for the day to day working on the ward.

Q In the event that drugs were prescribed by a doctor who would that doctor be?
A Dr Barton was our clinical assistant. If she was not available – on holiday or days off or anything or out of hours – we got in touch with her practice and one of her partners deputised for her. At one stage I think we were also covered by Primecare, which was a deputising service.

Q Were you really?
A Yes, I think that was the name.

Q Interesting.
A This was some years ago.

Q Who was the consultant in charge, do you know?
A We had several while I was there. There was Dr Lord; there was Dr Tandy, Dr Reid. Who else? We had several while I was there but they are the three that sort of stand out. We also had Dr Sethers(?) at one stage but I do not think he stayed with us very long. We also had another gentleman, a consultant, but I cannot think what his name is now; he was with us quite some time as well though.

Q Good relations at the hospital?
A Most of the time, yes. It was only a small hospital and because a lot of the staff like myself had been there years we all tended to know each other, even if not to stand and have a conversation we would speak to each other in the corridor. So we tended to know each other.

Q That can have a converse effect, can it not, if you are working in a small unit, that you can get on people's nerves and have fairly fractious working relationships?
A I do not think so; we had a fairly good working relationship with everybody on the ward. Obviously we all had our off days, everybody does, but 99 per cent of the time we all worked well as a team – we got on well.

B Q Can I ask you about prescriptions? The doctors would write up prescriptions.
A Yes.

Q The prescriptions would then be drawn from the pharmacy.
A Yes,

Q And you would administer the drugs?
C A Trained staff were the only ones that would administer the drugs.

Q But you were trained staff.
A Yes.

Q When the drugs were administered in that way was the record card, Cardex system signed and countersigned?
D A If it was just a normal medicine round, a general medicine round then it would only be signed by one signatory and you had to initial the drug that you had given at the time you had given it. But what we called controlled drugs had to be signed by two people – or had to be witnessed and signed by two people, two general nurses.

Q Would that have been signed by both nurses or would one nurse sign and say that another nurse had been there?
E A No. In the drug book it had to be given – it had to be signed and witnessed. So one nurse would witness, would sign as given and the other nurse would sign, as witnessed as giving the drug.

Q That is in the drug book.
A Yes, and on the prescription chart itself the person who had actually given the drug would finish up where they had given it.
F

Q On the Cardex system, I was concerned yesterday that there was a suggestion that one of the signatures was not a signature but was a name written.
A I see what you mean; you mean in the actual Cardex where we made our notes bigger?

Q Yes.
G A If it was just in the Cardex where we made general notes on patients, such as "not very well today" and things like that, if you did something with another nurse then, yes, my practice was to put, so and so given by me and witnessed by – and I would write the nurse's name. If she was available to sign it while I was writing it then I would ask her to initial it at the side to say that she had seen me do that. But on occasions I would just write that this person had actually witnessed. That would not happen in the drug book or anything like that; that would just be in the nursing notes.
H

Q The Cardex.
A Yes.

Q The suggestion was that you would treat a "ditto" entry similarly. So if you had done something and it was merely a repeat of that it would be a ditto entry. Does that mean anything to you?
A No. My practice was always to sign my name and to say what I had done. As I say, hopefully if the person was there, to get them to sign it as well, but if not I would just make a record of who I had been working with at the time.

Q The prescription of drugs, was that a physical prescription that you were given?
A Sorry?

Q Doctors writing up diazepam, the doctor would physically write a prescription?
A Yes, the doctor had to be physically there to write on the prescription chart.

Q That would then be taken to the pharmacy.
A Yes, sometimes, but at one stage we did actually have a pharmacist who came to the wards, which that practice was not done; so it was sent to the pharmacy in block form.

Q The drugs would then be returned to you.
A Returned to us, yes.

Q The difficulty with out of hours access to doctors, it has been referred to in the statements that I have read this morning, and in particular the general practitioner from Dr Barton's practice, the last one I read, Dr Brigg, who said that it was the practice that if you were in need, or a patient was in need urgently he may give a verbal order; is that right?
A Yes, I have on occasion taken verbal orders but there was also a protocol that we used to do for that as well. If we had to take a verbal order then that verbal order had to be given to two members of staff, to two trained members of staff who would phone. Say it was me or one of my colleagues, it would have to be repeated to me and then again to another member of trained staff; then the verbal order would be written on the chart and the doctor that had given the verbal order had to physically be there within 24 hours to sign the chart.

Q Or what?
A Or we would be ringing him and finding out where he was and then the pharmacist would be told and they would be asking where he was.

Q When the doctor then attended would he acknowledge the verbal order?
A He would look at the verbal order and make sure that it was written correctly in the dosage that he had said, as well as obviously examine the patient while he was there. Then he would sign the notes – sign the entry, and make a record in the patient's notes.

Q The patients that you were dealing with, were they rehab patients or palliative care?
A No. When we initially went on to Dryad Ward we were long stay and palliative care and most of our patients stayed with us for months and even years because the majority of patients that we had, we brought down with us from Redcliffe. So our initial group of patients were actually ones that we brought from Redcliffe with us, so they had been with us for months and years. One of our little old ladies had been with us 12 years. Then that carried on for some time. Later on in years we became what they called slow stream

assessment, which was just another way of saying long term care really because we had these patients as well for months and years. We got patients that nobody else knew what to do with, basically, I am sorry to say. We had all these fancy titles of slow stream assessment and slow stream rehab but basically we were continuing care really – long stay care – because they stayed with us for a long time.

Q Was there a prospect of rehabilitation?
A We used to get physiotherapy on the ward, which I have to say was a bit of a joke really because it was only an hour a week and what they were supposed to do in that hour I do not quite know. We used to get physios in to ask – if we had a particular problem with a patient we would get the physios in to give us an idea of how to stand them, how to walk them and in that way, but we did not have really intensive rehab, no.

Q So how did you see your job? If I were to ask you in 1996 what unit did you work on, what would you have said?
A I would have said a long stay care elderly ward.

Q Medication – you would administer that.
A Yes.

Q Syringe drivers?
A Yes.

Q Were you familiar with the use of syringe drivers?
A When I first came to Redcliffe, no, I had not used them; but I got what you call on the job training in the use of them.

Q If the doctor was prescribing analgesia and that was to be given orally there was no problem that that – you would get the pills from the consultant.
A Mm hmm.

Q If it is to be subcutaneous in normal circumstances you would administer that.
A Mm hmm.

Q Again, writing it up as you go.
A Yes.

Q When the syringe driver is employed would the doctor authorise that and insert it at that moment?
A Once it had been authorised then it would be the nursing staff that actually set it going.

Q Would that be when it was ---
A When it was authorised, yes.

Q Was there any time that it was authorised but not implemented at that time, on a PRN basis – if it became necessary you could do that?
A I cannot remember a syringe driver being on a PRN basis, no.

Q The suggestion is that Dr Barton may have prescribed opiates and the use of a syringe driver because it was likely to become necessary in the next 24 hours. Do you remember anything like that?
A No.

Q The dosage of opiates, you would have some kind of idea of what was right and what was wrong?
A Yes.

Q If you were administering the drugs yourself would you have considered dosage? Would you have thought, "it seems all right to me"?
A You always do; as a trained nurse you look at the dosage and if you had a concern about it then it is up to you as your code of practice to bring that concern up.

Q You would be aware of the analgesic ladder.
A Yes.

Q You would start low and if the patient was coping with that and was comfortable that would be in order for you?
A Yes, as long as it was alleviating symptoms and the patient was comfortable then that dose would remain.

Q What if the patient becomes uncomfortable?
A If it was noted by the staff that symptoms were reoccurring, that the patient was in pain on movement or complaining of pain then it would be up to the nursing staff to report that to the doctor.

Q So each time that happened it had to be reported to the doctor and the doctor would pick it up from there.
A Yes.

Q Were you ever aware of any variable doses of drugs being prescribed?
A Yes.

Q That would be for a maximum and you could go up to that maximum if the threshold was not ...
A We would never increase the dose without medical advice first.

Q So you would check patient needs, contact the doctor and increase dosage.
A Yes, if necessary.

Q That would seem to indicate that the doctor had prescribed a higher dose than that initially being administered.
A Yes.

Q So you could go up to a maximum. Prescribe 20 mgs diamorphine and the prescription may say up to a maximum of 100; does that make sense?
A Yes.

Q Whatever the figure.

A Yes.

Q But that each time you went to increase the dose you would check with the doctor?
A Yes.

