GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Monday 15 March 2009

The Guildhall,
Guildhall Square,
Portsmouth,
PO1 2AJ

B E F O R E:

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

In the matter of Mr Leslie Pittock & 9 Ors

(DAY FOUR)

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 by), 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: Good morning. Do sit down. Gillian Hamblin is what I want to deal with first this morning, and the issue is rule 37. You ought to be aware that I spoke to Dr Stuart Morgan, who is the author of that letter. The content of that conversation was that Mrs Hamblin very much wanted to give evidence, and the effect of the condition is the physical effect and the fact that she can't cope with the formal court setting. She cannot sit for much more than ten minutes and she cannot be without facilities for a very short period of time because of the condition from which she suffers. Against that background, I would be unwilling to subject her to what is going to be, I would imagine, a protracted period of giving evidence, not just to me but in answering questions from others.

I will listen now to what any of you want to say but I felt it fair to say that is where I think I am coming from in the light of my conversation with Dr Morgan and in the light of the letter that he has written.

Against that background, Mr Leiper, do you want to go first?

MR LEIPER: Sir, I am very happy to.

MR SADD: Sir, before Mr Leiper "leaps up", as it were, I am a barrister who has just been instructed today. My name is Patrick Sadd.

THE CORONER: Good morning.

MR SADD: Good morning, sir. I am acting on behalf of Mr Wilson and the Wilson family. I am afraid – and I mean no disrespect to any of the families here – I am still playing catch-up, as it were.

THE CORONER: There is quite a lot to catch up on, if that's any help.

MR SADD: There is quite a lot to catch up with, and I have been doing some reading on Friday and all day yesterday. I have yet to look at the medical records and if you show me some forbearance in the course of today while I might be popping in and out, that is who I am. I am on behalf of Mr Wilson.

THE CORONER: Certainly. If there's anything you need, if you just say so, it is important that you can catch up as much as you can.

MR SADD: Thank you very much.

THE CORONER: Mr Wilson will keep you straight. Mr Leiper?

MR LEIPER: Sir, Jarvis paragraph 12.107.

THE CORONER: Yes.

MR LEIPER: The objection to this statement going in – this is the statement of 23 October of 2007 and a supplementary statement of 16 February 2008 – is essentially the same objection which is made to hearsay. Sir will be familiar with---

THE CORONER: Would it be helpful if I were to say, if I were looking to admit the Hamblin evidence, it would be in its original form and not in the form that is being submitted now by Mr Jenkins? Is that helpful?

MR LEIPER: That is very helpful.

B THE CORONER: I feel it should be in its original form, in the same way that it was originally taken, because it is almost a double hearsay, isn't it, with what we've got now from you? I think that's right, isn't it?

MR LEIPER: So, sir, your present thinking at the moment is not to admit either the statement of 23 October 2007 or the 16 February 2008 but simply read out those statements which she prepared.

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THE CORONER: Which she originally gave.

MR LEIPER: Well, I have no representations to make. Thank you. Ms Ballard?

MS BALLARD: No, myself neither, sir. If the situation were that the October statement was going to be admitted, we would be happy for that to go in as well, with the proviso that the
D appropriate warning be given to the jury regarding it being hearsay evidence and the weight to be attached to it. Of course, the same goes to be said for the statements which would be admitted in regard to those which you would read out, her original statements. Apart from that, I have no observations, sir.

THE CORONER: Thank you.

E MR TOWNSEND: Sir, I have really a couple of observations. The first is this. My client would certainly be happy with the 23 October 2007 statement going in. That is because it sets out in somewhat fuller form her position and her understanding. That is important for this additional reason. In relation to the police statements which you are proposing to read, those, as you will have anticipated, were ones of a number of statements that were taken from her, as indeed many other nurses' statements were taken. She is concerned that there are
F qualifications and explanations that she would have wished to have given to the Court had she been physically able to attend and, indeed, I have quite significant instructions in terms of the contents of the police witness statements, which cause her some concern.

The statements, sir, that you are proposing to read contain both general observations and specific readings from the medical records. Now, in so far as the latter is concerned, obviously, I have no observations because it is appropriate for those to go before the jury. However, in relation to some of the other matters contained within the witness statements,
G she is unhappy and concerned about the contents and, if you are to admit the police witness statements, I would in due course be inviting you, sir, to consider redacting those by deleting certain matters with which she is unhappy which do not, in my submission, alter the thrust of the rest of the statements.

THE CORONER: Is it suggested that they are statements that she has not made?

H MR TOWNSEND: No.

THE CORONER: So what you are seeking to do now is to qualify the statements that she has made, hence effectively giving evidence on her behalf.

MR TOWNSEND: No.

THE CORONER: How are you going to deal with it?

MR TOWNSEND: When I say that she would have wished to have qualified those matters, of course, she is not here and therefore she cannot qualify those matters as a matter of evidence. What I am inviting the Court to consider is whether there are passages that could be removed, without any qualification, which do not alter the essential evidence that go in front of the jury in terms of the patient history.

THE CORONER: Right.

MR TOWNSEND: So the jury is being in no way misled. What is being read to them is the statement that she has made, edited, as, of course, so often happens both in this jurisdiction and possibly even more commonly in the criminal jurisdiction.

THE CORONER: Right. Then, subject to anything else I hear, that I would want to be agreed by the other advocates and by the families that are unrepresented.

MR TOWNSEND: Of course.

THE CORONER: But let me hear from Mr Jenkins. Is there anything more that you want to say?

MR TOWNSEND: That is what I would wish to say at this stage and, if that is a course that commends itself, I would propose to provide a brief list setting out the paragraphs that I would seek to have deleted for your consideration, and, obviously, for the other advocates' and the families' consideration.

THE CORONER: It doesn't leave me comfortable but I hear what you say and let's bear it in mind.

MR TOWNSEND: I only invite the Court to take this course because of the medical difficulties. I simply say this: there is a danger of unfairness to the witness if she doesn't have the full opportunity to do what she would otherwise do in the witness box, and there is an obvious and, in my submission, legitimate concern in relation to that, but perhaps until the Court sees the particular passages it is difficult to form a judgment.

THE CORONER: All right. Thank you. Mr Jenkins?

MR JENKINS: Sir, I have little to add. It is for you to decide which statements are to be read and you have obviously got a number to choose from and you have made a preliminary view.

I would prefer it if the statements that we supplied you with were read as well because those do give an overview, as it were. The police statements just deal with, in the main, the day to

day treatment of patients, what happened and when it happened. They are rather less strong on the general approach that was taken both by nursing staff but also by medical staff. The statements that we provided you with go into rather more detail and give a fuller picture and, if I may say, a rather reassuring picture for the relatives and patients. That is why I would prefer the statements that we have provided you with to be read as well but I accept, if the witness is not well enough to come to court, that we have to cut the cloth accordingly.

B THE CORONER: Yes. Thank you. Mr Wilson, do you want to say anything in the light of that?

MR WILSON: Yes, please.

THE CORONER: Well, Mr Sadd, are you going to deal with this or is Mr Wilson going to deal with it? I am quite happy to take it from him.

C MR SADD: The position we adopt is entirely that of Mr Leiper. It is the police statements that should be read but not the statements that have been introduced more recently.

MR LEIPER: Sir, if I might address you again just in relation to what my learned friend Mr Townsend has said. He appears to have indicated that the section 9 statements which have been signed by Gill Hamblin are inaccurate in material particulars. In those
D circumstances, before any of those statements are read, we have to be absolutely clear as to why it is being suggested that her signed statements are inaccurate.

THE CORONER: I think that is exactly right. As I say, it is not something that would leave me comfortable and it is not something I would do unless it is agreed by everybody in this room, and I would take it as agreed evidence, but other than that, my inclination at this stage is to read through all her statements in full, except the ones that you've got. I think the ones
E that have been submitted latterly, I am not comfortable with those. I fully understand that they probably say very comforting things for lots of people but that's not the object of the exercise, and that's not what we are here to achieve. We are here to look at the situation as it was in 1996-99, the facts as they were, the medical records, and perhaps – and forgive me – not necessarily to give you comfort. That's not what we're here for.

F MR LEIPER: Sir, just to clarify the position in relation to the families in relation to the original police statements, their contents are not agreed. We simply do not object to them being read in the circumstances of her being unwell.

THE CORONER: You do not have the power to do that. I have the power to do that. Thanks for the indication. I am grateful.

G I think the answer is that I am going to read the Hamblin statements. I think on a balance of fairness to all concerned, I am not going to put Mrs Hamblin in any kind of position that would jeopardise her health. The risk to her health is a physical one arising from the treatment that she has had as a result of her condition – not just the surgical treatment but the radiotherapy and chemotherapy that cause her real difficulty, not just in being able to sit down but being able to stay with us for any appreciable length of time without having to accommodate herself. Against that background, I will read those statements. I will not do that until probably the end of this week or the beginning of next week and if anyone wishes to

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pursue any action in the mean time, they can do so, but I will not change my mind at this point.

Right. I suppose the jury is not here yet. I did say 11 o'clock. I was anticipating fierce arguments. Obviously that is a disappointment.

MR JENKINS: We will have the fierce arguments later, I can assure you.

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THE CORONER: Thank you very much. Are the jury here, do we know? If I rise, when the jury are here in full, we will get going. Mr Sadd, yes?

MR SADD: Sir, as I understand it, the intention was that the Wilson brothers were to give evidence today. Is that right?

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THE CORONER: Yes, you were on the list for today but I understand that's not good for you. You want to get through the medical records first.

MR SADD: That is what I was going to say, and indeed, Neil Wilson is in Bahrain so he has to make arrangements.

THE CORONER: We are not going to pay, I am afraid. I don't have the power to pay.

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MR WILSON: Sorry?

THE CORONER: I don't have the power to pay the air fare.

MR WILSON: So his expenses won't be covered?

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THE CORONER: Not of travelling from Bahrain, no.

MR WILSON: OK.

THE CORONER: I can't. It's not a question of being unreasonable or anything.

MR WILSON: No, no, I appreciate that.

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THE CORONER: The facility doesn't exist. All I can do is to get the cost of the train fare. I have put you in for Thursday. Is that going to be all right for you? The 26th. If you are not going to be able to do today.

MR WILSON: I think Thursday should be all right but I won't know until I make one phone call later on.

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THE CORONER: OK, well, if you do that and let me know. Mr Sadd, if you can let me know or if somebody can let me know and provisionally we will take you on Thursday.

