GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Wednesday 25 March 2009

The Law Courts
Winston Churchill Avenue
Portsmouth,
PO1 2DQ

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 SIX)

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

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

THE CORONER: Good morning. Ms Ballard, I have found this extremely useful and, subject to any observations anybody else might have, I would ask that the jury might have sight of a copy of that. Is that all right? Mr Leiper, is there anything you want to raise in regard to that?

MR LEIPER: I have not had an opportunity to take final instructions on it; I am going to do so but over lunch.

THE CORONER: Okay, if you could do that I will be grateful because it is a useful document for them. The drug chart we had for Cunningham yesterday, has that been amended, or not?

MR LEIPER: No, it has not.

THE CORONER: I shall leave that in your hands.

MR LEIPER: I am grateful. Is it a document that sir would be happy should go forward to the ---

THE CORONER: Yes, as long as it is factually correct, then I have no observation on that at all.
MR LEIPER: I am grateful.

THE CORONER: Anything else before the jury come in? Jury, please. We are trying to see if we could fix up any other arrangement; if you need a break just say so. Right? The order I was going to take this morning was, again subject to any views was: Packman, Devine, Gregory, Wilson and Spurgeon. That does not fit with you at all. Where are you now?
A I have Devine, but I am very happy to start with Packman.

THE CORONER: Are you all right with Packman first?
A Yes.

(In the presence of the jury)

Questioned by THE CORONER

THE CORONER: Good morning, Ladies and Gentlemen. Are you all okay? Let us get started. Professor Black, you are still on oath from yesterday and if we just continue. I am just going to go to Packman next. Geoffrey Packman, 68 year old.
A Indeed. Well, as you say, Mr Packman was 67 I got, but he may be 68, in 1999 he was admitted as an emergency. He had obviously been extremely obese, gross obesity I think was the word, morbid obesity for many years and suffered some of the consequences of that, for example having severe leg ulcer disease. He appeared to have got increasingly immobile, and his wife who was caring for him was also ill, so it was not possible to continue at home so he got admitted as an emergency and they found that he was really quite unwell. He had cellulitis, it is an infection of the skin. It is far more common in people who have leg ulcer disease, and it can be very serious. It can have complications. It is also quite difficult to treat

because it is getting the antibiotics into these areas, these areas of the skin is much harsher, actually, than getting it into other parts of the body. Although it may be seen as a simple problem, it can be quite serious. Indeed, he had a very high white count. His heart was in (inaudible), so he had an abnormal rate of his heart. He also had some impairment of his kidney function, which could have been due to either dehydration or a direct effect of the infection. They identify A Streptococcus that is causing it and they have got him on an appropriate antibiotic, but despite that, and the nursing on the ward, he clearly deteriorates, developing blisters on his heels, then I think also sacral sores over the next week. On the 13th, a black bowel motion appears to have been mentioned by the nursing staff. The significance of that is that if you bleed, if you have a bleed from a gastric or duodenum ulcer at the top end of your stomach, which starts off with bright red blood, but as it passes through the gastro intestinal tract it oxidises and will go black. It will go black as the end of this pen. When someone says that to you, you think: ah, have they had a bleed from somewhere up at the top of the GI tract, but he is examined. The doctor does not find any black stool so there may have been one, there may not have been but he thinks: well, let us just wait, wait and actually see. However, I think it is important to note that they do not start him on treatment, which you could have done, or tablets to try, if he did have an ulcer, to heal it, so you could have just done that. He continued on injections that he was having of heparin. That is very appropriate for somebody who is very obese. There is a high risk of getting clots in the legs where he has infections, he has ulcers, so we routinely give such patients heparin to try and prevent that. However, the side effect of heparin is that it makes you much more likely to bleed if you have a source of bleeding. So was that discussed? Did they make a decision? I do not know. There is no comment on it in the notes, but if he did have an ulcer, that would make it much more likely that it would bleed again.

THE CORONER: Right.

A He then gets transferred because he is not making progress to the ---

Q Just a second. Would it have been a reasonable thing to do to look at endoscopy at that point or was that not a practical ---

A No. I think that it would have been difficult. It is extremely difficult to do it on a very, very large man but not impossible. That would be the normal next step in an otherwise reasonably fit patient and I feel it could have been done at that stage.

Q What are the problems, similar to post mortem in ---

A The problems are just managing a very big person, getting them into the endoscopy suite, getting them into position, giving them sedation, and so on. It would have -- the practical problems would have been there, but they are not insurmountable. I think it would have been helpful to have done it at that stage, I think you are right. He then gets transferred I think on 23 August to the Gosport War Memorial Hospital. His haemoglobin was done on the 24th, it was actually 12, so it is still within normal range, although perhaps slightly lower than it was when he was originally admitted, but it was within the normal range. He did now have deep, complex pressure sores. I think that somebody who is very seriously obese and has big pressure sores has a very poor prognosis, but not necessarily a terminal prognosis. I think that would be the best way to put it. The chances of getting out of hospital are small, but you could not say that they will not. On the 25th, the nurses apparently, which I found in the notes, recorded that he was passing blood from his rectum and he was vomiting, but there is no evidence that he was seen by a doctor. However, on the 26th he was seen and found to be clammy and unwell and the doctor, I think it is Dr Barton, suggests that he might have had a heart attack overnight, but also suggests there might be a GI bleed. It says is not well

enough for him to be transferred to an acute unit and should be kept comfortable. The anti-coagulant I mentioned is also stopped. A full blood count is sent off. It is clearly recorded in the notes that it was now 7, so it was 12 a few days before, it is now 7. He has lost four or five pints of blood. I have no doubt at all that he had had a definite second, because I think there was one earlier, massive gastro intestinal haemorrhage, a bleeding in the upper part of his GI tract. The full blood count, which gets filed in the notes, says that many attempts were made to phone the Gosport War Memorial Hospital but no response from switchboard. Of course, the person that ordered it, and I do you know who that was, you would normally have expected them to have rung up to find the results. I do not think you can blame the pathology lab for failing to get through to the switchboard. I do think there is a problem there if someone does not follow up an - what is the point of doing an investigation if you do into follow it up?

Q In the normal course of events that would have been ordered by Dr Barton?
A Yes.

Q She would normally have picked up that result from the lab by ringing them?
A Either ringing them or, I mean, or it arriving the next day presumably on the ward.

Q She would pick it up when she was doing her ward round at that point?
A Indeed. By the 27th or 28th, I think the point, what is really important here is that this is the point at which there is an important - there is a crucial decision to be made in the management. As you have already indicated, there are investigations that could be done for gastro intestinal haemorrhage. There are treatments. Some of those can be done fairly simply with an endoscopy as you have mentioned, but quite often you might have to go, certainly in somebody that has had a re-bleed, a second bleed, to surgery. The risks of surgery in someone who is ill with bed sores of mass obesity are huge. Emergency surgery has a very high risk. Similarly, doing nothing has a very high risk. The chances are that if you have had a re-bleed and you do nothing at all about a gastro intestinal haemorrhage then it will continue to bleed and you will finally die. That is the likeliest outcome; not inevitable, but it is the likeliest outcome. I think this was an important and serious decision, at this stage. Do you take this gentleman and move him back to the acute hospital to have investigations, possibility of surgery or actually, because of his other problems, is this just a marker that he has come to the end of his life? It is just the sort of thing that happens. Other diseases happen as you gradually get worse and get frailer. I think that decision was difficult. I think it should have involved a consultant and I think it should have involved the patient and their relatives because everybody would have an opinion about that. Some patients would say: "No, I have had enough, doctor. I am just not having any more. If it comes to it, keep me comfortable." Others would say: "I want absolutely everything done". I think the patient has a major role in that decision.

Q I think Dr Barton took the view that he was too sick to move at that point and too ill to put back to QA. I think that was the comment that was made.
A I think that is part of that decision-making process, is it not? You have to assess the risks of moving somebody versus the risks of doing nothing where he may die anyway.

Q Yes.
A I think it is important that all parties are involved in that decision because I do not think there is a black and white answer here.

Q As it transpires he remains where he is?
A He remains where he is. I would presume - well, we know he continues to bleed because I think there are other mentions in the notes. If he is continuing to bleed, then he is gradually going to become frailer, he is going to become probably breathless, he may feel unwell. You are heading towards - he also has this large pressure sore. He has pressure sores on his heels and his buttocks. If there is nothing else and this is not going to stop then you take the decision that you want to relieve symptoms and that will eventually become terminal care. He receives - just go back to my charts - he is started off on oral morphine. I am afraid I find it quite difficult to tell exactly the dose, having looked at the drug charts on a number of occasions, but he appears to receive either 60 or 100 mg of oral morphine in regular doses from the 27th, the 28th and the 29th, and then is put on diamorphine, 40 mg, on the 30th. Again, judging the starting dose would be quite difficult in what is a relatively young person now who is also very, very obese, and probably with variable absorption from injections. Again, back to assessing the patient: are you giving enough, are you managing the symptoms. Certainly, I would have expected his pressure sores to have been extremely painful, particularly when they are being dressed.

Q Can I just ask about a practical management problem. If you have somebody that is morbidly obese and they have sores that you describe, turning them, presumably, is very difficult?
A You would have to be using hoists.