Q And that would normally be Dr Barton?
A Yes.

Q Would that be the case whether it was a syringe driver or not?
A Yes. Nurses are not allowed to deviate from dosages without first being told, basically, and having a correct prescription.

Q But your prescription is for up to 100 mgs of diamorphine; you are giving 20 and you are going up to 40 and that you discussed with Dr Barton, or whoever it was.
A It would not go up to 40 anyway because we were only allowed to increase the dose if necessary by 50 per cent of the previous dose.

Q Right. So you increase by your 50 per cent.
A Mm hmm.

Q Would the doctor then write that up on her next visit?
A With Dr Barton she would make it her business to come in during that day and make a note.

Q Make a note on what?
A On the medical notes.

THE CORONER: Thank you; wait there, please? Order?

MR LEIPER: (?) Sir, are you going to go through individual patients with this witness?

THE CORONER: Do you want me to do that because this lady has no knowledge of them. What do you have for Mr Pittock? Do you have anything, any knowledge of him? Tell me what you are looking at?
A I am actually looking at ... I think in here it is only that I have written various statements on his nursing notes. I think the first one is on 9 January I wrote: "Small amount of diet taken; very sweaty this evening but is apyrexial", which means I would have taken his temperature and it would be within normal limits. "And has stated that he has generalised pain. To be seen by Dr Barton in the morning.

Q That is 9 January 1996?
A Yes. The next thing I have written is on 16 January 1996: "Condition remains very poor. Some agitation was noted and being attended to. Seen by Dr Barton. Haloperidol 5 to 10 mgs to be added to the driver." Then another entry that day, 13:00 hours: "Previous driver dose discarded. Driver re-charged with diamorphine 80 mgs, Midazolam, 60 mgs hyoscine formula with micrograms and haloperidol 5 mgs given at a rate of 52 millimoles hourly. Visited by daughter, not Sister Wiles, who is now aware of poorly condition. All nursing care continued. Right ear found to be blistered along upper edge. Please nurse only on back and left side. Marking very easily."

Q Is that 16 January?
A Yes. Then: "I was shown ward control drug book and witnessed an entry with Staff Nurse Freda Shaw." I made another entry in his nursing notes on 18 January 1996: "Poorly condition continues to deteriorate. All nursing care continued." I think that is it really. On 26 January 1996 I wrote: "Poorly but very peaceful. All care given today. Daughters have visit and spoken to Sister Hamblin." Then at 15:15 the same day: "Driver re-charged with diamorphine 120 mgs, Midazolam 80 mgs ... 1200 micrograms and nozidan 100 mgs at the rate of 43 millimoles hourly." Then on 23 January 1996 I wrote: "Poorly condition remains unchanged. Has remained peaceful. All care has continued. Pastor Mary has visited." Pastor Mary was the pastor for the hospital and she would come in and visit patients that the family maybe expressed a wish to see a religious adviser. I think that is it, really.

Q You were not involved in the death announcement with him?
A No, not that I can remember. I do not have anything here. I find it quite sad that I do not remember him; I would like to think I remember all my patients but unfortunately I do not.

Q There was nothing in your dealings with him that was untoward so far as you were concerned from the notes that you have seen?
A No. From the notes that I have written here I can see that I have put that the gentleman obviously was very poorly and that his condition did continue to deteriorate and he obviously did not get any better.

THE CORONER: What I would like to do – and I would be grateful for your views on this – is perhaps to deal with this particular matter and then move on as separate identities to Spurgeon and Devine. Does that make sense?

COUNSEL: Yes.

THE CORONER: If we can deal with Mr Pittock; then I will ask her to deal with Mrs Spurgeon and then when we have done that round we will go on to Mrs Devine. That means we can then release Mrs Barrett and you do not have to put yourself back into that position; but it means that you have to do the mental gymnastics of moving on to somebody else. But this is all Mr Pittock now.

MS BALLARD: Sir, I would like to ask a couple of general questions if that is acceptable at this stage.

THE CORONER: Yes.

<u>Cross-examined by MS BALLARD</u>

MS BALLARD: You started at the Gosport War Memorial Hospital in 1987 and then you retired at some point and took early retirement; when was that roughly?
A 2006.

Q So you have worked at the Gosport for a considerable period of time?
A Yes. That includes Redcliffe Annex as well because although we were not on site it was still part of the Gosport War Memorial.

Q And you moved with it when it became Dryad Ward?
A Yes.

Q You recollect when Dr Barton became the clinical assistant?
A I do not remember when; I remember Dr Barton sort of being there, but I have to say I do not remember exactly when she started.

B Q You say that you were aware – to ask you a few questions regarding prescribing and the administration of drugs – that there were variable doses being prescribed for patients.
A Mm hmm.

Q By that do you mean a range of doses being prescribed for a patient?
A Yes.

C Q Was that specific to any medication or did that cover a wide range of medications?
A It was usually specific to analgesic medications. Normal general medication was usually dose specific.

Q But you do not recollect a practice of prescribing a medication which was not needed at the point that the prescription was made.
A No.

D MS BALLARD: I am grateful; thank you, sir.

MR TOWNSEND: No questions, thank you.

<u>Cross-examined by MR JENKINS</u>

E MR JENKINS: Mrs Barrett, I am asking you questions on behalf of Dr Barton. You have more than 20 years' experience in nursing and nursing in different settings.
A Yes.

Q And many years nursing alongside Dr Barton as a clinical assistant.
A Yes.

F Q She started at the Gosport War Memorial Hospital, I am reminding you, in 1988.
A Oh!

Q Do you recall that she resigned in the year 2000?
A I do not recall. I was told that she had resigned but I do not remember it happening.

G Q After she had resigned, do you remember was she replaced by a full time doctor?
A We did have several doctors on the ward, yes.

THE CORONER: I think the question being put is do you remember a particular doctor that was full time?

MR JENKINS: Do you remember that any doctor appointed was full time?
H A Yes, during the week, Monday to Friday, yes.

Q That is what I mean, nine to five.
A Yes.

Q And from your answer are you saying you recall that certainly the first doctor did not stay full time?
A We had several, one after the other.

Q Did the first one say or complain that he did not have enough time?
A I cannot remember; I cannot answer that.

Q What we know is that she was on Dryad Ward in the mornings and Dr Barton would be there for a limited period of time before she went off to do the other work she was contracted to do as a general practitioner.
A Yes.

Q The hospital management had arranged for her to be there for just a very limited period of time during the working week, Monday to Friday.
A Yes.

Q And you knew as well that she was required to provide services for patients on Daedalus Ward as well as Dryad, where you were working.
A Yes.

Q Was this your understanding, that on a Monday to Friday Dr Barton would be in the hospital and walk round to do a walk round ward round of the patients on Dryad.
A Yes.
Q Then she would go off to do the same exercise with regard to the patients on Daedalus Ward?
A Yes.

Q I think in a statement you made you say that her ward round around Dryad was between 7.30 and 8 in the morning.
A Usually, yes.

Q If you had 20 beds that would not give her very much time with each patient.
A No, unfortunately it did not. We were not always completely full.

Q I understand. But if you had 15 patients that might give her two minutes with each one and if you had 20 it would be a minute and a half.
A Yes.

Q But that is what the hospital managers had arranged for medical cover, Monday to Friday.
A Yes.

Q After she left the ward round or her walk round in the morning, would she sometimes come back at lunch time?
A Yes, she would sometimes come back several times during the day.

Q Again in the evening, to talk to relatives?
A Yes, very often.

Q What impression should we have from your recollection of how busy Dr Barton was when she was on Dryad Ward where you were?
A She was always very busy; she would come in at around about half past seven and she was there sometimes by gone 8 o'clock in the morning. She always had something to do because there was always something we needed to know. She went round and said good morning to all the patients, so she was very busy when she was there.

Q I think you would say that the nursing staff were keen to have as much contact with relatives as could be done.
A Yes.

Q To explain to them what was happening, what the options were, what the treatment was and what the future may hold for the patient.
A Yes.

Q What about Dr Barton communicating with patients' relatives?
A She was always very courteous; she was very honest and answered any questions that the relatives had. She was usually very nice to them and made herself available whenever they wanted to speak to her.

Q You say she was always very honest.
A Yes.

Q Does that suggest that sometimes the news may have been difficult for the relatives to hear?
A Yes. We very often had patients that were very poorly and not expected to survive and Dr Barton was usually the one that had to pass that news on to relatives.