MR SADD: Sir, I am conscious – I know this sounds strange coming from a barrister – of the expenses involved, but one suggested way that could solve the problem of the expense is whether or not you would entertain a video link with Bahrain, because I understand that Neil Wilson is very keen to give live evidence. You can see that from his statement, and

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were arrangements to be made, if I investigate that possibility, is that something, sir, that you would entertain?

THE CORONER: If that's what he wants to do, I would accommodate him to do that and if the court here can accommodate that, and I know that they do have a video link and it is just a question of the organisation of it.

MR SADD: Thank you, sir.

MR JENKINS: Sir, it may also be a question of the cost. In my experience, it is often cheaper to fly people long distances than to arrange a video link.

THE CORONER: Really?

MR JENKINS: That is my experience. I am not placing any damper on the proposition at all but the budget is a concern.

THE CORONER: Tell me what Mr Wilson was going to say over and above his statement, because I am quite happy to take his statement, and I will hear from this Mr Wilson, Ian, anything that his brother might have told me. I will take that as hearsay. I don't have any problem with that. Do you want to address that with him?

MR SADD: I will. Sir, I will find out, if I may. My hands are tied at the moment because I don't know the reasons but I will find out.

THE CORONER: Absolutely. I will rise until the jury are here.

(A short adjournment)

MR TOWNSEND: Sir, I wonder if we might raise one matter before the jury come in. I anticipate you are going to call Anita Turbritt as the witness.

THE CORONER: I was going to read Wyles first. She is in north Yorkshire, she is not well, and she has no intention of coming. How does that sound? The normal degree of co-operation.

MR TOWNSEND: We are where we are.

So far as Anita Turbritt is concerned, I know Mr Leiper wants to ask her about 1991 and you know that she touches upon events in 1991 in her statement. At that time there were concerns about the use of syringe drivers and the powers that be in the administration of the hospital ensured that nursing staff who were not familiar with syringe drivers were told about them. I don't know if Mr Leiper wants to go beyond that. You will have seen that the statements make various observations about patients who were treated with syringe drivers prior to 1991 or in the time leading up to that meeting, but I am concerned that we should not talk about other patients or patients in 1991. The scope of this hearing is already extremely wide. For us to go and talk about other patients or treatments provided to other patients, in my submission, goes way beyond the evidence that we need to canvass in this inquest. I am concerned that the jury should not be told about deaths of other patients on syringe drivers. Last Wednesday, dealing with the written submissions I put in, you agreed that we would not

be talking about any other patients' deaths at all, and I just seek the reassurance that that is the position you will take.

THE CORONER: It depends how it comes in, doesn't it? If it is a question of there had been concerns in the past, I think that has got to be right; I would admit that. If we are talking specifically about meetings and other people who have died, I very specifically don't want to do that.

MR TOWNSEND: I am grateful.

THE CORONER: That is actually quite important from my point of view and for the jury to understand that these are ten inquests into ten specific cases and ten family members. That is what we are talking about.

MR TOWNSEND: I do not object at all to reference being made to the fact that the hospital administration ensured that nurses who weren't familiar with syringe drivers were told about them.

THE CORONER: Absolutely.

MR TOWNSEND: I do not think it needs to go further than that. I do not think it should go further than that.

THE CORONER: I hear what you say. Thank you. Mr Leiper?

MR LEIPER: Sir, yes. Can I make absolutely clear at the outset that there was no question of my exploring other deaths which happened back in 1991. Sir's ruling on that on the first day was quite clear and I have no intention of going beyond that. Sir has said that it is relevant that concerns were raised in 1991. What I was proposing to do with this witness was to explore what those concerns were.

THE CORONER: Would that be helpful bearing in mind that is 1991 and the earliest death I am looking at is 1996? If you are going to suggest that the issues were not addressed, so that there were problems continuing, then I think I would have to listen to that but if we are going to say the problems being expressed in 1991 have been addressed and have been resolved, before the jury come in let me be clear, because my understanding of the problems from 1991 are differences of opinion between nursing staff and clinicians, and I think in particular Dr Barton, and the nursing staff seeking reassurance on the purpose of analgesia. That is my understanding of the problems in 1991.

MR LEIPER: Sir, the problems in 1991 were in many ways identical to the problems in 1998-99. The concerns which were expressed by the nursing staff in 1991 are identical to the concerns which are being expressed now by the families about events which happened in 1998 and 1999.

Sir will in due course have to consider what verdicts should properly be left to the jury. In determining the admissibility of evidence, sir has to give consideration to what those verdicts might be. At this stage it is conceivable that the families will be asking sir to leave a verdict of unlawful killing to the jury. Whether or not that is appropriate will depend on the evidence

which comes out. Whether or not it is appropriate will depend on what evidence there is in relation to the state of mind of particular individuals.

THE CORONER: Yes.

MR LEIPER: Sir will be aware of the fact that it is the families' contention that the analgesic ladder was not complied with and it was as a consequence of non-compliance with what appear to be clear hospital protocols that the deaths subsequently ensued. This is the families' case, an overview of their concerns.

In the circumstances, sir will have to ask, and the jury may well have to ask, why it was that it was not being complied with in 1998 and 1999, and of central relevance to that are the events which happened back in 1991. We do not know at the moment why it will be contended that the analgesic ladder wasn't being complied with but if it is being suggested that there was a lack of awareness of its existence, if it is being suggested that there is a lack of awareness of the consequences of non-compliance, those two contentions are clearly met by the contents of what transpired in the course of 1991. In the course of 1991 sir is aware of the fact from the documentation that Nurse Turbritt was clearly concerned about non-compliance and was clearly concerned at deaths resulting as a result of that non-compliance.

In the circumstances, sir, should the evidence be sufficient to allow the jury to consider an unlawful killing verdict, the jury will have to consider evidence in relation to particular individuals' states of mind, and this evidence is of central relevance in relation to that.

I do not propose to be long about it. All I propose to do is ask what her concerns were and who knew about them.

THE CORONER: I don't think I could possibly object to that because it is germane, isn't it? I wouldn't want to take it any further as to any specific instance in 1991.

MR LEIPER: No.

THE CORONER: But the fact that it had been raised before I think is relevant.

MR LEIPER: I am grateful, sir.

MR TOWNSEND: Sir, might I express one concern in relation to that matter? If Mr Leiper is proposing to go as far as he has just stated, it does mean that this inquiry is going to stray at least into the possibility of other deaths, and that does cause some concern.

THE CORONER: No, it won't. I can tell you it won't.

MR TOWNSEND: It flags up that issue and what I invite you to consider, sir, is whether the legitimate concerns about what happened in 1991 can adequately be dealt with by eliciting from the witness the fact that there were concerns about the level of prescribing of drugs, in particular perhaps diamorphine, via the use of syringe drivers, and leaving it there.

THE CORONER: Yes, but I can't ignore the fact that there had been previous meetings, and one would expect there to be meetings on these subjects. I don't want to take it any further

than that but there were concerns expressed in 1991 and those meetings were minuted. It is there.

MR TOWNSEND: Sir, do I take it from that that you are intending that the minutes should go before the jury?

THE CORONER: No. I do not want that to happen because that immediately gets us into a different arena, doesn't it? It puts us into a 1991 arena and I don't want to be there. Any allusion to it has got to be that there were concerns expressed in 1991 and if those concerns continue, so be it, but I certainly don't want to take it any further.

MR TOWNSEND: Sir, yes. My simple point is I am asking you to consider whether it can be limited to eliciting evidence that concerns about the use of opiates were raised in 1991.

MR JENKINS: Can I raise a couple of matters? Firstly, if Mr Leiper asks the question of Nurse Turbritt "What were the concerns?" what answer do you anticipate she will give?

THE CORONER: I don't know that I want him to ask that question.

MR JENKINS: It is a question he has said he will ask.

THE CORONER: I think the answer to that is were concerns expressed in 1991 and what concerns were there in 1996, 1997, 1998 and 1999. I would not want it to go any further than that. I am quite happy to take the concerns for the period that we are talking about but it has got to be analgesic ladder, hasn't it, that we are talking about? Aren't we all talking about it?

MR JENKINS: Yes. Can I deal with one matter that Mr Leiper talked about and she will certainly give evidence to the effect that she was one of the authors of the Wessex guidelines so he need have no concerns that she didn't know about.

THE CORONER: I think she was also at the meetings in 1991, wasn't she?

MR JENKINS: She was.

THE CORONER: She will be able to give us firsthand evidence of that.

MR JENKINS: Can I raise one last matter? I am slightly surprised to hear mention of unlawful killing at this stage. We may have more discussions about that as a topic as the hearing continues, and there are certainly some coroners who, given the history of this case, knowing that the proper authorities have looked at far more evidence than is going to be called in this inquest, they have looked at all the expert reports, and if the proper authorities do not think it appropriate to entertain the possibility of criminal prosecution, unless something surprising happens---

THE CORONER: Mr Jenkins, you know better than that. A coroner's verdict of unlawful killing has nothing to do with a successful prosecution for murder or manslaughter.

MR JENKINS: I agree with that.

THE CORONER: Let me reiterate something I said to Code A She mentioned something similar and I said I thought it was probably preferable to hear the evidence before one took any kind of view and that is the position I am in now. I hear what Mr Leiper says, I know what my views are, but they will be conditioned by the evidence that I hear, and I have to say that, until I have heard that evidence, I am not going to form any view at all that is going to colour things. I really am trying desperately to remain dispassionate completely in the face of adversity, and I do not want even to listen to submissions on verdicts at this stage, in whatever form they are.

MR JENKINS: I understand. I hope I am not adding to the adversity. I was simply making the point that I know of a number of coroners who, in the circumstances in which you deal with these cases, would say "We will not be going down that route" and they can say so at an early stage.

THE CORONER: In fairness, I may well be saying that when I have heard the evidence but I will not say it until I have heard it.

MR JENKINS: I understand.

THE CORONER: Yes, Mr Sadd?