Q So dressing the wounds would be difficult?
A They would be painful and many nurses would give, if you are not already on some form of regular analgesia, they would give an injection of an analgesia, strong opioid before they actually dress them.

Q Presumably for Mr Packman, he is going to be put back down on to the sores. He is going to be on his back, is he not?
A Not necessarily. They might have managed to nurse him on one side.

Q Right.
A You would have to take the nurse - I do not know what they did so we would need to take the nursing ---

Q I am just thinking of a management problems.
A It is a huge management problem; there is no argument about that.

Q Sorry.
A No. Anyway, he is then seen by a consultant on 1 September when the consultant is clear that he is dying of his gastro intestinal haemorrhage and that where they are at now is that he is dying and you press on with terminal care. If there was a decision to do anything else, it is well passed by the time of 1 September. Then finally he dies on 2 September, and I guess, sorry?

MS BALLARD: 3rd.
A I stand corrected.

THE CORONER: Have we got it right?
A I note - well, a report I was given by the police said that the cause on the death

certificate was myocardial infarction, in my view that was inaccurate and the death certificate should have read "1 (a) gastrointestinal haemorrhage" and "2" pressure sores and morbid obesity".

Q Because the bleed is certainly documented, is it not?
A There is no question.

Q And it is unresolved?
A And it was unresolved.

Q It is not necessarily going to stop of its own accord. There was nothing there to stop it.
A It is unlikely - certainly, people, when you first bleed, there is a reasonable chance of it stopping of its own accord. People who have had two, and it has clearly continued, then you have to do something to stop it, if that is - it is inevitable, as much you can be ---

Q What would the options be at that stage to try and resolve the problem?
A Well, the point at which I said that you had to make a decision where he had obviously had this big bleed on the 24th - well, sorry, he had had it on, sorry, on the 25th the nursing staff first noticed it and then he was seen by the doctor on the 26th. Do I have that right?

Q Dr Barton sees him on the 26th.
A That is right.

Q Says it is either an MI or a ---
A At that stage, if you had come to a conclusion that this was for active treatment, because it was the major problem and he was going to recover from his other things, then he would have had to have been transferred back to the District General Hospital. He would have needed a blood transfusion. He would probably have had to have gone to the intensive care unit because of the complexity of dealing with his problems. He would have had this endoscopy, which is a test where patients are usually given a sedative and swallow a tube which looks down into the stomach. You can see the ulcer. Sometimes, and it was certainly available at the end of the 90s but not as available as it is now, you can inject it with adrenaline or you can use a heat approach to try and stop the blood vessel which is pumping blood into the stomach because the ulcer has eroded into a blood vessel. In a fair number of cases that would stop it. Equally, if it does not, then the only thing to do is to have surgery. That would be a massive undertaking.

Q It would have been for Mr Packman, would it not?
A Well, it is almost - surgery for gastro intestinal haemorrhage has a high mortality attached to it, probably of around 20 per cent no matter what, but it would have been much higher for Mr Packman.

Q So that is all part of the decision-making process in the balance?
A That is all part of the balance, yes.

Q The terminal event you would give as the GI bleed?
A Yes.

Q And other relevant factors: the pressure sores, morbid obesity?
A Yes. Cellulitis.

THE CORONER: Anything else? Mr Leiper?

Questioned by MR LEIPER

MR LEIPER: Professor Black, Geoffrey Packman was in his late 60s.
A Mm.

Q At the time when he was admitted to the Gosport War Memorial Hospital, so he was substantially younger than a number of the other patients you have been asked to have a look at?
A Absolutely.

Q For that reason perhaps falls into a slightly different category?
A I think it is one of the factors you take into account, but you do not make decisions just because of someone's age.

Q No, of course, but considerations which may be relevant to those who are - who obviously fall within the care of a geriatric - a consultant, would not necessary apply to somebody who is 68?
A I think the important point about this is that the older you get the less reserve you have. All systems age.

THE CORONER: With the point you are raising, is there not a direction that the Health Service cannot be ageist? That you need to treat people to the best of the healthcare, the best quality regardless of age. There is a direction somewhere.
A Oh, that was many, many years - you are right.

Q I am a very old person?
A If we went back, I think ten or fifteen years, there were rules that nobody over 65 could go to a coronary care unit and all such rules have been outlawed. You cannot use age as a pure determinant of treatment, but, of course, there may be things that you know that just is not relevant in a very old person.

Q It is the thing that removed those directions that I was concerned about, that say that you cannot be ageist now in consideration of treatment. That is not to be a factor in the ---
A Absolutely.

THE CORONER: Sorry, Mr Leiper.

MR LEIPER: I am grateful, sir. He was in the Gosport War Memorial Hospital for about 11 days between 23 August and 3 September. So a period of under two weeks. On the third day while he was there he became acutely unwell; this is on 26 August.
A Although I think the nurses said that he had been vomiting and had passed blood on the 25th. Yes?

Q Yes. So acutely unwell either on the second day or on the third day while he was there.
A Yes.

Q And your opinion is the reason why he was acutely unwell at that time was because of a gastro intestinal bleed?
A Yes. I think that was the cause of his significant deterioration at that time.

Q And you think it was that that he ultimately died from?
A Yes.

B

Q That was not the cause of death which was attributed at the time of his death.
A I understand that it was myocardial infarction on the death certificate. If that was the case then I do not think that was the case.

Q It appears that those responsible for his care did not know the cause of his problem.
A I do not think that follows because, quite clearly, he was seen by the consultant who
C was ultimately responsible for his care two days before death who was clear that there was - that he was having a gastro intestinal bleed, so I am quite clear that the consultant knew what was going on.

Q Is there any evidence that the doctor who saw him on the 26th and 27th, Dr Barton knew what was going on?

D THE CORONER: Her note might help.
A Sorry?

THE CORONER: Her note might help.

MR LEIPER: What it does, it puts a query: gastro intestinal bleed?
E A I think I mentioned that, yes.

Q You have had the opportunity, as I understand it from the Learned Coroner, to have a look at Dr Wilcock's reports?
A I have seen some of them since I wrote my original reports. I cannot tell you whether I have seen Packman's report, no, I cannot tell you that.

F THE CORONER: It was sent to you.
A It was sent to me? By you?

Q Yes.
A I have not received any reports from you.

Q Have you not? Who did I speak to in your office: your girl, your secretary is it, who
G said that she had not got them and would I send them, and I sent them.
A I have not seen any reports from you recently.

Q Not recently. This is some weeks ago.
A Sorry, I have no recollection here now.

Q I will have to check from my end of things?
H A I apologise.

MR LEIPER: He reaches a number of conclusions which appear to be similar to yours in relation to omissions in the care given to Mr Packman?
A Right.

Q He thinks there was an omission to adequately assess his condition on 26 August, which I think is a conclusion that you share?
A I have explained how I would set about that, yes.

Q There was an omission to obtain and act upon the blood test result?
A Yes.

Q He was not discussed with the on call medical team and there was a lack of consultation with colleagues, with senior colleagues?
A There is no record that that happened.

Q He also concludes that Mr Packman was put on doses of diamorphine and midazolam which were not obviously justified and likely to have been excessive to his needs. That is his conclusion.
A You will obviously take evidence from him. I think, as I said yesterday, that the doses will need to be justified that the patient was put on. As I said, I have struggled to find exactly what the dose was, whether it was a 60 or 100; I had difficulty with the notes, and so on. 60, as we discussed yesterday, would be very much at the top end of a starting dose although he was, as I described, and you have just pointed out, a younger man who was very, very obese. 100 mg would be very much harder to justify. I agree, I cannot see exactly what that justification was recorded in the notes.

Q There is no justification recorded in the notes, so you cannot sanction - you cannot say that that was an appropriate decision unless you have heard what Dr Barton has to say about it?
A I think that that is - at the end of the day, I think she has to explain, I will presume she has to explain that to the jury and the Coroner. It is the jury that need to understand that.

THE CORONER: Same argument as yesterday.
A Yes.

MR LEIPER: Mr Wilcock is of the view that the most likely explanation for the gastrointestinal haemorrhage was a peptic ulcer.
A I have said I thought an ulcer in either the stomach or the duodenum, both of which are referred to as "peptic ulcers" is the likeliest cause.

Q Thank you. He regards that as being something which is a potentially reversible condition?
A And we have discussed that with the Coroner.

Q Instead of the nature of the problem being addressed, instead of his being given the treatment that he could have been given, he was commenced on what appears to be a palliative regime of pain relief. Do you accept that?
A I accept that was the management, yes.

Q So instead of this being a case of rehabilitative care being administered following the acute problem, we move immediately to a palliative care regime?
A I do not think that follows. As I said, I think the issue is about assessing all the problems at that stage. It is very difficult if you just take one issue out of context of everything else. That is why I feel that it was important, in my view, to have had a review of all the issues. I thought it would be appropriate to involve the consultant in that and the family and the patient. I think that would have been the appropriate way to come to a decision about whether, at this stage, you are heading towards a palliative situation or whether you are going to go in a different direction and to try - you think this is another problem that you can cure and maybe you can improve things. I do not think that is easy from the information I have here. I do not I think I can make that judgment. I can only set out the parameters.

Q 11 days before his death when he was admitted to the Dryad ward he was admitted for the purposes of rehabilitation, was he not?
A He was admitted, absolutely, to treat his underlying - his medical - his acute medical problem, yes.