Q Was there any other doctor there on a regular basis who would be in a position to do that?
A No.

Q Sister Gill Hamblin, we know, was the sister on Dryad Ward from 1988 when Dr Barton started, all through until after she resigned in the year 2000.
A Yes.

Q Sister Hamblin would have had a key role in ensuring treatment for every one of the patients that passed through Dryad Ward.
A Yes.

Q Would Sister Hamblin have been present on a daily basis when Dr Barton arrived in the morning to discuss how patients had been getting on.
A Yes.

Q And to hand over information from the night staff.
A Yes.

Q Would Sister Hamblin have had a role in discussing with Dr Barton on any ward round when a consultant came every two weeks the continuing progress of the patient and any treatment that might be thought appropriate.
A Yes. Dr Barton and Sister Hamblin had a very good working relationship.

Q What about your relationship and that of the other nurses with Dr Barton?
A We all liked Dr Barton; I got on very well with her. I always found her easy to approach and ask questions. The staff respected her; they all liked her.

Q This is not a trial of Dr Barton but I just want to ask you one more question. What would you say was her level of commitment to patient care?
A She was very committed; patient care was always a number one priority.

Q We know that with patients some of them would arrive on the ward in poor condition.
A Yes.

Q The expression you used was, "We got patients that nobody else would take".
A Nobody else seemed to want.

Q Perhaps it is clear from that, but let me explore it: are you saying that a lot of patients transferred to Dryad Ward were in terminal stages?
A Yes.

Q You have told us in answer to a question from the learned Coroner, you were asked was there a prospect of rehabilitation and you said: "We used to get physiotherapists, but it was a bit of a joke."
A It was only about an hour a week.

Q They would only come an hour a week.
A Yes.

Q You are not being critical of the physiotherapists at all?
A No, no; in no way. I know they were very, very busy on Daedalus Ward because they were a rehab ward.

Q But that was just the way things were managed.
A That is what we were given.

Q And you said, "We did not have really intensive rehabilitation".
A No.

Q Can I ask about medication for patients? What we have heard is that essentially it was Dr Barton who was prescribing for patients.
A Mm hmm.

Q She would receive information from her own assessment of the patients, from previous medical records and nursing records, where they were available.
A Yes.

Q Can I ask if a patient was transferred to Dryad did the medical records always accompany them or were there sometimes occasions when the medical records came at a later time?
A That happened.

Q Did that cause difficulties?
A Yes. Not a lot of the time but sometimes the notes did not come at all until maybe 24 hours later, or if the notes did come there were parts missing; and on a lot of occasions it was actually the drug charts that were missing from the notes and we would have to get in touch with the previous ward and have them sent back over.

Q If patients are transferred and they are in poor condition when they are transferred in your experience how did patients respond or react to being transferred from one hospital or a nursing home?
A Not very well in a lot of cases because we always kept in mind that these people were elderly people who were usually very frail. Elderly people do not take kindly to being moved anyway because they get used to one set of staff and they get to trust them and things like that, because a lot of the patients that we used to get had been at previous wards for a long length of time, so they have got used to the staff there. When they moved them to us for whatever reason they had a whole new set of staff to have to get used to and they did not always do very well for a few days.

Q What about other patients who may have been treated in a surgical unit in one of the major hospitals locally; were there ever occasions when such patients ... Are you in some discomfort, are you all right?
A It is just my knees; I have to keep moving my knees.

MR JENKINS: If you need a break just ask and I am sure you will be given one. I want to talk about surgical patients, post-surgery patients. If any of those were transferred to the Gosport War Memorial and Dryad Ward, were there ever occasions when it seemed that the patients had been transferred before they were stable, before they were ready to be transferred again?

THE CORONER: That is actually quite a difficult question and I am not sure that it is fair to put that to Mrs Barrett. Are you able to answer that?
A I can only say from my opinion.

Q If you are not comfortable answering the question.
A I think all the trained staff on the ward commented at some point that patients were being transferred to us just a little bit too soon, but that is really all I can say.

MR JENKINS: It was the trained staff saying that?
A All the staff used to mention. I had comments made to me by all staff to say, "Don't you think that Mrs So and So was transferred a little bit too soon?" It just happens.

Q By transferred "too soon" what do you mean in so far as the patient is concerned?
A Because Dryad Ward was not a surgical ward the surgical team maybe thought that that was okay to transfer them at that stage, but we used to think sometimes that they were maybe just a little bit still in pain or maybe their wounds were not quite healed sufficiently – just things like that, really.

THE CORONER: Was that anything to do with the pressure on beds at the transferring hospital?
A Very much.

MR JENKINS: In the late 1990s, the second half of the 1990s was it well known amongst medical people, nursing people that there were significant pressures on beds in hospitals?
A I think it was a big topic, yes.

Q And was it your understanding that that led to a high level of patients being transferred to units such as yours.
A Yes.

Q So we have dealt with patients who arrived on the ward. You have told us whether the notes or the medical records were always there. They would always be assessed by Dr Barton once they arrived.
A Yes.

Q Or if it coincided with a ward round perhaps by the consultant.
A Yes, that happened sometimes, yes.

Q Again, if there were drugs to be prescribed for the patient it would be Dr Barton typically who would do that.
A Mm hmm.

Q If over the course of their admission to Dryad Ward the patient's condition changed would Dr Barton be told about that?
A Yes, any change would be told to Dr Barton.

Q Would that happen in two ways, either if it could wait Dr Barton would be told the following morning, if it was a weekday, when she arrived to see patients; or if it could not wait would a phone call be made.
A Yes.

Q Would you be involved in making phone calls or would that normally be left to Sister Hamblin?
A No, it would always be the one of the trained staff on duty at the time. If it was me I would make the phone call; if it was one of my colleagues they would do it.

Q Again, was there ever any reluctance on Dr Barton's part to deal with the matter?
A No.

Q Either by coming out or giving advice over the phone?
A No, she would always give advice over the phone.

Q We know that patients would occasionally require pain relief, analgesia.
A Yes.

Q We have heard of occasions when there may be a range of medication prescribed. What you have been asked about if pain relief perhaps to be given by a syringe driver and a

range of, let us say, 20 mgs of diamorphine up to 200 mgs; is that something that happened from time to time?
A Sometimes.

Q If a syringe driver was to be started what would the nursing staff do so far as that range of medication was concerned?
A We would always start at the lower dose.

Q If the patient's pain was not controlled and they were in pain, agitated, distressed and the nursing staff had a view about whether the medication was controlling the patient's pain, would you let Dr Barton know what that view was?
A Yes.

Q What you have told us was that as a trained nurse you always look at the dosage.
A Mm hmm.

Q You said it is up to you, and I missed the next bit. Were you talking about the Code of Conduct that applies to nurses?
A We have to make sure that when a prescription is written that it is readable, that the dosage is readable, that it has been signed by a doctor and that the times that it needs prescribing have also been written.

Q What about when any medication is administered to the patient?
A It has to be signed for.

Q I understand. But were you making the point that it is the nursing staff who were giving the medication to the patient?
A Yes, the nursing staff do it.

Q Either in tablet form or by some form of injection.
A Yes, the nursing staff do the medications.

Q I want to be clear. Were you saying that when you are giving it you clarify in your own mind that it is appropriate for that patient?
A Yes.

Q Not just that the doctor has written it out but that the patient will benefit from it.
A Yes.

Q That if the doctor had prescribed something which you thought was inappropriate for the patient, what would you do?
A Speak to the doctor.

Q Would you expect any trained nurse to do exactly the same?
A I would expect them too, yes.

Q So for any dose of medication that you gave to any of the patients on Dryad Ward, can we take it that you were satisfied that it was medication that was for the benefit of the patient?
A Yes.

Q And you would expect any nurse to be in the same position?
A Yes.

MR JENKINS: There has been a lot of press publicity about this case and the press have reported the suggestion that patients were being given too much medication ---

THE CORONER: No, I do not think we can go there in that way. If you would like to put that differently. I think if this lady feels that there was a problem with medication or if her mind has been affected by the publicity, but I think you need to watch how you put that to her.

MR JENKINS: I was inviting her to deal with it – a suggestion that is in the press, and to give her response to it, because it is not a suggestion made in the inquest.
A I have not seen any of the reports.

Q You have done well.
A I do not watch it on the television either.

Q Can I invite you to consider this as a proposition – and it is not what I am suggesting is the true position? There is a suggestion that patients were being over-treated with medication.
A Yes.