MR SADD: Sir, can I add my ha'penceworth to Mr Leiper's submission, which I support? One thing I would like to elucidate with you is clarity about the issue of the extent to which those concerns are identified because, certainly on behalf of Mr Wilson, we would want to make it clear that those concerns relate to the practice and use of the analgesic ladder and the currency of the analgesic ladder used in 1998 so far as it concerns Mr Wilson's death. The reason why I say it – and it is a trite matter perhaps – but as we know, this is a fact finding inquiry, and a fact finding inquiry as to how individuals died. How is a limited issue, but when one looks at the statements put forward, for instance, by the Wilson brothers, they provide you at the end of their statements with questions, and one of those questions raised by Mr Ian Wilson, behind me, is how is it that diamorphine was prescribed at such an early stage, as he sees it. Hence the reason for it being clear that the question that can be asked of the nurse relates very much to the issue of the analgesic ladder rather than simply leaving it at concerns, so that you are not taken by surprise. Does that make sense to you?

THE CORONER: Yes, it does, but is it not right that, on any interpretation of this, one would ask the witness about the events relevant to Mr Wilson and to that period, that there had been previous concern expressed but for the relevant period and for Mr Wilson particularly to be able to ask that question and for the relevant nursing staff to be able to answer – or not, as the case may be – and for that question to be put to Dr Barton?

MR SADD: I just wanted to clarify the issue about concerns. Thank you very much.

MR LEIPER: As I understand it, the effect of sir's ruling is that it is absolutely clear that no particular deaths are to be mentioned.

THE CORONER: Absolutely.

MR LEIPER: But there is no objection to asking whether or not previous concerns had been expressed in 1991 and identifying what those concerns were.

THE CORONER: Yes.

MR LEIPER: I am grateful.

THE CORONER: I think that will be a fairly common feature as we move forward. Can we have the jury, please?

(In the presence of the jury)

THE CORONER: Good morning, ladies and gentlemen. Welcome back. To start this morning I am going to read another statement to you and that will be that of Linda Marian Wyles, a statement which was made on 8 November 2004. She will talk about her father, who was Mr Pittock. Meanwhile, back on your Pittock bit of paper, she is the daughter and gives a history. She is from north Yorkshire and is not terribly well and asks that she does not attend, and I am more than happy to take her statement under rule 37, which is the witness statement rule.

She says: "I am the daughter of Leslie Charles Pittock, born Code A who died in Gosport War Memorial Hospital on 24 January 1996."

She says that her father was born in Hemel Hempstead, and gives me her father's family set-up. He was a submariner in the Royal Navy. "Whilst in Canada he met and married my mother, Audrey. With my brother Paul, the family came to England in 1947." She is one of three children. Her father suffered from severe depression for a great deal of his life. He made several attempts to end his life and had to be admitted to hospital for treatment. He was admitted to Knowle Hospital, Wickham, on a number of occasions throughout the Sixties, Seventies and Eighties and received ECT treatment.

He was physically a very strong man and it was mainly due to his strong constitution that his attempts to end his life failed. Her father retired from the Navy after 22 years' service and then worked as an instructor at the Nautical Training School TS Mercury on the River Hamble. "My father loved sailing and he enjoyed his job but when the training school closed he seemed to lose his purpose in life and withdrew into himself."

"Some time round about 1993-94 my father was admitted to Alberstoke(?) Ward at Knowle Hospital. He was very depressed and had no motivation. My mother had been caring for him at home and the strain this placed on her was giving concern to my father's psychiatric nurse and his social worker. Because of this, a decision was made that my father would be discharged to a rest home. My father left Knowle and went directly to Hazeldene Rest Home, where he lived until he was admitted to Mulberry Ward on the Gosport War Memorial Hospital.

"My father became progressively worse whilst at the nursing home. He would not socialise with any of the other residents, who were predominantly women. He remained in his room and rarely spoke to anyone. He wasn't rude; just wouldn't initiate any conversation. It would be the same when the family visited. He stopped eating and drinking properly and was eventually admitted to Mulberry Ward, which is a psychiatric ward at Gosport.

"My father continued to deteriorate mentally and physically. He didn't respond to treatment. He seemed to have given up. The nursing staff in the ward were excellent and took great care of my father. The family visited regularly. Virginia and I would take it in turns to take my mother in to visit my father.

"After a period of time Dr Vicky Banks told us that my father had a chest infection. She informed us that the clinical team had considered and rejected treating my father with ECT because of his physical condition. She told us that there was nothing more that could be done for him on Mulberry Ward and that he was going to be moved on to Dryad Ward. I knew that my father was not eating or drinking. He would lie in bed all of the time and ignore everyone. He believed that he had Parkinson's Disease. I understood that my father was going to Dryad Ward for terminal care. This was never actually said to me but my knowledge of the type of patient that Dryad took led me to believe that. I visited my father regularly with my mother and as a family we watched as my father died through what I would describe as self-neglect. He had become extremely frail and just seemed to have lost the will to live.

"I remember asking the nurses if he was in any pain and if he had any pressure sores because he was immobile. The nurse told me that my father's skin was breaking down and that he cried out when the nurses turned him. I remember that morphine was mentioned to me for pain relief but I cannot recall if I was told that my father was already receiving it or was going to receive it. I knew that his body systems were breaking down and that he would have been uncomfortable. I was not alarmed by the thought that my father was being given morphine. I considered it to be appropriate care.

"The nurses turned him regularly and I recall that he had a blister on his ear. My mother was spoken to about the use of a drip and we were kept informed about my father's condition and how grave it was. I have no recollection of ever seeing a drip being used in relation to my father, so I assume that my mother was referring to a syringe driver. The family acknowledged that invasive or aggressive treatments would be inappropriate in my father's case. By this I mean to force-feed him or to use ECT to try and lift his mood. I remember that it seemed to take my father a long time to die. I expected him to die as he was in a debilitated state, wasn't eating or drinking, and had a chest infection. My father died on 24 January 1996. His death was certified by Dr Jane Barton and his cause of death was given as bronchial pneumonia. He was cremated at Portchester Crematorium on 30 January 1996.

"I have been asked if I ever spoke to a doctor during the time that my father was in Dryad Ward. I didn't speak to a doctor as I was kept fully informed of my father's condition by the nursing staff. Had I felt that I needed to speak to the doctor, I would have taken the necessary steps in order to do so.

"My father's GPP was Dr Asbridge(?), who had a very good understanding of my father's condition and was very supportive of my mother. I think it is pertinent to mention that I am a retired qualified registered mental nurse, having nursed the elderly and mentally ill for most of my career. At the time of my father's admission to Mulberry Ward and subsequently Dryad Ward I was the G grade clinical manager at Phoenix Day Hospital within the Gosport War Memorial Hospital."

OK. Do you have that? Fine. Mrs Turbritt, please.

MRS ANITA TURBRITT, Affirmed
Examined by THE CORONER

THE CORONER: It is Anita Turbritt, is it?
A It is.

Q Have you got copy statements with you?
A I have, yes.

Q Can we deal with Lake first, please? Tell me about your job at Gosport.
A I currently work as a senior staff nurse on night duty. I've worked at the War Memorial Hospital for almost 22 years, starting as a staff nurse and working my way up. I've enjoyed working at the hospital. I've found it quite fulfilling.

Q Have you worked for the whole of that time at Gosport?
A Yes.

Q So your knowledge of Gosport is second to none really?
A Hopefully.

Q We'll find out. All right. You were involved with Ruby Lake.
A Yes.

Q Do you remember dates and times or is your memory of her solely from the records you've got?
A My memory would only be from the records in front of me.

Q Then let's have a look at those. You say she was admitted to Dryad Ward on 18 August 1998 and that she died on 21 August 1998.
A Yes.

Q The prescription sheet for Mrs Lake. Dr Barton prescribed drugs to her. She chose when and in what quantity the drugs were administered. Entries signed by the senior nurse involved. What was the general procedure for administration of drugs? You would do that?
A Possibly me. It would depend which nurse was in charge of the shift but it would be a trained nurse.

Q And in the event of administering opiates, would that be done by one of you, two of you?
A It would be two nurses, one to administer, one to witness.

Q Right, both of whom would sign...
A Both would sign.

Q ...the cardex?
A Both of whom would sign the drug book, controlled drug register.

Q What about the cardex?
A The cardex, usually the nurse in charge but possibly the nurse in charge of the shift, who might not necessarily be the same person.

Q Would that be countersigned or would the name of the witness be added to that?
A Possibly.

Q What is your practice now?
A Usually, practice now would be the nurse that administered would probably make the entry into the nursing notes, and that's how it is now, the way I remember it.

Q Do you remember that system changing at any point or would that have been what it was?
A The only thing I can recall from that time, because we were a community hospital, especially at night, sometimes we possibly didn't have as many trained staff on duty, so on rare occasions drugs may be witnessed by a support worker, who would have had some training, would receive some training.

Q Do you remember anything about Ruby Lake's condition, why she was with you?
A No.

Q 18 August 1998 Dr Barton prescribed Oramorph 2.5-5 ml, digoxin 62.5 mcg, slow release potassium, bumetanide, a diuretic, and there's a lovely word I can never say, allopurinol. Is that it?
A That is correct.

Q I'd never be a drug man, would I? 19 August do you remember?
A I don't remember, no.

Q You've got a note there though. What's that?
A I've got a note. On 19 August---

Q Can you keep your voice up?
A Sorry. Would you like me to read?

Q Yes, please, if you would.
A In addition, on 19 August 1998 Dr Barton also prescribed temazepam, night sedation, 10-20 mg. The following were also prescribed by Dr Barton: diamorphine, pain control, 20-200 mg; hiazine, to dry up oral secretions, 200-800 micrograms, and midazolam, muscle relaxant, 20-80 mg. These last three drugs were written up as "sc", which is subcutaneous, in 24 hours, which means that they were to be introduced by way of a syringe driver over a 24-hour period.

Q Can I stop you for just a second?
A Certainly.

Q The diamorphine 20-200 mg. What would regulate the dose that you were actually giving? How would you know how much you were giving?
A The patient's physical condition.

Q What would determine that? What would determine what you were doing? Where would you start with the administration?
A If you mean initially setting up the syringe driver...

Q Yes. What dosage would you give?
A The lowest dose.

B

Q Would you always start with the lowest dose?
A I can't really recall but I would imagine most of the time.

Q If that wasn't solving the problem, what would you then do?
A Gradually increase the dose.

Q By what kind of increases?
C A Five mg to 10 mg over a 24-hour period.

Q So in this case you would have started at 20 mg.
A Yes.

Q If that was solving the problem, then there is no need to do anything else.
A No.

D

Q If she is still then in pain, after what period of time would you look to increase?
A We would initially have tried other physical things: repositioning, you know, practical situations to try and relieve any pain or discomfort, and if this didn't help, then we would consider an increase.