Q It was rehabilitative treatment which was clearly recorded in the notes as being the reason for his being admitted?
A Well, he was being admitted for acute treatment, but you are right, you are quite right. He had become immobile because of his infection. If you resolve the infection without any complications then you would expect to get him back on his feet and get him back home. That would have been the intention at the start.

Q Yes. The jury will, in due course, hear from Victoria Packman, his daughter, she will tell the jury: "Dad quickly made" - this is prior to his going to the Dryad ward - "Dad quickly made good progress. He had injections of antibiotics and soon his legs dried up and he seemed much better. I remember thinking he looked the best he had for years. He was happy and chatty and keen to go home. He was eating and drinking properly and quite able to do things for himself. Because of Dad's lack of mobility around the house Mum and I were told that he would be going to the Gosport War Memorial Hospital for rehabilitation and remobilisation. Whilst he was there, the Social Service department were going to assess our house in order to put in hand rails in order to help Dad get around. Everyone seemed very positive." He is then assessed at the Dryad ward on 23 August and the relevant I entry think is at page 54 in the bundle of medical records.
A Yes. I do not have that, but, yes, I accept that is where the page on which his problems are recorded and I have some of those in my notes here.

Q I am grateful. There is a bundle.
A Should we need it, we will do that.

Q Should you need it. Included in the findings, although there is little on examination, and this is Mr Wilcock's interpretation of that note, there was little to find on examination bar his obesity, swollen legs and pressure sores. That is what Mr Wilcock says about that entry?
A I think also in the notes I found that he had a Barthel, a dependency score and a Waterlow Score recorded.

Q Yes.
A You will come on to those?

Q I was not going to. All I was going to put to you was that there was nothing in that entry to record that he was terminally ill?
A Oh, I would agree with that. Absolutely.

Q During the first two days when he is in the Gosport War Memorial Hospital his daughter will, in due course, tell the jury: "When Mum and I visited him there he was sat up in bed and he seemed very cheerful. He was given a room on his own which was three to four doors away from the nurses' station. He was eating and drinking properly and he was in very good spirits. He never complained of being in pain, nor did he show any signs that he was in pain. He was supposed to be in GW, in Gosport War Memorial Hospital for remobilisation, but I never saw him out of bed." We then come on to what happened on 25 August which you have recorded, but he is meant to be passing blood rectally. Yes?
A Yes.

Q On 26 August, he is seen by Dr Barton. Yes?
A Yes.

Q She believes the nature of the problem - and it is at page 55 which is her medical note - the next read: "Cool to see. Pale clammy, unwell. Suggest? Myocardial infarction", which is heart attack?
A Yes.

Q Yes. "Treat stat diamorphine and oramorph overnight", and then it says, "Alternative possibility: gastrointestinal bleed, but no haematemesis?
A Yes.

Q "Not well enough to transfer to acute unit, keep comfortable and I am happy for nurse and staff to confirm death."
A Yes.

Q There was no entry in the medical records of basic observations in relation to heart rate, blood pressure, temperature or the results of a medical examination, were there?
A Absolutely not.

Q You would expect those details to be in the medical notes would you not?
A I would.

Q When a patient's clinical condition changes very much for the worse you would expect a very thorough medical assessment to have been carried out?
A I agree.

Q It is not apparent from the notes that that was done?
A There is nothing recorded in the notes.

Q It certainly would not have been appropriate to rule out the existence of the gastro intestinal bleed on the basis of there being no haematemesis. If I could just explain to the jury what haematemesis is?
A If you are bleeding into - you have a peptic ulcer, an ulcer which can be either in the stomach or the next bit just beyond the stomach which is called the duodenum. Blood, if it is

particularly a gastric one, will accumulate in the stomach, can irritate the stomach and you may vomit, as if you have food poisoning. If you do that, you might vomit up blood, which can be bright red. Many people, though, just feel unwell and it passes through the gastrointestinal tract and then it becomes black at the far end and technical term for that is "melena". So haematemesis can be a sign of upper gastro intestinal haemorrhage, and as has been quite correctly mentioned, neither while if you have it, it is very likely that you have got one. If you have not, it does not exclude it.

Q Dr Barton decided that he was not going to be transferred to the acute unit. Yes?
A That is what is recorded in the notes.

Q You have told us that doing nothing in these circumstances where there is evidence of - or there may be evidence of this having had an earlier bleed, would mean that the likelihood is that he would die.
A I think that is - the likelihood is he will die from it, yes.

Q It was a consequence of her decision not to transfer him to the acute unit that he did die.

THE CORONER: Well, no, it is not. It is as a consequence of his condition that he died. You need to phrase that differently if you are going to look at Dr Barton's action or inaction because that was one of the options at the time the care plan was devised. That is what you were saying to me.
A That is exactly what I have said, yes.

Q So it is his condition from which he dies, the decision of his management, the decision of how to manage that is a different matter, and doing nothing was one of the options that Professor Black was talking about. You may criticise that. You may have observations on that.

MR LEIPER: Yes.

THE CORONER: They may be better dealt with with Professor Wilcock or with somebody else and you can certainly ask Dr Barton, but that was one of the options.

MR LEIPER: Thank you, sir. The decision-making process in relation to treatment of gastro intestinal haemorrhage, would you say, require a balancing act of the risks involved in his being transferred to another hospital? Yes?
A I think the risks of transfer are very low; a lot of discomfort, but actually a risk of transfer, it is what would then happen that would be crucial. When someone says a risk of - I do not think they are thinking about: oh, well they might be a problem in the ambulance. They are thinking about: well, what will happen when they get there and what would that involve and does that give you a better outcome or a more appropriate outcome than not doing that? That is the balance of risk. This is not something about being put in an ambulance.

Q That is the decision which is an extremely complicated decision and would require input from the senior consultant?
A I would normally expect that.

Q A general practitioner will not be in a position to make that decision herself?
A I would normally expect a consultant in charge who is essentially responsible for these patients to have been involved in that decision.

THE CORONER: Do forgive me, I am interrupting again. Is there not a problem in this case in that the consultant would only do a fortnightly ward round?
A Yes.

Q If a consultant was to be participating in that decision Dr Barton would have to call a consultant in. She was the person that was the doctor on the ground.
A Yes. Absolutely.

Q She was the one making the decisions. I am not even talking about the quality of the decisions. I am talking about the fact that she was the one that was actually making the clinical decisions. I think there is a difficulty in saying: well, yes, a consultant should have been there and if he had been in a district hospital the consultant would have been available. I think the point you have to move to is: should Dr Barton have perhaps expanded the decision-making process at that point or is this a decision that it was almost incumbent upon her to make. I mean, that is a point we will take with her, but, you know, it is that level of argument, is it not?

MR LEIPER: Sir, perhaps I could come back to Professor Black in relation to that. It is clear that there was not a consultant there at all times?
A Absolutely.

Q That does not mean to say that a consultant was not contactable?
A I would agree with that.

Q Had Mr Packmen been moved to a hospital which had appropriate facilities for dealing with him, then at such a hospital there would have been a consultant available?
A Well, if you made the decision to move, of course that was the case.

Q Yes.
A I think at this stage, no, it seems to me that in such a difficult situation that it would be appropriate for the clinical assistant to ring the consultant on call and ask for advice. There is always a consultant on call.

Q You have made clear to the jury that transferring the patient, itself, the process of transfer would be a relatively low risk?
A Would be low risk; not necessarily easy and not necessarily with discomfort in somebody who is very obese and has pressure sores, but I think in terms of some problem happening, clinically, during that transfer, that would be low risk.

Q So in the event of Dr Barton not being able to reach a senior consultant or advice over the telephone, what she could have done is get Mr Packman transferred to an appropriate hospital where he would receive care from an individual of appropriate seniority?
A That would have been an option.

Q The blood test results were available on 26 August. According to the notes you have referred to ---

A The blood was done, the lab had them. I have no idea when that form eventually arrived at the Gosport War Memorial Hospital; you may have that information, but it was in the notes that I received. It is possible that that form arrived a week later.

Q You are aware of the entry on page 205, certainly referred to it in your report, from the Portsmouth Pathology Service which says: "Many attempts were made to phone these results. No one was on the Gosport War Memorial switchboard."
A It is exactly the point I am making is that there had to be something proactive done to ensure, by the doctor or the nursing staff, to ensure that blood report would have been known about.

Q As a result of his not being transferred, and as a result of his receiving no treatment for his gastro intestinal haemorrhage he died?
A He dies of gastro intestinal haemorrhage, yes.

Q So far as the starting dose is concerned, you have said in your report that a starting dose of 40 mg of diamorphine, if that is what it was, was a higher dose than most clinicians would start with, which will be more likely to be 10-20 in the first 24 hours?
A I think that the problem is, I think you may have an original version of my reports.

Q I have the statement that you swore was accurate. It was a statement you gave to the police.
A Well, as I say, I have re-reviewed those notes last year and tried to get - tried to fully understand the drug chart. As far as I can see, and I have already explained that I am still not absolutely certain, I think he started off on the oral morphine, either at 60 mg or at 100 mg a day, and then received the 40 mg, as you say, of diamorphine. Now, just to follow that through, if he had been started on approximately 100 mg a day of oral morphine, as we discussed yesterday, that would be higher than would be the conventional normal starting dose and would need to be justified. That justification I could not find written in the notes. If that was the dose that he was given, though, and there were no problems with it, then it would be appropriate to give 30-40 mg of diamorphine.