Q That there were prescriptions which were in excess of what the patients required and that drugs were being administered in excess of what patients needed for pain relief. What do you say about that?
A Rubbish.

Q Rubbish?
A If I had any concerns about people having too much then I would have voiced my concerns, and I never did.

MR JENKINS: Thank you very much.

THE CORONER: Any generic questions? Mr Wilson. This is Mr Wilson, whose father died at Gosport, which is one of the inquests that we are doing. What I have said to the families is that if they have questions of a generic nature, unless it relates to their relative then I will listen to the question and if it is appropriate allow it to be put.

<u>Cross-examined by MR WILSON</u>

MR WILSON: Going back to the administration of prescriptions out of normal hours, you said that two trained nurses – one would administer it, one signed it, etcetera, etcetera. You also stated that if you had to up the prescription it would be phoned through to a doctor and a doctor would give that authority over the phone.
A Yes.

Q Then the doctor must come in and sign that prescription within 24 hours.
A Mm hmm.

MR WILSON: What happens if he or she does not?

THE CORONER: I thought I asked that question; I specifically asked that question.

MR WILSON: I do not think you got an answer to it though.

B THE CORONER: Yes, she said that all she would do was take it back to the pharmacist and ---

MR WILSON: No, no, no, I am asking what would be done ---

THE CORONER: Sorry, I am talking ---

C MR WILSON: What is the official ---

THE CORONER: I am talking and I am talking to you and what I am saying to you is that this witness said that if she could not get a doctor and a doctor did not come in it was referred back to the pharmacist; I think that is what you said?
A Yes.

D THE CORONER: And the pharmacist would need to pick it up at that point.

MR WILSON: And what would be the sanctions at that point?

THE CORONER: You would not know.
A I do not know what the pharmacy would do.
MR WILSON: What I am trying to establish is, what would happen if the doctor, for
E argument sake, was on an emergency and could not get in for, say, 36 hours to sign that prescription? What would happen in that case?

THE CORONER: Would you know?
A No. Obviously if it was getting up to the 24 hours we would ring to remind him and get them in touch with the pharmacy but what happened after that I do not know what they would have said to him. I presume they would have said, "Get in and sign it."
F

MR WILSON: And if that was not signed what would then be ... What I am trying to establish is if a prescription is authorised in the middle of the night by a doctor and it is not signed up by the doctor within that 24 hours, what happens? Does anything happen to the doctor? Is the doctor under any sanction or can the doctor come in at 48 hours ---

G THE CORONER: I am not sure that the ward sister would know the answer and she is saying to me she does not know the answer. There may be a protocol in the health authority that deals with it; somebody might pick it up as a result of your question.

MR WILSON: You mentioned patients who had transferred without medical notes sometimes. How often would you say this happened?
A I would have to say rarely.

H Q Rarely? At a minimum. Most patients did transfer through?

A The vast majority of patients had their notes with them.

MR WILSON: Thank you.

THE CORONER: Mr Farthing. Mr Farthing's step-father died, Mr Cunningham.

Cross-examined by MR FARTHING

MR FARTHING: If I can ask whether you were dealing with Dryad Ward in 1998?
A Yes.

Q You mention that some cases came from surgical units to the ward too early.
A Yes.

Q Because it was not that type of ward.
A Mm hmm.

Q What was it?
A It was a long stay continuing care ward for elderly patients.

Q Are you talking about Dryad Ward?
A Yes, Dryad.

Q Can you describe what the ward was? What did it comprise of? Was it five or six cubicles with four beds in each?
A We had three wards with four beds and the rest were single cubicles.

Q What I am driving at here is, from my recollection there were about half a dozen cubicles with four beds in each and I recall clearly one person in each cubicle in different states approaching death.
A We had three four-bedded units and we had eight single rooms and the patients who were very poorly usually went into the single rooms out of a matter of respect for them and their families really.

Q Perhaps I did not see the whole ward.
A It was quite a long ward.

THE CORONER: Can I just say, Mr Farthing, that I think you are on a hiding to nothing for any number of reasons. You can tell us about it when you talk to us. This witness's recollection is not quite the same as yours. She says there were eight single cubicles and three cubicles with four beds.

MR WILSON: Can I ask a direct question which you may not want to answer? Have you ever heard of that ward being called the "death ward"?
A No.

Q If it is decided to introduce a syringe driver at some stage in what condition would the patient be placed? Would he be given drugs beforehand?
A I did not quite understand.

THE CORONER: You say as part of a drug regime it would not be the first step on the ladder; is that what you are suggesting? So the patient would have been medicated before the syringe driver?

MR WILSON: (Inaudible)

THE CORONER: So it would not be the start of a drug regime?
A No, they would have been taking oral medication first. Then when they were unable to swallow or for whatever reason could not take oral medication then the syringe driver would be considered.

MR WILSON: What I am driving at here is what state would the patient be put in before the driver was actually applied?
A They would not be put into any state.

Q Would you not expect them to be in a somewhat drowsy state beforehand?
A No. It is only a tiny needle under the skin; there would not be any need to sedate them, if that is what you mean.

Q Yes, it is.
A No, there would not be any need.

MR WILSON: Thank you.

Questioned by THE CORONER

THE CORONER: We are going to do a quick mind shift, ladies and gentlemen, unless you have anything in particular relating to this particular matter. What I want to do is to move on to Mrs Spurgeon. I do not know how long we are going to be with Mrs Spurgeon but I would suggest that we make a start and if you could tell me what your dealings with Mrs Spurgeon were in your note, that would be the easiest thing to do.
A Yes. I think my notes were just basically explaining the care plans that were used on the ward and explaining the named nurse system. And the few entries that I seem to have made in the nursing notes.

Q What page number are you looking at, top right?
A Page 3 – 2 and 3.

Q That is your statement of 3 February.
A Yes.

Q You talk about a nursing care plan, a recognised document which sets out for all patients coming on to the ward activities of daily personal needs, including dietary and mobility put into place to ensure that all members of staff are aware of those needs. Care plans are updated as and when the patients' needs change. This may be on a daily basis or otherwise depending upon the individual.
A Mm hmm.

Q So in 1999 you are on Dryad Ward – an elderly care ward you describe it as.
A Mm hmm.

Q Tell me about the practice then?
A The practice then, the ward was not physically split into, but it was split into two halves and we had what they called the named nurse system. I was the named nurse for one half of the ward and my colleague, staff nurse Shaw, was named nurse for the other half of the ward. The named nurse is basically a point of contact really for relatives and families to get information from so that they recognise a face on the ward when they come on to the ward and just to be updated by really.

Q So what was your involvement with Mrs Spurgeon?
A I cannot remember Mrs Spurgeon, but, as I said, a lot of these were explaining what the care plans were. 26.3.99 the care plan for (Inaudible). Then it goes on to explain what the care plan is.

Q "To make sure Enid was warm and comfortable in bed. Offer commode/bedpan as required; offer warm night drink."
A That is the sleep one, yes.

Q "Give prescribed analgesics, night sedation and monitor effectiveness. Ensure drinks, call bell within reach and ensure privacy and dignity at all times."
A Yes.

Q That was your night care plan.
A That was the night care plan which would have been filled in by the night staff rather than the day staff.

Q So when do you come into that?
A It just seems to be care plan.

Q Page 84 care plan reads 26 March 1999, "Enid is experiencing a lot of pain and movement. (Inaudible) to eliminate pain if possible and keep Enid comfortable, which should facilitate easier movement and mobilisation. Nursing action: given prescribed analgesia to monitor effect. Position comfortably. Seek advice from physiotherapists regarding moving and mobilisation." Is that right?
A What page is that?

Q That is page 5, page 84 in the care plan.
A Yes.

Q Then 27 March: "Having regular Oramorph but still in pain."
A Yes.