Q I think the question I am asking you is, if your physical comforts are not working,
E would you leave it for the 24 hours before you increased the dosage?
A Probably not.

Q And you would make that decision, would you?
A On discussion with colleagues.

Q What about the prescribing doctor? Would she be consulted?
F A At night things were different. At night we would probably... our means of contact would be an out of hours doctor and, from previous experience, they weren't often keen to intervene in ongoing treatment.

Q Was there a recognised situation at Gosport for you if you wanted to increase analgesia overnight?
A Well, we were given the 20-80 mg or 20-200 mg brackets in this case. We used our
G own initiative. We had training and we used our personal judgement. If we were unsure, then we did contact a doctor to seek advice.

Q Right, and that doctor would have been whoever was on call?
A Yes.

H

Q Would that present its own difficulty, in that that doctor would not be familiar with the patient?
A Yes.

Q And presumably wasn't on the premises and was being consulted by telephone?
A Yes.

B

Q So what would your practice be? To tell him where you were on the analgesic scale?
A Yes.

Q And to say, "It's not covering the problem; where do we go from here?"
A Yes.

Q Would that be the tenor of the conversation?
C A I would imagine it would, yes.

Q I don't want to have an intellectual argument about it. What would you have said to the doctor?
A I imagine I would have given my opinion, how much or what I felt needed to happen from that point.

D

Q Right, and really just seek the doctor's approval?
A Yes.

Q What time did your night shift finish?
A Seven forty-five in the morning.

Q So would Dr Barton be with you before you went off?
E A Quite often, yes.

Q When would she arrive normally?
A Somewhere between 7.30 and when we actually went off duty.

Q So if you had had difficulties overnight, would you have discussed those with her?
A Yes, we would have done.
F

Q So she would be aware of what had happened overnight?
A She would, yes.

Q Her attendance was Monday to Friday.
A Monday to Friday, yes.

G

Q Did you ever see her at the weekends? Did you work at weekends?
A I did work at weekends. I can't recall offhand.

Q So whatever the position, there would be some kind of medical supervision available for you in the event that you wanted to alter the dosage of analgesics?
A Via a telephone call, yes.

H

Q Take me back to Ruby Lake if you would, please.
A The last three drugs were written up as subcutaneous in 24 hours, which means that they were to be introduced by way of a syringe driver over a 24-hour period. They are not dated but I make the assumption that it would have been on 18 August 1998. I make this on the basis that the prescription was made on that date and that Nurse Hallan(?) made an entry about commencing the syringe driver on 19 August, page 394.

B Q Yes.
A Had the diamorphine not already been prescribed, I would have expected to see that reflected in Nurse Hallan's notes, i.e. it would have read something along the lines "doctor prescribed" or "doctor visited". Clearly, the nurse could not have withdrawn the drug nor given it without a doctor having first prescribed it. I would explain the procedure for controlled drugs. Doctors may also write prescribed drugs up in the medical notes but on this occasion there are no such entries.

C Q Right, can I ask you this then? If the doctor was prescribing 2-200 mg, it is expected that that is a range within which you can administer the drug. Is that right?
A Yes.

Q In the event that the dosage is changed, you've got the discretion to do that.
A Yes.

D Q But would you have discussed it with the doctor after the event?
A Yes.

Q So the doctor would be aware of where you are on the scale?
A Yes.

E Q And presumably, if the prescription is written up for 20-200, that is a dosage that the doctor would consider to be appropriate.
A Yes.

Q It is something I don't quite understand, that if it is 20-200, how do you cope with that kind of incremental balance? How do you say the doctor is not going to be seeing her for three and a half months and therefore we can do the 20-200, or if the doctor is going to be F here tomorrow, why would it be necessary to do the 20-200? Does that make sense?
A Yes, it does.

Q Why would it be written up in that way? Do you know?
A I think, as I explained, to cover, to support us. If we needed to call the doctor out of hours or over the weekend, the guidelines were in place. Does that make sense?

G Q Yes, so that it did allow you to exercise that discretion?
A Yes.

Q Right. You say with Ruby Lake, the prescription sheet shows that Oramorph was last administered at 1150 on 19 August and that at 1600 hours the same day the syringe driver was commenced. Entry in the book dated and timed 1600 on 19 August shows that 20 mg of diamorphine was withdrawn and that is two 10 mg ampoules, entry witnessed by senior staff H nurse Ann Holman. Right. So that's when it actually starts and you started at 20 mg.

A Yes.

Q It shows it was given by Ward Sister Hamblin. The patient's name recorded as Ruby Lane. Lake, isn't it? Is that a misprint or is that how it was actually recorded?
A No. I believe it was Ruby Lake.

B Q Entry signed by Sister Hamblin and Nurse Holman. Corresponding entry on the prescription sheet shows that at 1600 hours the same day the same dose was given to Ruby Lake by Sister Hamblin. It also shows that 20 mg of midazolam was also given at the same time and Sister Hamblin signed both entries. So that really is a belt-and-braces check and confirmation. Is that right?
A Yes.

C Q The entry in the book dated and timed 0915 on 20 August shows that 20 mg of diamorphine was withdrawn. This was again in two 10 mg ampoules. It tells me that was witnessed by Nurse Patricia Shaw, given by Staff Nurse Ring. Again, they have signed the book. That dose was given to Ruby Lake by Nurse Ring together with 400 micrograms of hiazine and 20 mg of midazolam. Again, Nurse Ring has signed the entries.
A Correct.

D Q Two further entries in the book of 20 August timed at 1655 shows that 40 mg of diamorphine was withdrawn, and this is one 10 mg and one 30 mg ampoule. Now that again has gone up, hasn't it?
A Yes.

Q The reason for that would be presumably that the original dose wasn't...
A ... wasn't sufficient.

E Q ...controlling the pain.
A I would imagine so.

Q Again, I don't want to have an intellectual argument with you. Is that why you would have done that?
A Yes.

F Q Entry in the book 0735 on 21 August shows that 60 mg of diamorphine was withdrawn, again, two 30 mg ampoules. The witness Nurse Turnbull. "Entry signed by myself and Nurse Turnbull." Again, the dose has gone up. Is there a set increment that you would have used to increase each time?
A Not that I can recall.

G Q Nurse Barrett told us that she would have expected a 20 mg dose then to be increased by half as much, to go up to 30. The increments here I think are doubling, or adding 20, aren't they? So you go to 20, to 40 to 60.
A Yes.

Q So that doesn't reflect what she was saying, that you would expect it to increase half. I've become incoherent, haven't I? Do you know what I mean?
A Yes.

H

Q That if you are doing 20 mg, she said it would go to 30.
A Yes.

Q Here we are looking at a doubling of that and then another increment of 20.
A Yes.

Q That would be your understanding, that you would have done that?
A That is the way I understand it, yes.

Q You say, "All the above administration of drugs to Ruby Lake were in accordance with the prescriptions as written by Dr Barton." You are then dealing with the destruction of drugs after the event. Right. Anything arising from Ruby Lake? Anything anyone wants to ask about Ruby? Can we go to Enid Spurgeon please? Again, let me ask you if there is any memory of Mrs Spurgeon?
A No, sorry.

Q Please don't apologise. It's a long time ago. In 1999, senior staff nurse on Dryad Ward, working night shift. Talk to me of Wessex protocols. What are those?
A Wessex protocol is actually a palliative care handbook. So if you ask other staff, they might not be aware of the Wessex protocol but they are aware of the palliative care handbook.

Q Right.
A So it was a manual, an advisory manual, on all aspects of palliative care really: pain control, other symptoms, bereavement, cultural attitudes, trying to cover every aspect of care that the patient would require.

Q Did it also cover the analgesic ladder?
A Yes.

Q Are the two synonymous? Are they the same thing or is the analgesic ladder a part of the palliative care handbook?
A It's a part of the palliative care handbook.

Q A fairly important part, I would have thought.
A Yes.

Q Talk to me of the care for Mrs Spurgeon. Page 3 of your statement.
A "I have been asked to detail my involvement in the care and treatment of a patient known Enid Spurgeon. I do not recall the patient but from referral to entries in her medical notes I can state that on page 125 I have initialled that I have administered Oramorph on or around 2200 hours on 26.03.1999. On the same page I have initialled that I have administered Oramorph on or around 6 o'clock on 27.03.1999. On page 47 of the Dryad Ward controlled drug record book Oramorph oral solution only, I have written at 2315 on 26.03.1999 that I have administered 10 mg in 5 ml of Oramorph to Enid Spurgeon which was witnessed by Staff Nurse Beverley Turnbull."

Q I think at 6.55 on 27 March you administered 5 mg in 2.5 ml of Oramorph.
A At 7 o'clock on 28.03.99 that I have witnessed Staff Nurse Ingrid Lloyd administer 10 mg in 5 ml of Oramorph to Enid Spurgeon.

Q Can I just query that, because that dose has gone down, hasn't it, effectively, for 27 March? You are looking at 5 ml in 2.5 and it's gone from 10 to 5 and then it goes back up to 10.
A Yes.

Q Would that be something that you would have expected, a decrease in the dosage at that point?
A From what I can recall, we were encouraged to give... because from 10, 11 o'clock round to 6 o'clock is a long period of time, so practice was to give a larger dose at that time of night to last the patient until the morning.

Q Right. Right, got it. Then you are over to 0715 on 11 April. You administer 5 ml in 2.5. That is again the daily dose rather than the night time dose.
A Yes.

Q You say, "The reason I administered Oramorph to this patient was that it was prescribed by and written up by Dr Barton on 26 March, the dose being 10 mg in 5 ml once a day." How does that tie in? That is a 2.5 mg dose four-hourly. I don't understand that.
A I'm not sure I understand it myself.

Q Because if the dose was 10 mg in 5 once a day, then you can't have a 2.5 mg dose four-hourly because that would only take you p to a 12-hour period, wouldn't it?
A Yes, mm-hmm.

Q Help. Does anybody know how to make sense of that? Does it mean anything to anybody? No?

MR TOWNSEND: Sir, it appears wrong.

THE CORONER: I think it must be. 10 mg in 5 twice a day the mathematics would be right, wouldn't it, but not once a day?
A No, I think that's an error.