Q It went from 40 to 60 to 90 and then he died?
A Again, I do not think I found any explanation in the notes for those increases.

THE CORONER: May I just say to the families: if you at any stage need a break, if you need to take some air, just say so. I know it is difficult for you and very difficult for you listening to it so dispassionately, but if you need some space, say so. All right?

MR LEIPER: The jury, in due course, will hear from Mr Packman's daughter to the effect that within three or four days of his being at the Gosport War Memorial Hospital: "Without any warning, Dad suddenly appeared what I would call spaced out. His eyes were glazed and his head would nod about. He was propped up on pillows and I believe he was catheterised. He would be very sleepy but was able to talk us to. He was not, however, able to hold a cup or pick up anything in order to eat. Mum and I would feed him grapes and hold up a cup with a straw for him to drink from. The change was very dramatic and he became progressively worse." So far as the family is concerned, that is as a consequence of his having received an excessive dose of analgesia. Are you in a position to refute that?
A Am I in a position to refute that? That is possible, but also it could be because he is continuing to bleed and become more and more and more anaemic.

Q Given the surprising lack of action in relation to the gastro intestinal bleeding and given the surprising decision in relation to the level of diamorphine and subsequent increases, does it not appear probable that a decision may have been made to hasten Mr Packman's death rather than provide him with the rehabilitative care that had been denied?

THE CORONER: Careful with that one, Mr Leiper. That is not why we are here. Seriously, it is not why we are here.

MR LEIPER: We are here to establish cause of death.

THE CORONER: Yes.

MR LEIPER: I will leave my questions there.

THE CORONER: All right. Thank you.

Questioned by MR JENKINS

MR JENKINS: The cause of death was natural causes?
A I think the cause of death, as I have said at the beginning, was his gastro intestinal haemorrhage.

Q Yes. You say in your report, I am looking at A document which you probably do not have in front of you any more, I am looking at a document which has 20 pages, and on the second page of which you say: "It is my opinion Mr Packman died of natural causes."
A I have just said that I think he died of gastro intestinal haemorrhage.

Q Yes. Can I come to the position on 26 August? I am looking at page 16 of your report. The printing says on 5 June 2006, looking at paragraph 6.8.
A You will have to read it. As I said, I am afraid I have a different set of later reports here, but they will be very similar. You can tell me where you are starting. I will find it.

Q Paragraph 6.8, I am not reading it all, but the third sentence of that paragraph you say of the 26 August: "Dr Barton makes the decision that the patient is too ill for transfer and should be managed symptomatically only at Gosport".

THE CORONER: You do not say symptomatically only at Gosport.

MR JENKINS: Yes. The emphasis the wrong way.

THE CORONER: Do you want to have a look at my copy of that?
A Yes. I think so. I may have slightly changed the wording.

THE CORONER: You can look at the rest of it if you need to.

MR JENKINS: 6.8.
A Right.

MR JENKINS: Do you have it?
A Yes, and I am reading if I made any - yes "... patient is too ill for transfer", what did I say here? "Serious ..." yes, I have used the same word. Yes.

Q You go on to say: "in my view, this" meaning the decision is too ill for transfer, "is a complex and serious decision that should be discussed with the consultant in charge as well as with the patient and their family if possible."
A Yes.

Q Yes?
A Yes, that is exactly the same.

Q You say: "I can find no evidence of such a discussion in the notes".
A Yes.

Q There is mention of a discussion with Mrs Packman, the wife, in the nursing records. Discussion with Dr Barton?
A I did not find that.

Q We will hear evidence from others about that. You say: "It is my view, however, that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage."
A Based on the evidence I have in the notes, I think that that is right. I think you would find that there would be a varying numbers of opinions.

Q Yes.
A One has to start with what you have in the notes, and that is why I keep coming back to what is critical is not just a dry decision based on some facts in the notes, but the opinions of patients and their relatives and senior experienced medical staff. That is why I think that it is very difficult to say "you must do this" or "you must do that". Life is not like that.

Q Is this right, that clinicians may take differing approaches as to how aggressively they treat patients in certain circumstances?
A I think not - I think that is perhaps a very, in a way, an old-fashioned patronising view of the medical profession. It may have been where we were 20 or 30 years ago. I think that that has changed very rapidly and that it should not be a case, nowadays, of "doctor knows best", but doctor can provide you with information and we will come to an agreement as to what is the right thing to do.

Q So far as the treatment with opiates is concerned, you say that diamorphine was required to control Mr Packman's symptoms?
A Apparently.

Q You say: "I can find no evidence there was any significant side effects from the diamorphine".
A There have nothing recorded in the notes to bring - to suggest that.

Q His symptoms do seem relatively well-controlled as described in the nursing notes?
A That is factual.

Q If it is right that he was talking with his daughter, he was not overdosed, if he is having a conversation?
A Obviously not unconscious.

Q You say of Dr Reid, the consultant who is involved on 1 September, that he is happy with the management?
A Yes.

Q Later that day, after Dr Reid has seen Mr Packman, the diamorphine was increased because the previous dose is no longer controlling his symptoms?
A I presume that is from the comment in the notes.

Q Well, it is your - I am reading what you put.
A I know. Exactly right, but I would have to go back and just reference that point, but I can see no reason why I would not have put that accurately.

Q Sorry, what you said in ---
A I said: "Nursing note". Elsewhere I have written "nursing notes note the dose of drug in the syringe driver should be increased. The previous doses were not controlling the systems." So that is what the nursing note said. So that is why I assume the dose was increased. So that was the evidence.

Q Can I take you back to the last sentence of the paragraph 6.8, in relation to the decision whether or not to transfer?
A Yes. "The chance of surviving any (inaudible reading) surgery were very small."

Q I do think the jury heard of all that. I am going to repeat the last two sentences.

THE CORONER: Thank you.

MR JENKINS: You say: "It is my view that in view of his other problems it is within boundaries of a reasonable clinical decision to provide symptomatic care only at this stage".
A Yes.

Q Ie, the 26th. "The chances of surviving any level of treatment, including intensive care unit and surgery, were very small indeed."?
A Indeed.

Q Did you know that a decision had been taken some weeks before at a different hospital that Mr Packman, given his medical condition, was not for resuscitation?
A I do not think that, in itself, is relevant. Just because someone is "not for resuscitation" it should imply that if you have a cardiac arrest and your heart stops then it is futile because of your ongoing problems to try and resuscitate somebody. It does not mean that he should not give them all other medical treatment apart from that. So that statement would not influence the decision as to whether or not somebody should go to hospital and potentially have a large operation.

Q I agree, but what it means is that the family will have been spoken to, the patient may well know that he is in (inaudible).
A It might imply that. It might not have involved the family, certainly 10 or 12 years

ago.

MR JENKINS: Thank you very much.

Questioned by MS BALLARD

MS BALLARD: You say that the decision to do anything else was well passed by 1 September?
A That is how I would assess the situation.

Q 1 September was the first time that Mr Packman was seen by Dr Reid, the consultant?
A It is the first time it is documented in the notes.

Q So by that stage death was inevitable?
A It would be my assessment.

Q Can I just refer you to paragraph 6.6 of the report that you do not have in front of you, if the Coroner could be so kind.

THE CORONER: Just keeping me fit, is it not?

MS BALLARD: Yes.
A Yes.

Q In that paragraph you consider Mr Packman's prognosis on an admission to Gosport War Memorial Hospital?
A Yes.

Q You specifically relate that prognosis to gross obesity, to Mr Packman being catheterised and to him having recent deep and complex pressure sores. Yes?
A Yes.

Q You make no reference there of the lists of matters to take into account when considering prognosis, his GI bleed suspected to have ---
A Because at that stage it was simply a suspected problem, yes.

Q You describe Mr Packman's prognosis at that point as "terrible", do you not?
A Yes.

THE CORONER: Is that the word you actually use in the report: "terrible"?
A That is the word I used, yes.

Q Sorry. You have mine. I do not have one.

MS BALLARD: I am grateful, sir.

Questioned by MR LEIPER

MR LEIPER: Sir, if I can just clarify, that was a statement that you have subsequently moved away from. It is not something which appears in your evidence today.
A No. It is - I have written in, in every version I have used exactly the same words. "The prognosis with patient whose gross obesity was catheterised and has recent deep and complex pressure sores is terrible. In my experience such patients often deteriorate despite the best efforts of staff and die in hospital."

THE CORONER: Can we just clarify what that used to say?
A Yes.

Q Did it say before: "In my experience such patients almost invariably deteriorate despite the best efforts of staff and die in hospital". You now say "often"?
A Well ---

THE CORONER: They can only die once.
A Yes.

THE CORONER: Mr Sadd, anything you want to ask?

MR SADD: No.

THE CORONER: Ladies and Gentlemen, anything?

UNIDENTIFIED FEMALE SPEAKER: Out of curiosity, when a patient like Mr Packman has, like, a gastro haemorrhage in your opinion he was going to die, he would be waiting for (inaudible)?
A I think that in my opinion that was going to be the outcome, yes.