Q Then 28 March; do you want to take me to that?
A Yes. "Has been vomiting with Oramorph. Advised by Dr Barton to stop Oramorph. Is now having Methyclothiazide tbs" – that means three times daily – "and co-codamol" – this is an analgesic. "Vomited this afternoon." And page 85 reads: "After using commode refused supper." On 29.3.99: "Please review pain relief this morning." And that was signed

by Janette (Inaudible) who was one of the night staff, staff nurses. 31.3.99, now commenced on 10 mgs of MST – that is morphine tablet bd twice daily. "Walked with the physiotherapist this a.m. but in a lot of pain. The physio demonstrated how to get Enid from chair on to a gutter frame, support round the waist and hip and bottom level and asked Enid to push herself up into a standing position. 13:15 (Inaudible) solution 2.5 mls in 5 milligrams given for pain but with not too much effect." This entry is by me. 1.4.99 seen by physiotherapist. To remain upon bed during day over Easter holiday. Do walk with gutter frame once or twice a day. See Sheridan ..." That is actually supposed to be Dunleavy and not Dunleary. Sheridan Dunleavy is a physiotherapist. "Still having pain on movement." 3.4.99: "MST 10 mgs bd continued. Still complains of pain on movement. 8.4.99 MST increased to 20 mgs bd. 9.4.99 to remain on bed rest. Dr Reid to see X-ray of hip. 11.4.99 in pain on movement. Oramorph 5 mgs in 2.5 mls given at 15:00 hours." Page 86 reads: 4.4.91?

Q The date is wrong.
A "Wound on right hip oozing serious fluid and blood. Steri-strip in situ at present." Then it is the care plan. "Decide outcome to promote healing and aim to prevent infection. Evaluation (Inaudible) daily. Nursing action: check wound daily. Clean, apply dry dressing; secure with hypafix, which is a type of tape. Page 87 reads: "4.4.99 dressings removed. No new leakage seen. Steri-strip intact; dry dressing reapplied." 6 April 1999: "Swabs taken from suture line right hip and right calf. Dressing removed off suture line, left uncovered. Wound on calf cleaned with normal saline and (Inaudible) to cover wound." 8.4.99: "Wound oozing slightly overnight. Re-dressed at edge of wound subsiding." I think that was supposed to be "redness" at edge of wound subsiding. 11.4.99: "Commenced antibiotics a few days ago. Wound not healing today but hip feels hot and Enid complaining of tenderness all round site. Enid very drowsy and irritable."

Q This was a post-surgical transfer?
A Yes, by the sound of it she had had her hip operated on.

Q Would this be an example of your suggestion that perhaps being transferred too soon?
A It was usually hip operations that we got.

Q Because you seem to be dealing with a fairly raw site.
A Yes.

Q That one might have expected would be in the main surgical unit.
A Mm hmm.

Q So the level of nursing care that you are giving to Enid at this point, is that more than one would have expected for this type of unit you were in?
A Yes, you could say that. I was actually the wound care nurse for Dryad so I had quite an interest in wounds and we did get quite a few that were not really ready; they were quite new.

Q Do you have any recollection of Enid?
A No.

Q So your recollection comes from the notes and what you are reading?
A And what I have read, yes.

Q Can you take Dr Reid; can you go to the entry on 7 April on page 8? You are finding more of the same. Seen by Dr Reid for X-ray, page 107.
A I have "Dr Reid see X-ray."

Q Yes. Do you remember what Dr Reid's involvement was?
A From that I presume that he was our consultant at the time.

B Q Do you remember Dr Reid?
A I remember Dr Reid, yes. I presume that would have been seen on one of his ward rounds.

THE CORONER: We need to stop now for one reason or another; maybe because the machine is about to pack up. Can we resume at 2 o'clock?

C I am slightly concerned because Mrs Barrett is also involved with Mrs Devine. Are you happy that we move on to that this afternoon?

VARIOUS SPEAKERS: Yes.

THE CORONER: Excellent. We will adjourn until 2 o'clock.

D (The court adjourned)

THE CORONER: Any questions for Mrs Barrett on Spurgeon? We have done generic questions with Mrs Barrett.
MR FARTHING: I have a couple more, actually; if that would be possible?

E THE CORONER: Tell me what they are.

MR FARTHING: The first is, when a patient is admitted with a clear care plan that prescribes Oramorph in what circumstances would that be changed to a (Inaudible) drug on the same day?

F THE CORONER: I think probably this is not the person to ask. I would be more comfortable with the answer, I think probably from Dr Barton.

THE WITNESS: I have never known it to be done the same day.

Cross-examined by MR FARTHING

G MR FARTHING: After the syringe driver has been applied how would a patient be fed and hydrated?
A Subcutaneous fluids are used occasionally, but if they were unable to swallow it would be a case of keeping them comfortable with mouth care and things like that.

Q You would not hydrate in any other way?
A No, not on our ward we would not, no. If they could not swallow we could not do a lot about it.

H

Q Would not the application of a syringe driver render the patient unable to swallow?
A Not on every occasion, no.

Q So what would be the determinants, would you say?
A Sorry?

Q What would be the determinants? Would it be the level of drugs (Inaudible)
A It depends on what drugs were in the syringe driver.

MR FARTHING: Thank you.

THE CORONER: Ladies and gentlemen, anything about Mrs Spurgeon? No. Right, Elsie Devine. Do you have a recollection of Elsie Devine?
A I have a recollection of Elsie Devine, yes; I do know who Elsie was.

Q Tell me what your recollection is.
A The recollection is bitty. I remember quite a small lady, quite confused at times, quite sort of ... I would not say aggressive but quite rude at times. She would wander around the ward, usually going into other people's lockers and things like that. I remember the occasion that really comes to mind is one occasion when I had come on duty at about ten past, quarter past seven in the morning and when I walked on to the ward Elsie had got one of my colleagues by both her wrists and was pushing her up against the wall and being quite aggressive towards her. I tried to get Elsie to release my colleague and hold my hand but she would not and she became quite agitated and was shouting at us and spitting at us, and it was quite distressing for all involved really.
Q That was not typical of Elsie, was it?
A What I remember, she could be rude and she would be very adamant and if she did not want to do something she would be very adamant about it and push you away and things like that, but that level of aggression, no, that was not typical.

Q How did that incident end, do you remember?
A Yes, fortunately Dr Barton came on the ward just at that time to do her ward round and she tried speaking to Elsie but Elsie would not have any of it and at that time we were in the corridor, I believe – because all we wanted Elsie to do was just to sit down so that we could talk to her but she just would not. We managed to get her into the day room but she was still standing and kicking out at us and I ended up with several bruises and things. But Dr Barton prescribed an injection of chlorpromazine, which we managed to get into her and after a few minutes she eventually started calming down, after a while. She calmed down and we managed to get her to sit in a chair and then two of the nurses sat with her for the rest of the morning really, just talking to her and holding her hand. Then when she had fully calmed down we managed to get her to lie down on her bed.

THE CORONER: I am just trying to fix a date for that.

MS BALLARD: 19 November, I think, sir.

THE CORONER: Where did you get the date from? From the very end of the statement?

MS BALLARD: I did not get the date from the statement, sir; it is from the records, it is the date of the injection.

THE CORONER: I can see from the drug chart that Dr Barton prescribed chlorpromazine on 19 November at 8.30, a 50 mg injection. "LB are my initials and I gave the injection to Elsie but I did not write the initials myself." Would that be about right?
A Yes.

Q Do you have a recollection of the date?
A I did not know, I must admit.

Q Anything else about Elsie?
A No, not really, no; just she would wander around the wards and things like that, but nothing specific, no.

THE CORONER: Ms Ballard, anything?

MS BALLARD: Nothing, thank you.

MR TOWNSEND: No, thank you.

MR JENKINS: No, thank you.

Cross-examined by Code A

Code A Hello, I am the Code A of Mrs Devine. I just have a few questions and you will have to forgive me if they are all over the place – I am not a barrister. With reference to the actual statement that you made regarding to her being quite confused at times, were you aware that in fact she was completely deaf and had 30 per cent hearing in one ear?

A I cannot remember that, I am afraid.

Q I know that throughout the medical file there are some medical notes whereby people felt that Elsie was confused and later it was picked up by the psychiatrist that in fact she was deaf. We only just got this file recently so it is quite difficult to give you page numbers. I notice from your statement taken five years after Elsie passed away – I think that is probably the one you have been referring to.

A Yes.

Q On page 1 you state that she was a very pleasant lady.

A From what I can gather she was not rude all the time; there were time when you could sit down and talk to her, from what I remember.

Q Certainly she would not have done anything that she did not want to do; she was of sound mind and body.

A I remember her being very adamant about things.

Q I will come back to 19th but if I may cross off some of the generic issues with regard to my grandmother. It is correct that you followed the protocols of the Wessex Guidelines during your position in Dryad Ward.

A Yes.

Q Can you give us a summary of what those outlines are?

A The Wessex Guidelines?

Q Did you follow the Wessex Guidelines during that period or not?

A I cannot honestly remember.

THE CORONER: Do you know what the Wessex Guidelines are?