Q All right. Anybody want to query anything on Mrs Spurgeon? It's really a question of the analgesic. Right. Elsie Devine, please. If we can go to page 2, dealing with her prescription sheet, a prescription sheet bearing the name Elsie Devine. You say, "I note that Mrs Devine was prescribed 40 mg to 80 mg of diamorphine by subcutaneous route over 24 hours on 19 November 1999." Is that again a variable amount, that you could administer the 40 and take it up to 80 without reference back to Dr Barton?
A Yes.

Q Twenty to 80 mg of midazolam, and that was again to be subcut?
A Yes.

Q Subcutaneous. You say, "I note these drugs were administered together on three occasions, on 19 November, 20 November and 21 November." You say, "On 19 November the drugs are shown as being administered by Gill Hamblin, on 20 November and 21 November by Beverley Turnbull." You then go into the witnessing of the drug

administration. You say, "At that time diamorphine was not available in 40 mg ampoules, therefore it was necessary to use a 10 and a 30 on each occasion to make up the 40 mg.
A Correct.

Q What did they come in: 10, 30 and anything more?
A Five, 10.

B Q All right.
A I can't remember offhand. I'm sorry.

Q You say that would have been administered in the presence of two trained staff.
A Yes.

Q "On each occasion a controlled drug is given to a patient a number of checks need to
C be made." Tell me what those are.
A Firstly, to check the prescription is correct, correctly written, clearly written, and it's dated and signed by a doctor; that the patient we administer the drug to is the correct patient. We check name, date of birth, hospital number, preferably with the patient if possible but also they have a name wrist band; we'd check it with that.

Q Right.
D A What else? Check the drug is correct, check the actual ampoules of the drug, check the packet of the drug, check the date of expiry, check that the drugs correspond to the prescription before drawing up and before administering to the patient.

Q When you draw up and you note it in your records, is the batch number noted?
A No.

E Q So it would just be the expiry date?
A The expiry date. That wouldn't be noted but we can only administer if it's within date.

Q Right. The prescription that you get from the doctor is written up for 20-200. What if it's seen to be 200-400? Would you query that?
F A Yes.

Q So you have a discretion to look at it and think "Hang on." You have been doing this a long time, haven't you?
A Yes.

Q You are getting used to it now, I should think.
G A Hopefully.

Q Yes, and you would have an idea of what would be an appropriate prescription for a particular patient?
A Yes.

H

Q And if it were out of line, what would you do?
A Firstly, we could consult a drug book such as the BNF to check prescriptions, normal prescription ranges, check with a senior member of staff – at night that would be the on-call manager – or even contact a doctor to check, to query.

Q And they would be able to confirm?
A Yes.

Q Presumably, only if they had knowledge of the patient.
A Yes.

Q So asking a doctor cold to say "Is this an appropriate dosage for this patient?" would be slightly guesswork, wouldn't it?
A I think if it was such a large range at such a high dose, most doctors would query, despite knowing anything about the patient.

Q If you had doubts about it, what would you do other than consult the doctor? Would you administer the dose?
A No.

Q Obvious question time, isn't it? No, it's relevant, isn't it, that you would exercise your discretion first, then check, and then administer the drug?
A And I would state in the nursing notes why I had refused to administer that dose.

Q OK. Anything else relating to Elsie Devine?
A Not that I can think of.

THE CORONER: Any questions? Mr Leiper?

<u>Examined by MR LEIPER</u>

MR LEIPER: Nurse Turbritt, the analgesic ladder that you've referred to – what is the first rung of the ladder?
A Paracetamol.

Q If paracetamol is ineffective, what's the next rung?
A Co-codamol, something like that.

Q Co-codamol, and then the rung after co-codamol?
A Possibly non-steroidal anti-inflammatory.

Q Yes, and then is there a rung after that?
A Oramorph, I would think.

Q Oramorph?
A Sorry. My mind's gone blank.

THE CORONER: It's not a test.
A No!

MR LEIPER: No, and if you're uncomfortable with any of the questions that I ask, please say so because it's not a memory test. I'm just looking to you to explain exactly what the analgesic ladder is. There can be risk factors associated with taking medication.
A Yes.

Q Are there risk factors associated with taking opioids?
A Yes.

Q By "opioids", Oramorph, is that an opioid?
A Yes.

Q Could you name some other opioids?
A Diamorphine – sorry, my mind's gone blank.

Q OK, diamorphine and Oramorph. What are the risks associated with diamorphine and Oramorph?
A Excessive drowsiness, constipation.

Q Is it possible that opioids can result in a worsening of confusion in elderly patients? Is that something you have come across?
A Yes.

THE CORONER: Can I just be clear in your answer to that? It would worsen their confused state? Is that what you're saying?
A Possibly.

MR LEIPER: So drowsiness, constipation, confusion. If an excessive dose, an extremely excessive dose, of diamorphine were administered, what is the risk associated with that?
A The patient would be unrousable. If it was an excessive dose, their respirations could decrease.

Q And what would be the consequence of that?
A Well, death ultimately, I suppose, if we're talking really excessive.

Q Is it as a consequence of the risk of death that the analgesic ladder provides for a stepped approach to pain relief?

MR TOWNSEND: Sir, I've allowed some latitude but---

THE CORONER: I'm just wondering if this---

MR TOWNSEND: ---if this witness is the appropriate witness to ask that question of.

MR LEIPER: If it's not an appropriate question for this witness, I will certainly move on.

THE CORONER: If the witness is able to answer the question, then fine. Did you write the book?
A No.

MR LEIPER: Do you understand the rationale behind the Wessex guidelines?

A I do. The analgesic ladder is a guideline.

Q Yes, and it's a guideline set out for the safety of the patient.
A Certainly, yes.

Q Did you at some stage have a concern at Gosport War Memorial Hospital that that guideline wasn't being complied with?
A When are we talking about?

Q 1991.
A I had concerns in 1991, yes.

Q Could you help as to what those concerns were?

THE CORONER: Can I just ask you: the concerns that you had in 1991 related to the administration of analgesia?
A The administration of analgesia, the amount of training we had had at the time, syringe drivers were relatively new to us on the ward.

Q So it was all those concerns. Were those concerns addressed?
A I think so, eventually, yes.

Q By the time we get to 1996, are you comfortable with the regime?
A Yes. If I was uncomfortable, I would have said so or I wouldn't have administered.

Q Hence the events of 1991, when those concerns were raised?
A Yes.

Q Obviously, from what you're saying, those concerns were, as you say, eventually dealt with?
A Yes.

Q And by 1996 you are comfortable with them.
A Yes.

MR LEIPER: I am grateful, sir. Just to identify three of the concerns that I understand you raised in 1991, you were concerned that no other form of analgesia other than diamorphine were being considered and the sliding scale for analgesia was not being used. That was one of your concerns.
A Yes.

Q Another of your concerns was that the drug regime was---

THE CORONER: It's fairly prejudicial. I'm not trying to be difficult in any way but what you're saying is that these concerns that were expressed in 1991 related to others, that they don't relate to the period we have in 1996, when this witness is saying she is quite comfortable with the regime.

MR LEIPER: As I understand it.

THE CORONER: I don't want to visit any areas outside that save to say that there had been concerns, those concerns had been addressed – yes?
A Yes.

Q And by 1996 you are comfortable with it and it seems to be working.
A Yes.

Q From your point of view.
A From my point of view, yes.

MR LEIPER: Sir, I just wanted to clarify with this witness whether or not a concern had been raised in 1991 that deaths were sometimes hastened unnecessarily. Was that a concern that you had raised in 1991?
A I don't recall myself stating that.

Q Do you recall anybody raising that as a concern?
A I don't recall it, no.

Q You attended a meeting---

THE CORONER: Can I stop you questioning for probably about a minute?

(End of recording)

MR TOWNSEND: Sir, I hesitate to interrupt but I wonder if Mr Leiper can tell us which of the ten deaths that the jury are inquiring into a minute from 1991 is going to help us?

THE CORONER: I suspect he is not going to be able to do that but what was put to this witness was that she had expressed concerns as to the analgesic ladder and she said that she had no recollection of that matter. (To the witness) Do you remember a meeting when the matter was discussed?
A I can remember a meeting but, as you can appreciate, I don't have access to any notes or minutes from any of the meetings and haven't seen any such documents for quite some time.

Q Absolutely, but I think the question is do you remember a meeting to discuss it?
A I do remember a meeting, yes.

Q I don't want to go much further into it than that, save that the concerns that were expressed, I think Mr Leiper was putting to you that there had been some question about the analgesic ladder. Do you remember that?
A I do remember that, yes.

Q As a result of that, you have said that was addressed and by 1996, which is where we start our investigations, that is resolved so far as you are concerned?
A Yes.

THE CORONER: Thank you.

MR LEIPER: Sir, what I was hoping to do is put this document to this witness for the purpose of refreshing her memory and just ask her to identify five of the concerns which were raised in that meeting in July 1991.

THE CORONER: I don't think I want you to do that, because I think that is taking me beyond where we are. If it had been 1996, I would be listening to you and I would be moving on. As it is, we are talking 1991 and somebody queried with me whether this was a rule 42 situation that I might... How can I? This is 2009 that we are now. I can't put myself back to 1996 for the first death I am looking at. Similarly, I don't think it's fair to look at events in 1991 save to say that the concerns were expressed, which is where I am, and I'm quite happy to accept that the concerns were expressed. What this witness has now told me twice is that those concerns had been resolved by 1996.

MR LEIPER: Yes.

THE CORONER: So if you want to go back to 1991 and deal with those, then let's get another set of statistics from 1991 and I'll start again, but I can't do that.

MR LEIPER: There was a specific point, sir, that I raised with this witness and it was as to whether or not one of the concerns in 1991 had been that patients' deaths are sometimes being hastened unnecessarily. That was the question I put. This witness said she didn't remember that specifically. It was for that reason I was going to ask her to have a look at this minute.

THE CORONER: Did you raise that matter?
A I honestly can't remember.

THE CORONER: I'm going to leave it at that.

MR LEIPER: Very good, sir. The Wessex guidelines that you have referred to suggest that an appropriate starting dose for morphine was between 20-40 mg of morphine.
A Yes.

Q If one takes a sort of mid point of that of 30 mg of morphine, the Wessex guidelines suggest that the diamorphine equivalent to 30 mg of morphine is, I think, 10-15 mg of diamorphine. Is that a ratio that you are familiar with, that diamorphine is about three times as strong or between two and three times as strong as morphine?
A Yes.

Q Yes? You were, I think, administering or aware of the fact that Elsie Devine was receiving 40 mg of diamorphine.
A Yes.