Q Would you have given them the chance of surgery if that is the only chance of survival?
A That is, as I said, that is a decision that is complex. I would never make the decision; it would have to involve a surgeon to do it, because the surgeon takes the risk as well and it would involve an intensive care unit, anaesthetist because he is going to be going on to an intensive care unit for potentially weeks, if not months, having had surgery. Everybody helps that it will be the best outcome, but we know that often, you know, whether it is often invariably, it is in that very high chance that it is going to be long, it is going to be drawn out and it is going to be very distressing for everybody. As I say, I think often, particularly if people are alert and orientated, it is very much their decision and people, obviously, it is their health. They have strong views about it. You give them the options and the chances as best we can. Everybody hopes for the best and then they will come to a decision.

THE CORONER: I think the point I am grappling with is Mr Packman's obesity as the prospects of surgery in the face of that.
A Well, that is why I have ---

Q It has to be the clinical decision at that point, has it not? You know, that is one of the factors you have to weigh in and hopefully Dr Barton will be able to help us on that. Right.

Anything else on Packman? No. Right. Then can we move to Devine. (Pause). Please, if would you?

A Yes. Mrs Devine who I believe was 88 years old when she had her final admission. I think, looking at the notes, she had been doing pretty well. In December - in March 1988 about a year or a year and a half beforehand she was seen in the geriatric out-patient department but she had had some infection of her legs, she had thyroid trouble, heart trouble but was managing, was okay and clearly I noted that.she had also seen an orthopaedic clinic in December of that year where she was found to be clinically fit for a knee replacement. I think that is quite a good marker. Orthopaedic surgeons do not like doing knee replacements in people who look very, very frail. However, something started going wrong early in 1999, and it was documented in the notes that her renal function had significantly deteriorated. It had been normal in 1988. It was now significantly abnormal. So something was going on and she was then seen by a geriatrician, who had now said that she was "moderately frail", so people are beginning to comment about that. It is very difficult to describe exactly what frailty is - I have struggled with it - but it is something that you know when you see it. So you are saying, you know: hang on, this is somebody who does not look right. She had a further deterioration of her renal function, so she was referred to see a renal specialist and saw - and also a blood doctor, a haematologist and on a number of out-patient appointments between June and September.

Essentially, the renal specialist found that she had irreversible progressive renal failure. With problems including that she was losing an awful lot of protein through her kidneys, so she was not maintaining her protein in her body, and therefore was getting a lot of swelling of her legs, oedema, and that there was nothing reversible, so it was not a disease that he could think: well, we could intervene and the evidence for that is that they found small kidneys on the ultrasound. If this had been a much younger patient, we talked about age, if it had been a much younger patient then at this stage you would have been talking about a transplant or dialysis because you now know that it is going to be inevitable that you are going to get progressive renal disease. How fast that is is very difficult to predict, although we can see that there has been really quite a rapid change. She has probably lost already 50 per cent of her kidney function in the first few months of the year. There is also found to be a blood abnormality called IGA paraproteinaemia. Now, what that means is that she has some cells in the bone marrow called plasma cells who have decided to produce a lot of this protein which is involved in your immune system. Now, it probably does not matter very much by itself. It may make you more likely to (inaudible) infections. It might be a marker that there is some other underlying condition going on which is related to the kidney trouble, but if it is that is never diagnosed. About 5 to 10 per cent, if you follow these people up over the years, will eventually develop a cancer of those plasma cells, but there is no evidence in this lady, she is called (inaudible), there is no evidence in this lady that she ever had this cancer of the plasma cells. So she certainly has a progressive renal problem that is going to eventually end in her death at some stage. On 9 October, the notes say she was admitted to the Queen Alexander Hospital and the story is of a confusion and aggression which had recently got worse. I think, as we discussed yesterday, that this sounds like an acute confusional state. The suggestion is: well, perhaps she has a urinary tract infection which has precipitated this, very common in old people, particularly if you have an underlying dementia or other illness going on, but they never find any evidence for that precipitating illness, so nothing is actually found. She did not have a UTI. She remains distressed and agitated. She had a CT scan of her brain. I have actually only just today been given the full report; I was never shown that before. It says there are involutional changes in keeping with the age of the patient, so people's brains get smaller as they get older. There is also patchy low density in the deep

white matter bilaterally consistent with small vessel disease. This is the picture you get when you get very small, little strokes taking out parts of the brain. Not uncommon at all. You do not know it is happening. It is not as if you will suddenly get a stroke and people know, you get a weak arm or a face or whatever, you do not know it is happening. It is a silent condition but it starts. to cause ---

THE CORONER: It is a degeneration?

A It starts to cause irreversible brain damage, and it can be related to the kidney problems that she had because this irreversible disease of the kidney, the doctor, being a specialist, says she has glomerulonephritis. That is a long word meaning inflammation of the bits of the kidneys that produce urine. That is often caused by disease of the very small vessels in the kidney. It would appear that she has disease of the small vessels in the brain and disease of the small vessels in the kidney. It is a progressive problem. So it seems very likely from the assessments that are then done by the psychiatrists, in the hospital, that she has an underlying dementing illness, that means just as I have explained yesterday, that means that there is a loss of mental capacity due to these small strokes, and on top of it, this acute confusional state which has made things much more difficult for which we do not know why that was precipitated. She does not really settle. She is described, I found descriptions of she is cooperative and friendly but tended to get lost. The view of the mental health team that assessed her was that she was almost certainly going to need residential care, care in a care home after leaving hospital. She was not going to get back to a situation where she was going to be able to cope at home. I think that often takes a long time to organise, so she was transferred to the Gosport War Memorial Hospital. When she gets there, she functions relatively well. She can was with supervision, she is mobile but she remains constantly confused. I things I think started to go wrong between 1 and 18 November. She becomes more confused. She now starts wandering, becomes more restless at night, she is aggressive. Some investigations are undertaken, again I think someone thinks she might have a urinary tract infection, sends off a test and there is no infection, although she did not even receive antibiotics. People keep looking for reversible causes for this increasing confusion. However, by the 19th, she is confused and aggressive and a further blood test is done which now shows that the blood test, her kidney function has got very much worse. So over the course of the last six weeks it has deteriorated very dramatically. I have little doubt that that - it is eventually the progression of her renal disease that is the inevitable cause of death. At that stage, they are obviously having trouble on the ward managing the restlessness, the wandering, the aggression. A number of medications are tried, including chlorpromazine and then Fentanyl, it is a patch. I am not clear why Fentanyl was started. I think that would be a question for Dr Barton. It does not say in the notes. It seems possible that it was thought to be a way of giving the drug that did not involve her taking it orally, but I do not know. It does not say in the notes. It is an unusual drug to start because it takes several days to have maximal effect.

THE CORONER: So if you were wanting it immediately, that is not what you would use?

A That is not what I would use. Then subsequently she is started on a syringe driver with diamorphine and midazolam and, if I get my notes, that was actually started on 19 November at 40 mg. So definite --

THE CORONER: 40 mg?

A 40 mg in 24 hours of the diamorphine, together with 40 mg of the midazolam, I think

that is correct.

THE CORONER: I think one of the points that was raised earlier on in this hearing, not with you, was the cross over from the Fentanyl to the diamorphine, and the effect that there would be with that cross-over.

A Yes.

B

THE CORONER: Any residual effects from the Fentanyl?
A Well, now, I am just trying to go back and look at my notes. I think the problem I have is that it is very difficult to know what effect the Fentanyl has. As I said, it takes three days, as I understand it, to get up to a steady state. So I think that it is very difficult for me to assess that that change in - the patch was removed immediately, the levels of the Fentanyl
C would start dropping. If you leave it on, so if they had left the patch on and started the pump then I think that would obviously have given you a significantly greater dose of opioid.

THE CORONER: Yes. That is the point we are making.

MS BALLARD: It does not take three days to take effect. It takes one day to reach a maximum and it lasts for three days.
D A I stand corrected. I am not an expert, I will say now in the pharmacodynamics of drugs and I think if you need further advice on that I would get it from an expert on pharmacodynamics.

THE CORONER: Got to 19 November?
A Yes, and there is a further deterioration overnight and, I am sorry, I have rather lost track of myself there, so I have written it is my opinion by 19 November this lady was
E heading, was terminally ill as a result of her renal failure, but it was possible that her more rapid deterioration was due to the use of Fentanyl on top of her other medical conditions. I also noted that she is written up for diazepam - sorry - for diamorphine and midazolam. As I say in my report, I think the addition of the diamorphine is more contentious. Though there was obvious seriousness, restless and agitation in this lady, no pain was definitely documented and diamorphine is particularly used for pain, though it can be used in the terminal ill episodes of restlessness. Equally, she starts on 40 mg a day of diamorphine.
F Again, we discussed yesterday what would be the normal starting range for diamorphine, unless there is a very good justification for not starting within the normal range. The notes, as far as I can see, report that after she starts the diamorphine she is then comfortable and without distress and she then dies about, I have said 58 hours after the diamorphine has been started.

THE CORONER: How much longer? The point that was in my mind was the uses of
G diamorphine, and it has been stressed that it is for pain relief but it is also to solve the problems with agitation and anxiety?
A Yes, we said that yesterday.