A Not offhand, no.

Q The chances are that you did not follow them then.

A No, I am sorry.

Code A That is all right. So you followed an analgesic ladder?

A Yes, yes.

Q So it is similar. Can you give us an outline of what that analgesic ladder would consist of?

A The analgesic ladder is a way of graduating pain relief, starting with the very lowest of paracetamol, going upwards through things with codeine in them and then going to the opiates at the top, which are things like diamorphine.

Code A If a person was starting to show elements of pain what drugs would you prescribe for that?

THE CORONER: This lady would not prescribe anything at all; it would have to be a doctor. What would you expect?

Code A Thank you. (To the witness): What would you expect to be prescribed?
A The lowest on the ladder that would alleviate the symptoms.

Q So symptoms that would require to move directly to a strong opioid would be symptoms such as, in your experience?
A A great deal of pain.

Q Pain that would probably be noticeable to other members of staff?
A Yes.

Q Pain that you might record in your nursing care plan?
A Yes.

Q If a person was in severe pain and required a strong opioid would you think that it would be appropriate to give them a form that gave immediate release of morphine or a sustained release?
A Initially something that would act straight away to alleviate the symptoms straight away and then be reassessed really; but, again, that would be a doctor's decision.

Q So initially then you would think it was extraordinary maybe, or out of the ordinary to administer an opiate that has sustained release rather than something that gives immediate effect to relieve pain?
A It would depend if the patient had been on analgesics beforehand.

Q If they had not been on analgesics beforehand?
A Then I would think a sustained release one would be a bit unusual.

Code A I have a copy of the Wessex Guidelines, which I understood was being followed on the Dryad Ward, so forgive me because that is the information that I am following. I wanted to clear up – because it is something that came up yesterday – with regard to ---

THE CORONER: Do remember that this witness was not here yesterday.

Code A I know, yes; but it has come up again today. (To the witness): With regards to the use of syringe drivers and the issue around when oral administration is no longer possible, could you explain that a little bit more? Would you ever give somebody a syringe driver if they were still swallowing?
A Very rarely. It would depend what was in the syringe drivers because syringe drivers are not always used just for pain medication – they can be used for other things like antiemetics and things like that, so it would depend on what was going into the syringe driver basically.

THE CORONER: Can I interrupt just a second and ask you this? You said a patient that cannot swallow – would that be a patient who will not swallow or a patient who would spit out the medication?

A Yes, we frequently did have patients that would not swallow.

Q But not an uncommon problem with older people?

A No, it is not uncommon at all.

THE CORONER: I am sorry, I interrupted you.

Code A That is all right. Just to that point, my understanding is under the Wessex Guidelines that syringe drivers are to be administered when the patients cannot swallow.

THE CORONER: Are you addressing me or are you talking to the witness?

Code A Both, I suppose, if that is possible. (To the witness): So you would admin syringe drivers if patients spat out their tablet?

A If it was analgesia and things like that, then if that was the only method then, yes, we would.

Q Even if they were taking food?

A If we could get the medication in the food and knew that they were going to get all the medication then that may be something that we would attempt, but it is not really something we would do on a regular basis because you are not supposed to hide medication in food.

Code A So that goes outside of my understanding of the Wessex Guidelines. What would you say, according to the analgesic ladder, might be an effective or appropriate starting dose of morphine for somebody who has not received an opiate for ---

MR TOWNSEND: Sir, I hesitate to interrupt but this is moving into the medical territory, I think, and I am anxious about that.

THE CORONER: There is a problem because both the witness yesterday and Mrs Barrett say that they would question the appropriateness of the dosage of analgesia and if both of them are going to say that, then I think both of them can be questioned as to what they think would be an appropriate dosage. Whether that is a starting dose, an habitual dose or whatever it is, I think it is a fair question to put, bearing in mind what both of them have said.

MR TOWNSEND: Sir, yes, there might just be a distinction between something that they thought was clearly inappropriate.

THE CORONER: And what they consider in their opinion is appropriate.

MR TOWNSEND: I do not wish to be pedantic but there is potentially a distinction between a nurse who might say, "There are some things that I really would look at and say, 'Oh, my gosh, that does not look right'"; and on the other hand the nurse actually exercising a judgment and saying, "I think that is the correct dose", rather than something more or less.

THE CORONER: It has been put the other way round.

Code A That is fine.

THE CORONER: Is there something that you think might not be appropriate.

Code A I will accept that, then. Is there a dose that you feel would be inappropriate as a starting dose for morphine, based upon no previous analgesic or …

A Are we talking about oral morphine?

Q We can do oral morphine and then we can do another form of morphine, if you like, yes.

A The dose is always started – you are talking about somebody who has never had morphine before?

Q Yes.

A Then it would be started on a low dose.

Code A In your opinion would an equivalent 135 mgs of morphine as a starting dose be inappropriate?

COUNSEL: It is a pharmacological question which can be put to a pharmacologist perhaps and it can be put to a doctor who is prescribing ---

THE CORONER: The difficulty is that both you and yesterday's witness have said that you would have a view of what is and what is not a dose that you would question. I think that what is being put to you is would you question that dosage?

A As a starting dose?

Q As a starting dose?

A Yes.

Code A Thank you very much.

THE CORONER: It does not mean that you are right or wrong, but that she would question it.

Code A That is all right; that is all I ask. I am sorry for jumping around. You stated earlier that most patients that came to Dryad Ward were terminally ill. So would you state then that opiates, syringe drivers were frequently used there with palliative care?

A When necessary, yes.

Q When necessary?

A Yes.

THE CORONER: Do you ever remember thinking, "I wonder why we have a syringe driver here"? Was that something that would stick in your mind?

A Yes, it would; and I do not ever remember thinking it, no.

Q With regard to the patients that came in that the nursing staff and yourself believed were terminally ill, would that be recorded on the patients' records?

A Not the initial assessment, no; something like that would not get written down until the family had been spoken to and everybody had had a discussion really.

Q I am confused. So patients that were admitted to Gosport, to the Dryad Ward, were mostly patients that were terminally ill?
A Mm hmm.

B Q That implies that they were terminally ill upon admission?
A Actually I have probably confused you. We would not write down the expression "terminally ill"; the expression would be "admitted in a very poorly condition" or something like that. That is the thing that we would use, the words that we would use.

Q And "poorly condition" that may relate to being terminally ill would be treated how? How would you recognise that maybe in a patient's medical file?
C A The fact that they were immobile, sometimes not eating and drinking, not making any verbal contact with anybody.

Q You also stated that there were some pressures on the hospital beds from the transferring hospitals. Do you feel that there were great pressures on the beds in Dryad Ward as well?
A On our beds personally?
D

Q In the same terminology that you referenced for the hospital beds in the transferring hospitals, did you feel the same?
A No, I would say no because our patients stayed with us all the time. So I do not think there was any pressure on us to get the beds empty because the vast majority of our patients we knew would be with us a long time.

E Q So if the patients were there for a long period of time – and it was a relatively small ward – how do you feel that you were getting a lot of patients? I am confused. If the turnover in the hospital was very low then surely the number of patients coming in must have been very low?
A We did have a – I suppose it was a fair number of patients admitted but because of the nature of our ward we nearly always had empty beds. So we used to get patients from other wards and other hospitals.
F

THE CORONER: Do you feel that that is a rewarding answer to your question?

Code A Not really.

THE CORONER: No, I do not quite understand it either.

G Code A Maybe I am not asking the right person.

THE CORONER: Is the impression that I got of your ward that it is generally long stay patients? That your patients do die from time to time and that leaves empty beds; but over and above that you were not full?
A Not always, no; we were not always full. A lot of the time we were.

H Q So generally you were full?

A Yes.

Q I am no further forward but do carry on.
A We did not always have terminally ill patients; we did have occasionally patients that we could get on to nursing homes and things like that.

Code A But most patients were terminally ill?
B A But most patients were long stay or palliative care.

Q I will leave that one now. You also stated that any change in condition would have been reported to Dr Barton.
A Mm hmm.

Q It would also have been recorded in the nursing notes.
C A Yes.

Code A Were you aware of patients becoming drowsy with the use of syringe drivers or opiates?

THE CORONER: Can I ask you to put that into two parts? The patients being drowsy, why do you think that was?
D A Sorry, could you repeat that?

Code A I will repeat it, that is fine. If patients became drowsy why do you think that was?
A Because of the analgesics and the sedatives.

Code A Is it common practice and in your opinion if a patient is drowsy could it be
E due to overdose?