THE CORONER: Sorry, how much?

MR LEIPER: Forty. If one takes the three to one ratio from the Wessex guidelines, that 40 mg of diamorphine would be equivalent to 120 mg of morphine.
A Yes.

Q Yes?
A Yes.

Q The Wessex guidelines, as you have confirmed, suggest that the starting point for morphine should be 30 mg.
A Yes.

B Q So it appears as though that 40 mg amount is four times... she was receiving four times as much morphine via the diamorphine subcutaneous driver as the original recommended starting point suggests.
A Yes.

Q You have said that you had no concerns in relation to the level of diamorphine that she was receiving.
C A Correct.

Q Notwithstanding that that is four times the amount that the starting dose according to the Wessex guidelines suggests as the appropriate level?
A Correct.

Q Your absence of concern – was that as a result of you having assumed that the
D analgesic ladder had been complied with?
A I think so.

MR LEIPER: Yes. Thank you very much. Thank you, sir.

MS BALLARD: I have no questions.

E MR TOWNSEND: No thank you, sir.

Examined by MR JENKINS

MR JENKINS: You have told us that you found your time fulfilling in nursing.
A Yes.

F Q Much of the time that you have spent in nursing has been looking after patients that Dr Barton was a doctor for.
A Yes.

Q We know that she would attend Gosport War Memorial Hospital and do a ward round of Dryad and Daedalus wards on weekdays, Monday to Friday. Can you tell us, were you there for the start of her visit much of the time?
G A Often Dr Barton would arrive before we finished our shift, so yes.

Q Would Sister Hamblin be there?
A Sometimes, if she was on duty.

Q She was a day sister.
A She was a day sister, yes.

H

Q For Dryad Ward.
A Yes.

Q Would you be present, giving feedback to Dr Barton about patients and how they had got on overnight if there were any concerns?
A Some of the time.

B THE CORONER: Can I just clarify that? If you were there and you had concerns, would you share those with Dr Barton?
A Yes.

Q When you say "some of the time", would there be times that you had concerns that you didn't share with Dr Barton?
A No. Some of the times... when Dr Barton came on duty and came on to the ward, if
C she saw one of us, she would generally ask us were there any concerns about any of the patients during the course of our shift.

MR JENKINS: Yes.
A Gill Hamblin might not necessarily have been present. It might just have been the nurse in charge and Dr Barton.

D THE CORONER: Sorry, Mr Jenkins. I just wasn't quite clear on the reply.

MR JENKINS: Is it clear that part of the role of the nursing staff was to ensure that the doctor knew the situation with each of the patients?
A Yes.

Q Was it obvious from Dr Barton's approach that she wanted to know what was relevant
E for each of the patients?
A Yes. She asked us.

Q Was it obvious as well that Dr Barton wanted to give the best level of care that could be provided to the patients?
A It was very obvious to me.

F Q Was that part of the reason why you found your job fulfilling, because you were part of a team that were working hard?
A I think so, yes.

Q What you have told us was that there were some concerns in 1991. You told us part of that was in relation to the training that you had had.
A Yes.

G Q Were you night staff?
A Yes.

Q Part of your concern was that syringe drivers were relatively new.
A Yes.

H

Q Did you know how to set them up in 1991?
A I honestly can't remember.

THE CORONER: How did you gain the experience to be able to do it? How did you learn how to do it?
A The very first syringe driver that I came across on Dryad, the nursing sister on duty, I asked her if she would show me, which she did.

Q So it was on-the-job training that you had?
A Yes.

MR JENKINS: I think the hospital ensured that you had proper training in syringe driver use...
A Yes.

Q ...as time went on.
A Yes.

THE CORONER: It is probably a cabbage question. Is it a standard part of nursing training that you are taught about syringe drivers now?
A It might be now but not when I trained.

Q I have just had a case from 2001 where nursing staff didn't seem to be aware of syringe drivers and how to apply them.
A I don't think it's part of standard training, no.

THE CORONER: My mind was going off for a while, I am afraid. Go on.

MR JENKINS: To come back to the administration of medicine to patients, giving them tablets, filling a syringe driver, nursing staff have their own obligations towards patients, don't they?
A Certainly, yes. Yes.

Q If a nurse felt that what was being suggested for the patient was inappropriate, a nurse has a professional duty to object.
A Yes.

Q Is that why you say that if you didn't want to give a particular medication to a patient, you would make an entry in the medical notes?
A Yes.

Q But with many of the patients at Gosport War Memorial Hospital that you were nursing and that Dr Barton was looking after, is it right that they were dying?
A Yes.

Q Was part of your nursing care to ensure that they died comfortably rather than in pain?
A Yes, it was.

Q You have told us about the dosage range that would sometimes be prescribed for patients. Is that to allow that patient to be given an appropriate level of medication?
A Yes.

Q You have told us you would always start at the bottom of the range but that the doctor would know where you were at any time.
A Yes.

B

Q We have heard – is this right – that if medication was to be given to a patient, there would be two trained nurses involved in giving it?
A Usually two trained nurses.

THE CORONER: I think you said because of your difficulties with night-time cover you may not have another trained nurse but you would take a support…
C A Two trained nurses as far as possible.

MR JENKINS: Does it follow that for any medication that you provided to the patient, it was your view that it was appropriate for the patient to receive?
A Yes.

Q Otherwise you would not have given it, as you said.
D A Otherwise I would not have given it.

MR JENKINS: Thank you very much.

MR SADD: Sir, I am slightly out of order and I can understand if my colleagues want to come back on my questions. I wonder if I might ask Mrs Turbritt some questions, please.

E THE CORONER: Yes.

Examined by MR SADD

MR SADD: It stems from puzzlement, Mrs Turbritt, in relation to some of the answers you gave to Mr Leiper. I, by the way, am for one of the families, Mr Wilson, sitting behind me. In relation to the concerns that you raised in 1991 you were able to remember some of those
F but not all of those. Is that right?
A Yes.

Q How is it then that by 1996 you knew that all those concerns had been met?
A Erm…

THE CORONER: Well, put it the other way round and look through the other end of the
G telescope and say in 1996 did you have any concerns about the regime at Gosport?
A The answer would be no.

Q So whatever the concerns had been in 1991…
A I must have felt that they had been addressed.

Q …they didn't exist in 1996.
H A Yes.

MR SADD: In 1991 are you directly aware whether or not Dr Barton was aware of your concerns?
A No.

Q She was not or you can't remember?
A I can't remember her.

MR SADD: Thank you very much.

THE CORONER: We can ask Dr Barton. She will remember. Right. Anything from the floor? Ladies and gentlemen, anything you want to ask? Yes.

Questioned by THE JURY

A MEMBER OF THE JURY: Sorry, could I clarify something that Mr Leiper spoke about, about the equivalent dosage? When you were talking about 120 mg, are you talking over a 24-hour period or as a single dose?
A A 24-hour period.

Q So the 120 mg of morphine over 24 hours is equivalent to 40 mg of diamorphine over 24 hours?
A Yes.

Q So in other words, that's an incorrect dose then, because you wouldn't have given 120 mg of morphine in one go, which is? You would have given it four-hourly.
A Yes.

Q Yes, which would be 20 mg four-hourly.
A Yes.

Q Six doses. So when he asked you if it was a high dose, you said yes, but in actual fact I think he might have confused you a little bit.
A I think so, yes.

Q Is that OK? Does that make sense?

THE CORONER: Yes. Anything else?

A MEMBER OF THE JURY: Just one question there. You said that if you weren't happy with the dosage that you would write it in your notes and refuse to give it.
A Yes.

Q Did that ever happen?
A It has but not with diamorphine that I can recall.

THE CORONER: It has happened but not with diamorphine. Yes?
A Yes.

THE CORONER: Good. Anything else? Thanks very much indeed. I am very grateful to you and I release you. Thank you.

(The witness withdrew)

THE CORONER: Right. The remainder of the day is going to be three rule 37s: Tuffy, Dr Rees and Dr Petch. Do you want to do those before lunch and then have the afternoon off or do you want to come back at two o'clock? Now? OK.

Alexander Tuffy. Helena Service we're moving on to here. He is Alexander William Tuffy, nephew of Helena Service, born on Code A

"My Auntie Helena was known as Nellie by everyone. She was born in Watford and up until her marriage to Frank Service in 1929 she worked at an auctioneer's. She didn't have any children and when Frank retired they moved to Stubbington to live. My Aunt Kath had moved to Stubbington so Frank and Nellie retired down there too. My mother Charlotte died from cancer in 1939 and Auntie Kath died from a heart attack whilst in her 70s.

"I have been asked if I know any of Aunt Nellie's medical history. She went deaf at an early age. She was always physically fit and very alert. She was a very intelligent woman. My uncle died shortly after they moved to Stubbington and eventually, after my other aunt and uncle died, Nellie was left on her own. She continued to live alone and was perfectly able to care for herself. She would visit us regularly.

"In the early 1990s Aunt Nellie had a stroke and though she regained all her mental faculties, she lost some use in her left hand. She continued to live alone but was supported by various home helps and meals on wheels. In 1993 the GP recommended that Aunt Nellie needed more care than she was getting and she moved into Willow Cottage Nursing Home. Aunt Nellie, after she had settled in, liked living at the home. She was able to get about with the aid of a walking stick and was mentally alert and active. She would do the *Telegraph* crossword every day and was a vociferous reader.

"In the early part of 1997 Auntie Nellie became ill. She got a bad cough and was taken into the Queen Alexandra Hospital at Cosham. She was there for a few days. We visited her here, as did Jeff and Elaine White, who ran Willow Cottage. They told Nellie that they were unable to take her back to Willow Cottage as she would need a greater level of care. Aunt Nellie was deeply distressed by this. Her cough had left her very frail and very weak. We spoke about where Nellie could go and Jeff White informed us that he had a friend who ran a nursing home which could accommodate Nellie and that she would be happy there. I can't recall who suggested it but someone within the hospital suggested that Aunt Nellie could go to a new unit for old people. The unit was marvellous and it wouldn't cost anything. That was Gosport War Memorial Hospital. I didn't know where the unit was, nor did I ever visit it.