Q Yes, I know, but it is relevant here, is it not, because here we have a lady that is distressed and is wondering, so it may be relevant. Shall we take a break, 5 minutes, and they can change the tapes.
H

(A short adjournment)

(In the absence of the jury)

MR LEIPER: Sir, can I clarify that you have the originals of Elsie Devine's medical records?

THE CORONER: I have.

B MR LEIPER: Can I also ask that Professor Black be supplied with a bundle of other medical records as well? I understand that there is a copy which has been here in court. I just want to make sure that he has it.

THE CORONER: I certainly have the originals here.
I have not quite finished with Professor Black yet.

C (In the presence of the jury)

THE CORONER: Cause of death is given?
A I would have said: renal failure.

Q Coroners do not like (inaudible).
A Acute (inaudible).

D

Q That will do.
A And under "2" I put: "Multiple infarcted disease and IgA paraproteinaemia".

THE CORONER: Just getting your own back now, are you not? Sorry, give me that again?
A Under "2: "Multiple infarcted disease and IgA paraproteinaemia".

E THE CORONER: Right. Thank you. Now Mr Leiper, sorry.

MR LEIPER: Sir, I have prepared a short table, Cunningham 1, and if I can hand that to my learned friends and if in due course it finds favour I will ask that a copy be given to the jury as well.

THE CORONER: If we could just check it through and the jury could have it in due course.
F A
MR JENKINS: You said you have one for Cunningham. Do you have one for Devine as well?

MR LEIPER: Yes. Elsie Devine was 88 years old with a history of (inaudible) problems and you describe her as "frail"?
A The notes describe her as "frail".

G

MR LEIPER: Yes. She ---

THE CORONER: It is important that we remember that Professor Black has not seen any of these people. It is all from hospital notes.

MR LEIPER: Of course. Prior to 18 November, she had had no previous opiate analgesia?
H A That is correct.

Q When she was originally admitted to the Gosport War Memorial Hospital oramorph was written up on admission, that was on 21 October?
A Yes.

Q You, at paragraph 6.10.1, of your report describe them this as being "unusual for a patient who has no known causes of severe pain"?
A Yes.

Q You go on to say, at the end of paragraph 6.10.2, that whatever the justification you say that it was poor clinical practice. That is what you said. Is that correct?
A Well, I just wanted to check with the Coroner whether you want me to comment on that in this instance.

THE CORONER: No, I do not think so. I note what is said.
A Thank you.

MR LEIPER: Elsie Devine's introduction to opiate analgesia was at a quarter past 9 on 18 November when she was given a Fentanyl patch. Correct?
A Correct.

Q There are circumstances where it may be appropriate to apply a Fentanyl patch, and those are outlined in the Wessex Guidelines as being "Fentanyl patches are especially useful where there is difficulty swallowing, vomiting, or intractable constipation". Yes?
A Agreed.

Q Do you have a copy of the Wessex Guidelines?
A I had them yesterday, but I am not sure where they have gone to. I am sure I have.

Q Is that the fourth edition?
A Yes.

MR LEIPER: Thank you.

THE CORONER: Which issue?

MR LEIPER: Fourth. This is the one that I was referring Professor Black to yesterday. Could I ask you, please, to turn to page 9?

THE CORONER: What does page 9 look like?
A Use of morphine.

MR LEIPER: Yes, exactly. The page immediately before that is a page headed "strong opioids". Do you see that?
A Yes.

Q Do you see in relation to the Fentanyl patch it says: "They are especially useful when there is difficulty swallowing, vomiting or intractable constipation".
A Yes.

Q Then do you see beneath that, sorry, yes, it suggests there that the minimum patch which can be applied is 25 mkg, so micro kilograms. Yes?
A Yes.

THE CORONER: Microgrammes.

MR LEIPER: I am so sorry. That was the nature of the patch that was given to Elsie Devine?
A That is correct.

Q Do you see beneath that there was a conversion table which gives an indication of the morphine equivalent to 25 mcg of Fentanyl?
A Yes.

Q Do you see there that it says that it is greater, 25 mkg patch, is greater than 135 mg of morphine?
A I thought it meant the other way round; it was less than.

Q Sorry, less than?
A Yes.

Q Or in the region of, anyway?
A Well it says "less than", yes.

Q It appears, if the recommended starting dose of morphine for an elderly patient is 30 mg, yes, which you confirmed yesterday?
A Yes.

Q For an elderly patient. A Fentanyl patch is equivalent to more than four times the recommended starting dose?
A I think I am getting outside of my area of expertise here. I do not use Fentanyl and I do not think I could comment without doing further research at this level because that is not how I remember things from when I did look this up. I would have to go back and do some research before I could comment further on that.

THE CORONER: I think you are probably asking the wrong man, but from my point of view, morphine milligrammes per day or microgrammes per hour for the Fentanyl, are you not, and then you are looking at release, are you not?
A My guess is you divide it by 3, but, as I said, I would have to go back and research that.

MR LEIPER: Can I help, please, by handing up a patient information leaflet on Fentanyl? If I could hand copies to you, a copy to the Coroner, to my learned friends. (document handed).

THE CORONER: Is this what you gave this morning?

MR LEIPER: Do you still have a copy of that already?

THE CORONER: The Sergeant gave me a copy this morning, but do not ask me what I have

done with it.

MR LEIPER: I have a spare copy here.

THE CORONER: Ah. There is a spare there if anyone else wants it. Which page of this are you looking at?

B

MR LEIPER: Page 1, please.

THE CORONER: This is all about Fentanyl patches?

MR LEIPER: This is the Fentanyl patch.

C

THE CORONER: You know what they are, do you not?

MR LEIPER: They are slow release patches, I think as you have confirmed.
A Yes.

Q We will hear from a consultant, in due course, that they might take up to 24 hours before they have an effect?

D

A Yes.

Q Do you see the first bullet point, this is patient information, it says: "What is the most important information I should know about duragesic", which is the trade name for Fentanyl. Yes?
A Yes.

E

Q Could you read it out, please, the first two bullet points?
A "Duragesic contains Fentanyl, a strong opioid narcotic pain medicine. Duragesic can cause serious side effects including trouble breathing which can be fatal, especially if used the wrong way. Duragesic is only for patients with chronic (around the clock) pain that is moderate to severe and expected to last for weeks or longer. Duragesic should only be started if you are already using other opioid narcotic medicines."

F

Q Then the final bullet point on that page, please?
A "You should not use duragesic unless you are opioid tolerant. You are opioid tolerant if you have been taking it at least 60 mg of oral morphine daily or at least 30 mg of oral oxycodone daily or at least 8 mg of oral hydromorphine daily or an equally strong dose of another opioid for a week or longer before starting duragesic. If you are unsure if you are opioid tolerant, discuss this with your healthcare provider."

G

Q It says that you do not get it unless you are opioid tolerant. You are not opioid tolerant unless you have been taking at least 60 mg of oral morphine, does it not?
A That is exactly what this patient information leaflet says, yes.

Q If you go offer the page, please, to page ---

THE CORONER: Can I just ask you, you seem to be putting this to Professor Black in a particular way, the difficulty I have is that he does not use Fentanyl and he is straying

H

towards the extremities of his expertise. I do not know what point you are going to make, but it might be a point better put to somebody else. I am not trying to stop you if there is a line of questioning that is right.

MR LEIPER: Well do we continue with this line?

THE CORONER: Certainly. As I say, I do not want to shut you up, but it is just a question that I know Professor Black may be in some difficulty.

A Yes.

MR LEIPER: If we then go please to, sorry, if you go to page 2, the penultimate paragraph there?

A It is the same point. You should only use duragesic if you have been taking at least 60 mg of oral morphine daily or at least 30 mg of oral ---

Q Sorry, yes, the passage above that?

A "Duragesic is only for patients with chronic (around the clock) pain that is moderate to severe and expected to last for weeks or longer."

Q Thank you, then over to page 3.

A Which bullet point?

Q The third paragraph. (inaudible) should not be used?

A Should not be the first opioid narcotic pain medicine that is prescribed for your pain.

Q Then it goes down to say: "Do not use duragesic, if you can just confirm the first bullet point there?

A If you are not already using other opioid narcotic medicines.

Q If you go to page 6, please, under the heading "what should I avoid while using duragesic", can you just read out the last bullet point there, please?

A Number 1: "Do not take other medicines without talking to your healthcare provider. Other medicines include prescriptions and non-prescriptions, medicines, vitamins and herbal supplements. Be especially careful about other medicines that make you sleepy."

Q Would that include diamorphine, do you think?

A It certainly would.

Q Then the next package beneath that: "What are the possible side effects of duragesic? Do you know that, please?

A It causes serious side effects including trouble breathing which can be fatal especially if used the wrong way.

Q Yes. Then if you go to the top of page 7, there is a reference to the possibility of Fentanyl leaving a patient confused, I think the second bullet point, yes?

A "Call your healthcare provider right away or get emergency medical help if you feel faint, dizzy, confused or have other unusual symptoms."

Q Then the first proper paragraph there is?

A "These can be symptoms that you have taken too much (overdose) duragesic or the dose is too high for you. These symptoms may lead to serious problems or death if not

treated right away."

Q Elsie Devine certainly did not meet the description of somebody who was opioid tolerant.
A Agreed.