THE CORONER: No, do not go there either.

Code A I only go there, sir, because in the Wessex Guidelines, which I understand were being practised on Dryad Ward, it states that if patients are drowsy for five days it is a suspected overdose.
F

THE CORONER: Having raised this question of the Wessex Guidelines with this witness and she not being aware of them, you can put it in a different way.

Code A Can I?

THE CORONER: Yes, you can.
G

Code A Maybe you can.

THE CORONER: Were you ever concerned that patients may have been overdosed with analgesic?
A No.

H

Code A Can I ask also if you were ever concerned about patients remaining unconscious for periods of time after the administration of analgesics?
A No. If I had had any concerns I would have raised them at the time.

Code A Bear with me, I am nearly there.
A That is okay.

B THE CORONER: Are you okay?
A I am beginning to feel a bit …

Q Are you diabetic?
A Yes.

Q Do you need something?
C A I have my chocolate bar, thank you very much.

Code A Would you like to take a break?
A No, I am okay.

Code A I am sorry; you might say you should have asked that question! I am so sorry!

D THE CORONER: No, we can move on!

Code A (To the witness): I know that you are unable to comment on some of the care that Code A received on the Dryad Ward but I would like to just talk about that morning of 19th, if I may? You say that you came on to the ward and witnessed my grandmother in the main corridor just outside of the main day room.
E A Yes.

Q And she was holding on to another nurse, who I will not name, by both wrists. Did you consider at that time what might have been wrong with her?
A We tried … I think all I was bothered about at the time was trying to stop Elsie hurting herself and hurting my colleague and I just tried to persuade her to let go of my colleague's wrist and maybe hold mine instead. It was all sort of a jumble at that time.
F

Q And that jumble continued for up to three-quarters of an hour.
A About half an hour, yes, because we were trying to calm her down and find out what was wrong and talk to her, but she was not really receptive to that.

Q That was quite a serious incident; it was out of the norm for Elsie.
G A Yes.

Q And it was not a regular occurrence on the ward, was it?
A I can say yes. Not with Elsie, obviously, but we did have it occasionally with other patients.

Q Would you have recorded something that is so out of the ordinary for a patient?
A In normal circumstances, yes.
H

Q How do you feel that perhaps maybe a record was not made?
A Very bad. It should have been done.

Q You also mentioned that Code A who, as you say, was quite a small lady, kicked you.
A Mm hmm.

B

Q And you ended up with nail marks on your right arm.
A In my arm.

Q And then a tranquiliser was administered.
A Mm hmm.

Q And that required four nurses in fact to hold her down.
C A There were four of us there but we were not all holding her down.

Code A Mr Bradley, I do not know if this is an appropriate time. I know that we discussed our independent review with you and there was a matter that we put in, hearsay. I cannot submit it? (Inaudible reply from The Coroner) No, okay.

Code A You did say that on email, Mr Bradley.

D

THE CORONER: On what?

Code A On reference our independent review. You wrote me and you said:

Code A there is a certain amount of that you can say. I can accept hearsay."

E That is in a document we addressed.

THE CORONER: Yes. What I am not prepared to do is to give a post facto judgment on what has happened. I am sorry, I do not even want to have this discussion at this moment with the jury here because it is not appropriate for me to do so, because it will affect their minds if we do that. It goes to the same argument of what are we judging, what are we looking at and where are we as at Elsie's death?

F

Code A I will leave it there then. (To the witness): Would you be aware of any medication she was on, that had been administered to Elsie in the previous 24 hours when she was in that state? Would the nursing staff have been aware of that?
A They should have been giving her what was on the drug chart.

Q You do not mention it in your statement but I would like to ask, if I may, whether you
G were aware that she had been administered 24 hours prior a phentanol patch?
A I honestly cannot remember. If I could answer it I would, but I cannot remember anything about phentanol on Elsie.

Code A If the phentanol patch in fact that she was wearing that morning, which would have reached peak delivery of morphine, was up to the equivalent of 135 mgs of morphine ---

H

COUNSEL: Who has put in evidence ---

THE CORONER: I do not know; where has that come from?

Code A That has come from the Wessex Guidelines.

THE CORONER: Does it come from that phentanol patch?

Code A Yes.

Yes.

THE CORONER: Can I have a look. (Same handed to The Coroner) When was it administered, do we know?

Code A It was administered at 8.30 on Thursday morning.

On 18th.

THE CORONER: So we are 24 hours later.

Code A It takes that long to (Inaudible).

Up to 17 hours.

THE CORONER: (To the witness): Have a look at that, at the figure that are there and tell me if it means anything to you. It is the conversion of the phentanol patch, the number of hours. (Same handed to the witness)

Will that be in my Wessex Guidelines book?

Code A I have no idea because it was Ms Deakes(?) that passed the copy to me.

MS DEAKES(?) It is a photocopy of the Wessex Guidelines that I think were extant at the time of this; there is a revised version now.

THE CORONER: That will be in the book that I have.

Code A That is still the conversion rate even today, so I should imagine it is.

THE CORONER: Could the barristers have a look at that, please? (Same shown to counsel)

Then could the jury have a quick look at it so that they can see the conversion figure in there and as and when we get a clean copy we can let them have a look at it. (Same shown to the jury)

MR JENKINS: People should be aware of treating oral morphine as the same as diamorphine and what is given as a conversion.

Code A I am sorry, I missed that point.

THE CORONER: People must be aware of the conversion of oral morphine to phentanol patches. Do you want to take this point on with the witness?

Code A Yes, please. It is not in your statement but do you think you would have been aware of that?
A Sorry.

B Q I am sorry, you did answer; you said you could not remember.
A I cannot remember Elsie ever having a phentanol patch; I honestly cannot remember.

Code A Just with regards to the injection of chlorpromazine – and I am sorry if I pronounce everything wrong because I have been saying these names in my head for ten years – do you think that 50 mgs is an appropriate dose ---

C THE CORONER: She cannot give that.

Code A She cannot say that is an appropriate ---

THE CORONER: She can say whatever she likes but I would not respect the opinion, I have to say, because I do not think it is an opinion that she can fairly give. I am not trying to be difficult or disrespectful in any way at all. If you ask me what the torque is on the
D converter on the E type Jag ...

Code A No, but as a nurse who said that when she administered the drugs she is happy with them, one would think you were happy with 50 mgs.
A Yes.

Code A Can I ask in your opinion whether you think it is appropriate when
E somebody is wearing a phentanol patch, which we have now seen is to that level of converted morphine, 135 mgs, would it be appropriate then to administer a syringe driver holding 40 mgs of diamorphine and 40 mgs of Midazolam?

THE CORONER: Do not go there, please. It is beyond this witness's capabilities. It is not one of those things. If you want to take it up with a pharmacologist or you want to take it up with Professor Black or Professor Wilcock, please feel free to do that, but I do not think it is
F fair to compromise this witness taking her beyond her expertise. You may ask her opinion evidence but not on practice – it is going beyond. Ask Professor Black or Professor Wilcock.

Code A I did ask her if she felt it appropriate to start on 135 mgs.

THE CORONER: She probably thinks that an awful lot of things are appropriate, but what weight am I going to attach to that evidence? Again, no disrespect, this is a matter of opinion
G from somebody who is not a pharmacologist and I think I have to stop it.

Code A I only wanted to ask purely on the basis that the nurses were administering syringe drivers; that is all.

THE CORONER: Did you have concerns about it?
A No.

H

Code A Thank you. One last point with regard to after the injection was given and the syringe driver was administered shortly after – 50 minutes after – what sort of nursing care plan would you expect at that time? Can you remember in fact what happened to Elsie after she was administered the syringe driver and the chlorpromazine?
A I cannot. I have tried; I have tried to remember but I just can't, it just does not come back at all.

B Q Would you expect her to be settled into a chair and comforted or would you expect her to be walked?
A I would expect her to be settled in a chair first and then hopefully at some point try and get her to a bed.

Code A Thank you; I think I am finished.

C THE CORONER: Anything arising from that?

Cross-examined by MR JENKINS

MR JENKINS: Just one matter. You were asked about whether any record had been made of the incident of 19 November. Could I ask you please to look at this document, page 222 of 419 in Mrs Devine's notes? The photocopy bit is a bit difficult to read. I want you to look, please, at the last entry, 19 November. Do you know whose handwriting that is in? Say if you cannot?
A With all honesty I cannot recognise it.