"A few days later I received a telephone call to say that Aunt Nellie had been moved to the hospital and that she had died in the early hours of the morning. My aunt died on 5 June 1997. I received a telephone call from the hospital asking why I hadn't been to the hospital to collect the documents relating to Aunt Helena. My aunt's death was unexpected. She had not complained of being in any pain. She was just frail. She desperately wanted to live until she

was 100 years old. Her cause of death is given at 1(a) as congestive cardiac failure and was signed by Dr Barton. In accordance with her wishes she was cremated."

That's his statement.

Dr Rees is a GP. He tells me about the positions that he has held. He is currently employed as a GP partner in the Stubbington medical practice since 1990.

"I have been asked if I remember patient named Helena Service. I can say I do remember her but not the details of her medical history. I have been asked to go through the entries in her medical notes. I have been shown her GP notes. From these I comment on the sequence of events.

"She had heart problems in 1984. I first saw her in 1990 when she had fallen at home. I recall that she lived alone, had nice neighbours who were also patient's of mine. In February 1991 she had symptoms of heart failure, with shortness of breath. She refused to go to hospital and so I treated her at home and her neighbours offered to look after her. She was given digoxin and furosemide, which were drugs used conventionally for the treatment of heart failure. I saw her the next day, when she was a lot better and her breathing had improved.

"In June of the same year I was able to cut down her furosemide, one of the drugs used to treat her heart failure, dose. I saw her several times that year, mostly on routine visits. In March 1992 I saw her on a routine visit and noted "Marvellous old lady, managing alone with help from her neighbours." In November of the same year I saw her after she had fallen. No treatment was required. In December 1992 she was seen by one of my partners, having collapsed on to the floor at home. Mrs Service was admitted to A&E at QA. Following a short stay in hospital she was discharged to Willow Cottage Rest Home as she was felt unable to cope on her own at home, where she remained.

"In May 1993 I treated her for an eye infection. She was seen by a GP colleague in October 1993 and treated for a chest infection. In March 1994 I treated her again for another chest infection. I saw her twice in May, firstly for back pain and then when she had a small stroke. In December 1993 I saw her on a home visit with increasing shortness of breath and treated her with furosemide for heart failure. I saw her once again the following month, January 1994. By then she was a little worse. I would have preferred her to go to hospital but she declined to be admitted. I prescribed an additional heart failure drug. I was concerned about her and I decided to discuss her case with a consultant geriatrician colleague. I spoke with Dr Lord, who suggested increasing her lisinopril and substituting her furosemide for bumetanide, a strong diuretic.

"I saw her in May 1996, when she had a skin infection followed in June by an itchy rash. In December 1995 Helena Service was treated by a colleague for a respiratory tract infection. In January 1996 I referred her to the orthopaedic department at QA with a swollen, hot right wrist as I was concerned she may have a joint infection. That diagnosis of septic arthritis was confirmed and she was treated in hospital. In September 1996 she was treated by a colleague for a chest infection. In March of 1997 she was seen by me as she was shouting at night, apparently keeping the other residents awake. I prescribed a small dose of a sedative, Mellaril, to be administered by a care staff at the rest home for night-time agitation. Early in

May 1997 she complained of low back pain and treated with paracetamol. A few days later she developed a fever, chest infection, and was treated with antibiotics.

"On 12 May 1997 her drowsiness increased, she had ankle swelling and her chest infection appeared to have exacerbated her heart failure symptoms. She was very unwell and in my judgement was dying and I did not think that hospital admission was appropriate. After discussion with the staff at Willow Cottage, I decided to recommend nursing care and monitoring at home. On 17 May 1997 I again visited her at home. She was hot, drowsy and dehydrated. The rest home were unable to provide the level of nursing care she now required so I admitted her to Queen Alexandra Hospital.

"I have been shown a copy of a letter contained at pages 51 and 52 of Helena Service's hospital notes. This is the letter sent with Mrs Service when she was admitted. The letter is written and signed by myself and reads as follows. 'Dear Dr Lister, thank you for admitting this elderly lady, who has a history of gout, non-insulin diabetes, CCF'" – congestive cardiac failure. "'She has been seen by Dr Tandy in the past. She recently developed a UTI and responded initially to antibiotics. She has now been increasingly short of breath, confused, disorientated and the rest home is unable to cope with nursing her. Her current medication is…" and he then lists that. "'Thank you for your help.'"

That is his statement.

Anything arising from that? Can anybody point me in the direction of Dr Petch?

MR TOWNSEND: Sir, it's towards the back of that bundle and that part of the bundle. It's just before Dr Wilcock.

MS BALLARD: Between Professor Black and Dr Wilcock, sir.

THE CORONER: In that case, I think I want to do this after I've heard Dr Black. It might not matter. Let's take him then.

In the next two days, we've got Dr Black, who is one of the experts to give evidence. Dr Petch is another but we're not calling him; we're taking him in writing.

It says "Report on Helena Service. A report has been provided by Dr Black."

I'm just going to try doing this right. Sorry about this.

He starts off with a summary of the conclusions. "Mrs Service was aged 99 years at the time of her death and had a long medical history, with evidence of heart disease by 1989, heart failure by 1995. The average survival of patients with this sort of heart failure is two years, and hence Mrs Service's terminal decline in 1997 was not unexpected."

If you go to your timeline you can fit it in where we are in that.

"Once the decision has been made that she was not for resuscitation, as it was in the Queen Alexandra Hospital in May 1997, then palliative care with increasing doses of diamorphine and midazolam were appropriate. These drugs were administered in accordance with cardiological practice in 1997.

"This report has been prepared on the instructions of the inspectorate at Operation Rochester. It is an investigation by the Hampshire Major Crime Team investigating the deaths of elderly patients at Gosport. The questions posed by the police are as follows. The central issue in this case is whether the death of Mrs Service was accelerated by the treatment that she received at Gosport and in particular the administration of diamorphine subcutaneously by syringe driver."

He then tells me that he is Dr Michael Charles Petch, MA Cambridge, Fellow of the Royal College of Physicians, Fellow the American College of Cardiology, Fellow of the European Society of Cardiology, consultant cardiologist at Papworth Hospital in Cambridgeshire. "After training at Cambridge University, St Thomas's and the National Heart Hospitals in London I was appointed to my present post in 1977 and have been in active clinical practice since. My experience includes all aspects of clinical cardiology, cardiac pacing and coronary intervention, teaching, research, management, legal work, et cetera. I have published over 100 papers and most recently on the subject of heart disease and ability to work. I have served on many national and European committees, including the Department of Transport's Honorary Medical Advisory Panel on Driving and Diseases of the Cardiovascular System, in recognition of which I was appointed an OBE in 2001."

So he's your heart man!

"This report has been prepared from copies of the medical records, including those from the Royal Naval Hospital Haslar, relating to Mrs Service's admissions in 1989 and 1992 and from Queen Alexandra Hospital, St Mary's Hospital, Willow Cottage Residential Care Home and Gosport War Memorial Hospital. The last are crucial to this investigation and have been identified for me by DI Dave Brocott(?). The handwriting is not always easy to read." That is because they are by doctors – not to mention lawyers!

"However page 164 of 401 dated 3 June 1997 entitled "Transfer to Dryad Ward" refers to Dr Jane Barton's notes. Pages 37 and 38 of 401 can be more reliably identified because page 37 has at the top "Hospital, GWM, ward Dryad." The nursing records cannot be attributed to Gosport War Memorial Hospital since the heading reads "Portsmouth Healthcare NHS Trust". I am however reliably informed that pages 22 and 23 dated 5 June 1997 relate to Gosport.

"In addition to the foregoing documentation, I have also seen the statement of Dr Jane Barton dated 27 October 2005, which helpfully describes the standard of care available in Gosport in 1997.

"Summary of medical history. Mrs Service had a long medical history, including a partial gastrectomy and cholecystectomy in 1981. Left cataract surgery in the same year. She suffered a stroke, left hemiparesis, necessitating a period in hospital between 29 October and 27 November 1984. In 1988 she suffered polymyalgia rheumatica and following treatment with prednisolone, developed diabetes mellitus which was considered to be heterogenic(?).

MR TOWNSEND: It means "brought about by the doctors".

THE CORONER: There you are then!

"On 15 August 1989 she suffered a fall with multiple rib fractures on the left side. For the first time her heart was mentioned; she had developed an abnormal rhythm, atrial fibrillation and her heart was noted to be enlarged on the chest x-ray. On 13 November 1992 she was again admitted to hospital with a chest infection. She was again admitted on 29 December 1992 with a left-sided weakness and kept in hospital until 8 January 1993. On 13 January 1995 Dr Alethia Lord describes her domiciliary visit and her findings of shortness of breath and heart failure. Mrs Service was therefore admitted to hospital for more intensive medical treatment, which appeared to be successful. By January 1996 Mrs Service had developed gout with painful swollen wrists. By that stage she was described as being profoundly deaf.

"By May 1997 Mrs Service had deteriorated physically, with a recurrence of her heart failure, urinary infection, chest infection and a physical state that was such that the senior registrar felt that, in the event of her cardiac arrest, Mrs Service should not be resuscitated.

"She improved to some degree but was not sufficiently independent to go back to Willow Cottage. She was therefore transferred to Dryad Ward at Gosport. On admission Mrs Service was seen by Dr Jane Barton. Her clinical note and typed version indicate that Mrs Service was not expected to live long. This was phrased as "Needs palliative care if necessary. I am happy for nursing staff to confirm death."

"The nursing records from 3 June 1997 describe her condition as at 0200 hours: 'Failed to settle. Very restless and agitated. Midazolam 20 mg given via syringe driver over 24 hours.' On 4 June 1997 the entry reads 'Condition appears to have deteriorated overnight. Remains restless. Seen by Dr Barton. Driver exchanged with diamorphine 20 mg, Midazolam 40 mg at 0920 at the rate of 50 ml per hour. Rang Mr Tipping, nephew, to inform him of poorly condition' and on 5 June 1997 0400 hours 'Condition continued to deteriorate and died very peacefully at 0345 hours. Nephew informed.'

"The prescription charts relate to 3 June 1997 and include diamorphine 5-10 mg, IM (intramuscularly) under once-only prescriptions and diamorphine 20-100 mg SC (subcutaneous) over 24 hours. This was administered starting on 4 June 1997 at 0920 hours as in the nursing records. Midazolam 20 mg was also prescribed and given as bumetanide, lisinopril and allopurinol, Lanoxin, aspirin, Midazolam but not the hiazine. This is in accordance with the witness statement of Dr Barton.

"There is no record of a post mortem examination, nor of any toxicology analysis. I have not seen a copy of the death certificate.