Q There is no record of her being in chronic pain?
A I think that is correct.

Q This patient information leaflet makes it absolutely clear that Fentanyl should only be given for people who are in chronic pain?
A I made it clear in my evidence I would not have given Fentanyl. I could not find the reason for it in the notes.

Q The Fentanyl patch was applied at quarter past 9 on 18 November?
A Yes.

Q It was not removed until the following day at 12.30?
A That is correct.

Q If a Fentanyl patch is not fully effective, for 24 hours after administration, it would have become fully effective at a quarter past 9 on 19 November?
A I have to take your word for that.

THE CORONER: You see, the problem is Professor Black does not know. He is accepting what you say to him.

MR LEIPER: Yes.

THE CORONER: Because, you know --

MR LEIPER: We could be hearing from Dr Reid in due course about that.

THE CORONER: And Dr Barton is going to give evidence and hopefully somebody will ask her.

MR LEIPER: Before the Fentanyl patch was removed at 12.30 on 19 November, Elsie Devine was commenced on diamorphine at 25 past 9 on 19 November. Correct?
A Correct.

Q When the diamorphine was begun, at 25 past 9 on 19 November, it was begun at 40 mg over 24 hours?
A Agreed.

Q That is the equivalent, according to your evidence yesterday, of approximately 120 mg of morphine.
A I suppose we said between the various documents there is debate, but between 80 and 120, yes.

Q But it could be more than if one used the quarter?

A Oh, indeed.

Q Yes? We agree.
A Yes, we agree.

Q That using the third was appropriate, so that 40 mg of diamorphine should be assumed to be 120 mg of morphine?
A I think that is a fair am assumption.

Q If the conversion table in the Wessex guidelines is accurate, and that a 25 mkg patch is equivalent to approximately 130 mg of morphine, one adds 135 mg of morphine from the Fentanyl patch which one assumes kicks in at 9.30 on 19 November, and one adds to that the 120 mg of morphine from the diamorphine, giving a combined total of 255 mg of morphine. Do you accept the maths on that? I will go through it again.
A What I think I certainly accept is that for a three-hour period there was twice the intended dose, or maybe not, maybe there was a deliberate - you would have to take evidence on that, but I certainly accept that for a 3-hour period, from 9 o'clock in the morning to 11 o'clock, there would be evidence that they were getting twice as much than they were getting before 9 o'clock or after 11 o'clock.

Q Professor Black, if you will just confine yourself to answering the question that I am asking.
A Well --

Q 120 mg of morphine, yes?
A Yes, but you do not know how much the morphine has already gone in. The problem is you have two curves. I think this is getting quite complex. I do not think the answer - I do not think the point is actually correct.

THE CORONER: I think the point is that there is a substantial increase in the dose for that period?
A I totally agree.

Q The mathematics may be plus or minus whatever it is, but there is a substantial - I mean, that is the point is it not? It is not just a marginal overdose, it is a substantial overdose.
A It is. It is.

MR LEIPER: If, and as you have suggested it may be appropriate to seek expertise from elsewhere, but if the figures used in the Wessex Guidelines are reliable, that the 25 mkg patch is equivalent to 135 mg of morphine?
A Per day.

Q Yes, and if that kicks in, becomes fully effective at 9.30 on 19 November, what you have then is 135 mg of morphine from the Fentanyl patch and 120 mg of morphine from the diamorphine, resulting in a combined total of 255 mg.

THE CORONER: Have we not just done this?
A I am afraid I disagree with that. I do not think that is mathematically correct.

MR LEIPER: Is it something that you know to be incorrect or is it something that you

suggest we get further expertise?
A I think it is something I have already said I suggest you get further expertise on.

Q Thank you, because if it is correct it would mean that Elsie Devine received 8.5 times the recommended starting dose of analgesia on 19th November. Yes?
A No because I presume it was removed and, therefore, she has not received three days worth of - I am sorry, I do not accept this argument.

Q Well ---
A I accept that she received for three hours twice the dose that apparently was necessary beforehand or after it. I do not think there is any argument about that, but I think there is an assumption here that she is receiving 24 hours' worth of drug in three hours and I think that is incorrect. I believe that to be incorrect, but you have already said you will take further evidence on that point.

Q But you accept that the 40 mg of diamorphine itself is 40 times the recommended starting point?
A I explained that it was higher without justification than would be the normal range; I said that several times.

Q And four times higher?
A We talked about the normal range yesterday as being between 5-15 I believe.

Q In the light of what, on any view, must be seen as a massive overdose of opioid, it is not surprising ---

THE CORONER: It is a substantial overdose, and --

MR LEIPER: Substantial?

THE CORONER: I do not want to get into the emotive terms, but, you know, and it is, on any interpretation you have a very high level of morphine being administered, by one means or the other. The mathematical calculation, I have to say, is somebody else's province, but, you know, it is substantial and we take that on board.

MR LEIPER: Thank you. In the light of what you were telling the jury yesterday about the serious fatal risks which are associated with excessive morphine, it is no surprise, is it, that on 19 November it appeared as though death was thought to be likely?
A I cannot necessarily relate those two events, I am afraid. It depends what the reason was that she was put on the doses, and certainly the high doses, as we have agreed, of those drugs, but the underlying problem is the renal disease.

Q We will come on to that.
A And I suppose - sorry.

Q In paragraph 6.17 of your report, you have stated that the overlap between the Fentanyl and the diamorphine is unlikely to have a major clinical effect. Do you see that passage?
A I did, yes.

Q That was a statement which you had prepared for the purposes of explaining to you those who have been instructed to you what the consequences may have been?
A Yes.

Q That was a materially inaccurate statement?
A Well, I am not aware of any evidence in the note that it had a major clinical effect for those three hours. I would need to have that --

B

Q It would not just be three hours, would it?
A Well, yes.

Q If you sustain a substantial opioid overdose on one day, that may affect you, that may result in your death two days later, three days later?
A I do not see why.

C

Q What, you do not see why?
A Sorry, I am not following your argument.

Q You do not see why an overdose on one day may result in a death three days later?
A I would certainly expect to see, if this was so important that the patient was going to die from this three hours of getting twice as much of the presumed intended dose, and we

D

have to take evidence that it was a mistake, then surely I would expect to see evidence then. I would have expected the patient to immediately have become unconscious, as we discussed yesterday, or to have stopped breathing or have had breathing problems. If that was going to cause death, then I would have expected actions then, and that the reducing it three hours later, and then the patient apparently is all right, I cannot find any evidence to support that statement is what I am saying.

E

Q We have to be careful about this. Is this something which actually falls outside your area of expertise?
A Which particular point?

Q Whether or not a substantial overdose on 19 November may have caused death on 21 November?
A What is clearly within my expertise is being able to try and interpret the notes.

F

THE CORONER: (inaudible) surely, that if there was to be an effect, sorry, forgive me working this through, but if there is to be an effect of an overdose of morphine the effect would be there and then, would it not? My experience of these things says that if you have an overdose of opioid drugs they are there and then, it does not happen three days later that it hits you between the eyes.

G

MR LEIPER: No, that the death happens. If there is an effect, which is an effect on level of consciousness, resulting ultimately in unconsciousness, ultimately resulting in death.

THE CORONER: Yes. That is a chain of events.

MR LEIPER: Yes.

H

THE CORONER: Not over a period of three days.

MR LEIPER: Yes.

THE CORONER: You are saying that that is your contention that it would be over a period of three days?

MR LEIPER: It is not my intention, but that is what we say happened here.

B

THE CORONER: What would you say?
A I could not find the evidence for that in the notes. There is nothing that suggests that there was an acute problem in those three hours or straight after them.

C MR LEIPER: The justification for giving the amount of morphine that was administered on 18 and 19 November, I think we see from paragraph 6.16 of your report that that is justified on the basis of any decision having been made that Elsie Devine was terminally ill. The next decision was whether or not to offer palliative care?
A Yes.

Q So the amount of opioid analgesia that was given would only be justified if it was done on the basis of an appropriate decision that Elsie Devine was terminally ill. You accept that?
D A Yes, I accept that.

Q Given that in 1999, and now, Fentanyl (inaudible) patches were only licensed for the relief of chronic intractable pain, you would expect the administration of that drug would only be appropriate if Elsie Devine was in that pain, severe pain?
A As I have said, I cannot find justification for the use of Fentanyl on this patient.

E Q On 18 November, if you want to check it is at page 405 in the medical records, there is a reference to Elsie Devine having a sore mouth.

THE CORONER: Can you give me the page again, please?

MR LEIPER: Page 405. Do you see that entry there?
A Sir, I cannot find it.

F

Q Page 405?
A

THE CORONER: Is this the one --

G Q Last, penultimate paragraph: "Reviewed on ward, happy, no comments, waiting for her daughter, not obviously paranoid. Says tablets make her mouth sore."
A Oh, I see. Yes, yes. I have found that, yes.

Q No comment there about chronic pain?
A No.

Q Page 156, top entry, an entry by the psychiatrist. Do you see that?
H A Yes.

Q Thank you. "This lady has deteriorated and has become more restless and aggressive again. She is refusing medication and not eating well. She does not seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry ward." No reference to chronic pain there.
A Indeed, I said in my original report here that there was no evidence that I could find of pain in the notes.