Q Do not worry, if you cannot you cannot. It is transcribed in type writing. Could you tell us what the entry for 19 November says?
A "Marked deterioration over the last 24 hours. Extremely aggressive and saying 'I am refusing all help from all staff'. chlorpromazine 50 mgs im given at 8.30. Taken two staff to special" – to special syringe driver.

THE CORONER: So there is a record of it.

MR TOWNSEND: There is a record of that morning.

F THE CORONER: Have you seen that? You have something you want to pick up from that?

Code A I did not mean on the nursing plan actually; I did not make that clear.

THE CORONER: Right, but there is that note on the nursing plan.

Code A I understood that any sort of attack like that would be recorded in an accident book.

THE WITNESS: If you want to record them in an accident book it is up to the discretion of the nurse that actually gets injured and I did not feel it was appropriate to do an accident booking because she did not do it maliciously. Maybe if she had come up to me for no reason and hit me with something then I maybe would have thought otherwise; but it was not typical of Elsie.

H

Code A Can I just answer that? I understand where you are coming from but from the point of view that Code A was accused of that very aggressive ---

THE CORONER: No, come on.

Code A Sorry, Mr Bradley, it is in the independent report.

THE CORONER: What you are putting to this witness is something that is not proper. You are saying that it is in your report; it may well be but what this witness is saying is that she did not complete an accident report form, she did not feel it was appropriate to do so and that is that; that is where we are.

Code A I understand that, Mr Bradley. It took me 18 months to find out from the Trust exactly what happened that day and I was very disturbed when I heard what did happen because it was written in those notes. So that is why I found it appropriate to mention it today.

THE CORONER: But it is written in those notes.

Code A It is not, not what happened that morning that Code A was administered all those drugs.

THE CORONER: Again, that is something you need to take up with Professor Black and Professor Wilcock because that is going to be a significant event, is it not? Seriously – horses for courses and you are not the horse for this course; that is the position.

MR JENKINS: (To the witness): The document you have been given has an entry at the bottom of 19 November. It bears nursing entries on 19 November 1999.
A Yes.

Q At the top of that page there is an entry for 21 October 1999.
A Yes.

Q It talks about Elsie Devine admitted this afternoon from Queen Alexandra Hospital.
A Yes.

Q "Was admitted there with increasing confusion and aggression. The aggression has now resolved."
A Yes.

Q There is talk about how much assistance she needs and says she is as very pleasant lady. "Her appetite on the whole is not good. Can be a little unsteady on her feet." There is mention that she was quite cold on admission, both feet swollen – "Seen by Dr Barton, see treatment chart for drug regime."
A Yes.

Q There are other entries for later on during the period of admission. There is an entry I think for 15 November, "Seen by Dr Reid", a referral made for Dr Lusznat. Is that a psychiatrist?
A She is a psychiatrist in old age, yes.

Q You were taken to the entry for 19 November, which the jury know was the date when a syringe driver was written up.
A Mm hmm.

Q They know that Mrs Devine died a couple of days later.
A Yes.

B Q You were not given the full document, I am afraid, for 19 November – we are going to give you the other part of the entry – but what we have heard for the 19th in the nursing record is, "Marked deterioration over last 24 hours. Extremely aggressive this morning refusing all help from staff. Chlorpromazine 50 mgs given, im ..." meaning an intramuscular injection, not an intravenous one of subcutaneous one – "... intramuscularly at 8.30. Taken to staff to special." I am going to give you the other sheet, if I may, because the entry continues over the page. Page 223 for those that have it. "Taken to staff to special ..."
C Special means?
A They sit with the patient and it is like on a one to one basis, basically.

Q "Syringe driver ..." – and then we go over to the other sheet – "...commenced at 9.25. Diamorphine 40 mgs and Midazolam 40 mgs. Phentanol patch removed. Mr Devine (son) seen by Dr Barton at 13:00 hours and situation explained." Not Code A Code A
D A Yes.

Q "Mr Devine's Code A seen by Dr Barton at 13:00 and the situation explained to Code A Code A of Elsie's poor condition." He will visit later.
A Yes.

E Q I think the Code A visited later and there are entries on that page to talk about it. I will show you another document, which is the doctor's entry for the same period. Sir, I am handing the witness page 156 – 419. This has an entry for 18 November 1999 and we know that Dr Reid on 15th, from the document we have just read, wanted Dr Lusznat's team to review Mrs Devine.
A Mm hmm.

F Q And I think that Dr Taylor has made an entry for 18 November, indicating the team that he or she was from – elderly mental health. Does the record read this?

> "Thank you, this lady has deteriorated and become more restless and aggressive again. She is refusing medication and not eating well. She does not seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward."

G Mulberry Ward, remind us?
A It is one of the psychiatric wards for the elderly.

Q Psychogeriatric.
A At the War Memorial, yes.

H

Q Just underneath that is an entry by Dr Barton on 19 November. Maybe you cannot read it terribly clearly.
A I do not have that written down.

Q It has not been transcribed.
A It is on the photocopy but it is not transcribed.

B Q I am going to suggest what it says. Dr Barton's entry on 19th November says, "Marked deterioration overnight." If Dr Barton arrived that Friday morning on 19th she would be told what had happened overnight with any patient about whom there were concerns.
A Yes.

Q If there was a marked deterioration noted by night staff would you expect them to tell
C that to Dr Barton?
A Yes.

Q I am going to go back to the record: "Confused, aggressive, creatinine 360." Creatinine is a constituent of blood?
A It is a constituent of blood, yes.

D Q Would you expect that information to have come from blood tests and results?
A Yes, and she would have been shown any that had come.

Q I am going back to what the record says: "Phentanol patch commenced yesterday." I break off – I am referring to 18th. "Today further deterioration in general condition. Needs sc ..." – meaning subcutaneous analgesia – "...with Midazolam. Son seen and aware of condition and diagnosis. Please make comfortable."
E A Yes.

Q You were asked whether it might ever be written that the patient was terminally ill in the medical records and your answer was to this effect, that that is not something that would be put in the notes.
A Not initially. It would be eventually but not on initial examination.

F Q Would you expect to see the sort of phrase, "Please make comfortable" or "for TLC" or "poor prognosis" in the records?
A Yes.

Q And would people understand by that that the patient was dying?
A Yes.

G Q I think Dr Barton has concluded her entry for 19 November by saying, "I am happy for nursing staff to confirm death."
A The thing we used was "verify", not confirm. As nurses we are not allowed to confirm; it has to be verified.

Q But I think in a situation where there were 23 or so hours of the day no doctor on the ward nurses could confirm it, or verify it?
H A Verify.

THE CORONER: Although the doctor has actually written "confirm"; that is what the writing says here. Nothing hangs on it, but that is what it says here.

MR JENKINS: Thank you very much.

Code A Sir, I have a few things I would like to say to that.

THE CORONER: Yes, go on.

Code A I would like to bring your attention to the entry made in 405 by the locum psychiatrist that visited Code A on 18th. This is a separate entry but relates also to the same visit, which states:

> "Mrs Devine now at Dryad. Transferred 21st October. Aggressive, wandering, moving other people's clothes and refusing medication for appetite. Reviewed on ward. Happy, no complaints. Waiting for her daughter. Not obviously paranoid but says tablets make her mouth sore. Plan: transfer to Mulberry when bed available."

I would also like to reference the note made on 19th by Dr Barton that indeed it does state: "Phentanol was commenced yesterday" and there is no note on 18th to say why the phentanol patch was started or that there was any deterioration or any note of pain made by Mrs Devine and no paracetamol or other drugs were offered, even though this particular type of opiate does take time to work.

THE CORONER: Do you remember anything of that?

THE WITNESS: No.

THE CORONER: Thank you very much indeed; I am very grateful to you.

(The witness withdrew)

THE CORONER: I do not think there is anything more useful we are going to be able to do this afternoon.

MR JENKINS: I just wondered what the news is from North Yorkshire.

THE CORONER: There is not any; we have no news from anybody there. I will as DS Stephenson to keep going at it and see if he can raise anything. I will not deal with the statement until next week. So if we are going to receive that evidence it will be next week and not this afternoon, and let us see if we can get the lady here. By how much is it significant? I do not know if I want to read the statement or just leave it out of account. You would prefer to have it read presumably?

COUNSEL: Certainly, yes.

THE CORONER: For us 10 o'clock on Monday and the jury 11 o'clock on Monday.

(The hearing was adjourned to Monday 23 March 2009 at 10 a.m.)