"Questions:

Was Mrs Service's treatment for her congestive heart failure appropriate for 1997?

Yes.

Given that despite her existing anti-failure therapy she remained breathless and heart sounds revealed a gallop, what would have been considered reasonable treatment options, taking into account her age, circumstances, biochemistry, et cetera in 1997?

Palliative care.

Would uploads have a role for the relief of breathlessness due to chronic heart failure in 1997?

Yes.

MR JENKINS: It should be "if".

B THE CORONER: Thank you.

"If opioids did have a role in the relief of breathlessness due to chronic heart failure in 1997, in what circumstances would they be used, in what dose and by what route?"

He replies, "When the decision had been taken, curative treatment was no longer possible and by any perinatal(?) route, for example, 2.5 intramuscular or intravenous or 20 mg
C subcutaneous initially, but tolerance would have developed and bigger doses would have been required."

A very significant point.

"What is your opinion of Mrs Service's likely prognosis from her heart failure point of view?

D Her heart failure was terminal, i.e. a few days.

What in your view on the prescription of diamorphine 5-10 mg intramuscular PRN for congestive cardiac failure?

It was appropriate.

E What in your view on the prescription for diamorphine 20-100 mg subcutaneous 24 hours together with midazolam 20-80 mg subcutaneously 24 hours by syringe driver PRN in case she deteriorated and developed pulmonary oedema?

It was appropriate.

What in your view on the subsequent administration of diamorphine---
F

MR JENKINS: Sorry. "What is your view..." You read "in".

THE CORONER: I am sorry.

"What is your view on the subsequent administration of diamorphine 20 mg subcutaneous 24 hours and midazolam 40 mg 24 hours in order to reduce the pulmonary oedema and the
G distress and agitation from the drowning sensation of the pulmonary oedema?

Appropriate and desirable", is what he says.

"Opinion. Mrs Service suffered from heart failure which was well advanced in 1997 and terminal by June of that year. She was receiving appropriate treatment to correct this, including the diuretic bumetanide to alleviate congestion. Lisinopril, which is one of the
H angiotensin" – what's that? "Angiotensin-converting enzyme inhibitor drugs..."

All I need is a course in biochemistry and I will be there!

"...has been shown both to improve survival and alleviate symptoms in heart failure and also digoxin, which improves the strength of cardiac contraction and slows the heart rate in atrial fibrillation such that symptoms are improved.

"Her other drugs, including allopurinol, to counter the gouty tendency and aspirin to reduce blood stickiness and prevent vascular complications. Mrs Service remained unwell despite the corrective treatment outlined above. Opiates, notably diamorphine, are standard drugs for the alleviation of shortness of breath and distress associated with pulmonary oedema and are particularly helpful at night. The administration of diamorphine has been standard practice for myself and other cardiologists for many decades, and remains so. Intramuscular and subcutaneous administration is usual.

"Mrs Service's prognosis was hopeless. The administration of diamorphine 5-10 mg intramuscularly would have been entirely appropriate and the prescription for diamorphine 20-100 mg subcutaneous in 24 hours together with midazolam is reasonable, given the circumstances of the practice described by Dr Barton in her statement. There would have been a clear, if unwritten, understanding that the nurses should start with the smaller dose, namely 20 mg, which, given the erratic absorption of subcutaneous drugs, would amount to less than 1 mg per hour. All opiates induce tolerance and with the passage of time the dose has to be increased. Hence the nurses would have been able to implement this without further reference to Dr Barton. This practice is in keeping with the recommendations of the British National Formulary, which reads as follows: 'Chronic pain, by mouth or by subcutaneous or intramuscular injection, 5-10 mg regularly every four hours.'"

MR SADD: Sir, could you make the point that it is the 2004 British National Formulary?

THE CORONER: The 2004 British National Formulary.

"In a section entitled 'Prescribing in Palliative Care' diamorphine can be given by subcutaneous infusion in a strength of up to 250 mg per ml."

Then he gives his expert's declaration saying that he was aware of his duty to the Court.

Anything arising from that?

Right. I think I have come to the end for today, haven't I, unless anybody is going to put themselves forward. Mr Wilson? All right. Are you OK for Thursday?

MR WILSON: I think so, yes.

THE CORONER: Any problems with that, if you can let my officer know sooner rather than later.

MR WILSON: I will know this afternoon.

THE CORONER: Thank you. Tomorrow Professor Black. It does concern me that we have Professor Black for two days, and two days only if we need him for any longer. He cannot

do Thursday, so I would be very keen to keep ourselves up to time. If we could avoid any kind of repetition of questions, repetition of points that have already been covered, really to keep it moving.

MR TOWNSEND: Sir, the only time saving device that I had in mind is to invite him to read the reports of Dr Wilcock after giving his evidence.

B THE CORONER: He has done it.

MR TOWNSEND: He has already done it?

THE CORONER: He has had those and Dr Wilcock has had his. So they have had the cross-over. What I was proposing to do with Professor Black is to get him to read his conclusions for each deceased in turn, and then to give him to you, effectively, to ask any C questions that you might have, and similarly to the jury. I don't propose taking him through each report in detail because I think the conclusions are relevant and the reasoning behind it may not be helpful, unless there is something that you want to pick up.

MR SADD: Sir, might I ask that in relation to Mr Wilson, I can attend on Wednesday rather than tomorrow, if only because I am still reading two papers, that is to say...

D THE CORONER: When did Mr Wilson die?

MR SADD: He died in October 1998.

THE CORONER: Yes, then that's going to be fine. Hang on. Or not, as the case may be.

MR SADD: Wednesday morning he is at a funeral, so if it could be Wednesday afternoon. E I'm sorry.

THE CORONER: I will fit it in when you get here, Mr Wilson. Is that any help?

MR WILSON: Thank you very much.

THE CORONER: All right. Then I am sorry for the short day. I had anticipated we would F have been slightly longer than that. Ladies and gentlemen, I will see you again tomorrow at ten o'clock.

MR JENKINS: Sir, I wonder if I could detain you after the jury has gone just to talk about which witnesses are coming and when. Clearly, the picture has changed.

G THE CORONER: Yes, as ever. That is it. Thank you very much indeed.

(In the absence of the jury)

THE CORONER: Tomorrow I've got Professor Black, the 25th Professor Black. On the 26th I now have Ian Wilson and I was going to start taking Dr Barton then.

MR JENKINS: Yes.

H

THE CORONER: Because I think we can pick up the first couple at that point, if she's comfortable with that.

MR JENKINS: Yes.

THE CORONER: Because originally I was going to take all of her evidence at the end but if we can pick it up bit by bit, that would be very helpful.

MR JENKINS: I just wanted to discuss with you which of the patients we could deal with with Dr Barton at that stage, whether it would be appropriate to deal with all ten or whether we would deal with just those where we have heard some evidence.

THE CORONER: I thought we could do Pittock, Lavender and Service, and Ruby Lake, I suppose, if we can. Does that fit? Because we will have had evidence and we will have had Professor Black by then.

MR JENKINS: Yes, I am comfortable. You said Pittock, Lavender, Service and Ruby Lake.

THE CORONER: On the 27th we've got Beverley Turnbull and Mr Farthing. Then on Monday 30th I've only got Carl Jewel(?) in on the 30th, and he is not going to be much more than half an hour, an hour, so, again, if we can fill in, if you are able to us then, I think we can give Dr Barton an update.

MR JENKINS: I was going to invite you to consider calling Rear Admiral Barton-Roberts. He is a surgeon.

THE CORONER: You have said he is local.

MR JENKINS: He is, and I think there might be some benefit over and above what he says in his statement of calling him.

THE CORONER: (Inaudible)

MR JENKINS: He is in relation to Ruby Lake. There is a statement from him.

THE CORONER: Yes.

MR JENKINS: I am going to invite you, through your officer, to make inquiries as to when he can come.

THE CORONER: Let's see if we can slot him in on the 30th. Could we see if he's available on the 30th at 11, 1130? That would be helpful. Then on the 31st Victoria Packman, Ann Rieves, Mrs Briggs and Dr Reid, Dr Reid going over to 1 April, Pauline Gregory and again Dr Barton. April 2 and 3 I have blank at the moment. Then on the 6th and 7th Professor Wilcock.

In the absence of the jury, I will give you an indication that I am considering at this stage narrative verdicts, and I think these cases may well lend themselves to that. With that in mind, I am considering whether it is appropriate for the jury to answer a set of questions and,

if that is something that you feel you could contribute to, you might like to think about appropriate questions the jury might answer. I think it might be quite helpful to me certainly if I could have your views on that – maybe not now but as we approach the conclusion of the evidence, just to have some kind of view of it.

MR JENKINS: Can I take it that Professor Wilcock is – I think it is Dr Wilcock, is it not, and Professor Black?

THE CORONER: I think he is Professor, funnily enough.

MR JENKINS: He will tell us.

THE CORONER: He will. Don't worry.

MR JENKINS: Can I take it that he is booked for April 6th and 7th?

THE CORONER: He is booked for April 6th and 7th, being the first dates that he could do. Otherwise I would have brought him forward. I wanted him as close to Professor Black as possible.

MR JENKINS: I understand that.

THE CORONER: But that was the nearest I could get.

MR JENKINS: Can I just raise April 2nd? I have another professional commitment in the High Court.

THE CORONER: Do you want the day off?

MR JENKINS: Well, I couldn't but if you could, that would suit me very well.

THE CORONER: A day off for Mr Jenkins. When do you need to know? Presumably now?

MR JENKINS: No. Clearly, it is a moving target so far as the batting order is concerned and some are dropping out and others filling in.

THE CORONER: I have to say, I don't ever remember having such a juggling exercise on something like this. It just has been completely impossible to predict.

MR JENKINS: I think hearings into ten days are unusual.

THE CORONER: I think that is probably right. This will probably the longest one I ever do. Right.

MR JENKINS: Sir, what you have said is on March 30th, which is a Monday, you would anticipate hearing some more evidence from Dr Barton at that stage.

THE CORONER: Yes, if she is able to do that. I am not going to push Dr Barton in any respect, because I was quite content to take her evidence at the end and it is a concession that you have made that you are happy to do it bit by bit, and that is extremely helpful.

MR JENKINS: Thank you.

THE CORONER: All right. Thank you. Anything else? Then ten o'clock tomorrow morning, please.

(Adjourned until 10 a.m. the following day)