Q If there had been chronic pain on 18 November, one would expect that it would be obvious to her relatives who visited her on that date, would you not?
A If she had had any pain, yes, although she was confused, but as I have said several times, I could find no evidence in the notes that this lady had pain.

MR LEIPER: On 18 November, the jury will hear from Sandra Briggs and from Henry Devine that they sat drinking tea with Elsie Devine and they were unaware of her being in chronic pain.

THE CORONER: Professor Black has said he has no evidence from the notes of any chronic pain; whether it is detected by others or not, there is no reference to it in the notes.

MR LEIPER: Given the strength of the Fentanyl patch with approximately 135 mg of morphine, if that is correct, the decision that Elsie Devine was terminally ill would, presumably, have been taken prior to the decision to apply the Fentanyl patch on 18 November? Would you accept that as being probable?
A As I said, you would need to clarify why the Fentanyl patch was used, and that is what I cannot tell from these notes.

Q But it would be consistent, applying four times the recommended dose, the reason for doing that was because a decision had been arrived at that she was terminally ill. Correct?
A No. It does not say that in the notes.

MR LEIPER: Okay.

THE CORONER: The difficulty you have, Mr Leiper, is that the notes are silent, however you want to tackle it. Well, they might be but there is no point in asking Professor Black because he will say: I do not know because it is not in the notes.
MR LEIPER: So be it. When she was admitted to the Gosport War Memorial Hospital there is no doubt that she was admitted for the purposes of rehabilitation, is there?
A I think she was admitted for assessment of where she goes. You can call, I am happy for you to use the word "rehabilitation". I think the intentions we discussed earlier was for her to find a place in a residential home.

Q Yes. She was moving on.
A It was a period of waiting and presumably assessment.

Q Should you want to check it, it is at page 26 which is a letter, from the local consultant which refers her and it says: "I found her chest clear, no evidence of cardiac failure and I find her suitable for a rehabilitation programme." Okay?
A That is fine.

Q Now, you say that as at 18 and 19 November Elsie Devine was terminally ill.
A I would say that her physical status had deteriorated because there had been a rapid deterioration in her renal function, and that there was evidence in the notes of increasing confusion.
Q Okay. Well let us begin with looking at her mental state during the time when she is at the Gosport War Memorial Hospital. If we begin with page 154, which is Dr Reid's assessment. Do you see the top entry there: 21 October 1999?
B A Sorry, 154?

Q 154, top entry?
A This is Dr Barton's notes.

Q Thank you. Then if you go to the entry below that you have the entry dated 25 October?
C A If you tell me that is Dr Reid I can see the entry.

Q Do you see there that it records her as being "mobile unaided, washes with supervision, dresses herself, continent." She is mildly confused and it records her blood pressure. Yes?
A Yes.

D Q And it refers to the chronic renal failure. Yes?
A Yes.

Q Dr Reid sees her again. He sees her again on 1 November and that is recorded on page 155?
A Yes.

E Q There he says that she is quite confused and disorientated, for example undresses during the day, is unlikely to get much social support at home therefore try home visit to see if functions better in own home.
A Yes.

Q So, so far as Dr Reid is concerned, there is an element of confusion there which he feels may be alleviated by her being at home for a period. Yes?
F A Yes.

Q She does not go home and by 11 November it appears as though her condition has deteriorated in relation to her experiencing confusion, such that the drug Thoridazine is prescribed.'
A Yes.

G Q That is a drug which is used for the treatment of agitation, restlessness and confusion?
A Yes.

Q She is on that drug between 11th and 17th November.
A Yes.
Q I can take you to the relevant medical chart.
A No, I am happy to accept that.
H

Q Just so that you can see what I am referring to, the reference is on page 276 in the bundle, The entry, the relevant entry, 277. The relevant entry for the drug that we are concerning with which is prescribed for her restlessness one sees here at the bottom. Yes?
A Yes.

Q And one can see from that that between 11 and 15 November she is being prescribed 20 mg.
A Yes.

Q A day. On 16 November, she is down to 10 mg, and on 17 November she is down to 10 mg again. Then if you go to page 194 in the medical records.
A Yes.

Q Do you see the four lines down alongside the date, 17 November 1999?
A Yes.

Q It says that that drug Thoridazine is no longer required?
A Uh-huh.

Q Yes?
A Yes.

Q She is assessed by a psychiatrist.
A Yes.

Q On 18 November?
A Yes.

Q I have directed you to the entries on page 156 and 405, yes?
A Yes.

Q So far as the psychiatrist is concerned it is appropriate that she be put on a waiting list for Mulberry ward. Yes?
A Yes.

Q 18 November is the day when the opioid was administered. Yes?
A The - yes.

MR LEIPER: So it appears as though ---

THE CORONER: Sorry, what was administered?

MR LEIPER: The opioid, Fentanyl was administered on the 18th.

THE CORONER: Sorry, I did not pick it up.

MR LEIPER: So far as the guardians of her mental health were concerned, on 18 November it is appropriate that she should be admitted for continuing care at the Mulberry ward, yes?
A Admitted for assessment on Mulberry ward, yes.

Q Exactly. No indication there that they felt that from a mental health perspective she was terminally ill?
A But they were clearly very concerned. I can see that she says that this lady has deteriorated and has become more restless and aggressive again. She is refusing medication and is not eating well. That is what they write on the 18th.

Q As we know, a number of elderly patients get confused and aggressive but it does not mean they are terminally ill.
A Nor does it normally lead to them being admitted to a psychiatric ward.

Q But just because you are being admitted to a psychiatric ward does not mean you are terminally ill, does it?
A No, I did not say that.

Q No. So from a mental health perspective there is no indication that she is terminally ill, is there, on 18 November?
A No, absolutely not.

Q If we turn, please, to evidence of her physical well being, 25 October 1999, page 154 of the medical records. We have already looked at the entry from Dr Reid. He will give evidence to the Court in due course and his recollection is that there was no marked change in her condition from a physical point of view. Yes?

THE CORONER: What date?
A Sorry?

MR LEIPER: That was on the 25th, between the 25 October and 1 November, no marked change in her condition?
A .No appeared to be quite (inaudible).

Q On 1 November he sees her again, and that is documented at page 155.
A Yes.

Q What he will tell the jury in due course is: "The main focus of my note on 1 November 1999 appears to be Mrs Devine's confusion. Had there been any concerns regarding her physical condition at that time I would have made a note of it." There is then a concern that she may have developed an infection and she is commenced on 11 November on the antibiotic trimethroprim, yes?
A Yes.

Q She has that for a period of five days. Yes?
A Yes.

Q Ultimately, blood tests come through and there is no indication that she does, in fact, have an infection?
A That is correct.

Q If we look at the nursing records, for what they are worth, on page 185, on 15 an 16 November - remember this is two days in advance of the opioids being commenced - there is no indication there that her physical state is such that she is likely to die, is there?

A I can see no indication there, no.

Q In fact, that psychiatric review which happened on 18 November records specifically, and this is page 156, that her physical condition was stable. Do you see that?
A Indeed.

Q She is seen by her relatives on 18 November and the jury, in due course, will hear from Sandra Briggs when she signed her pension book. They sat in the lounge having a cup of tea. So, no indication there that she was in a terminal state of decline; would you agree with that?
A I can see what is written in the notes here.

Q Yes. On 19 November, the jury have heard that there was an incident involving Elsie Devine where she, in a confused state - let me get the words absolutely right - it was suggested that she threw staff into a bookcase a staff nurse, Debbie Barker, during the night, that she had been pulling patients out of bed and hitting out at anybody or any thing. Yes?
A I ---

Q That is the evidence.
A I am not disagreeing at all.

Q What she did. It seems unlikely from that description that, as a consequence of her physical state, she was in a state of terminal illness on 19 November. Do you agree with that?
A No. Shall I explain why?

Q Please do.
A As I have said, I feel that the - not feel, I am certain that the medical condition that I think she dies of is her renal failure. There is clear evidence that there is a very rapid deterioration of her renal condition. I think that went along with the deterioration in her mental - the great variation you just described, some of the disturbed behaviour. I believe that was because she was in renal failure as well. That could happen very quickly. This is not like some of the cases where they are drawn out, a cancer or heart failure which may up and flow. This can be can be very quick and then a very sudden end. The evidence that I have seen in the notes for the renal failure, which is rapidly progressing and irreversible, plus what appears to be, from the evidence here, progressive problems, they fluctuate in dealing with her mental state, I saw as being the progressive, irreversible problems.

THE CORONER: You were suggesting there might be some correlation or some similarity in the brain function and renal function from the small vessels?
A Absolutely. I think that you may well have an underlying etiology of both diseases.

MR LEIPER: In your report you give a number of other reasons why you suggest she may have been in terminal decline and the first one you suggested is that she had been in hospital for over two weeks. It is paragraph 6.8 of your report. Not a reason in itself, but --
A Indeed, but it is a marker of severity of illness. We will be talking about the longer people are in hospital the less likely they are to leave hospital. I do not think that particularly helps in this case.

Q It does not at all, does it?
A But it is a factor.

Q The jury need to understand what it was that did cause her to die. The fact that she was in hospital for over two weeks is an irrelevance, is it not?
A No, but it is a marker of the severity of her problems.

THE CORONER: --- irrelevance.

MR LEIPER: That is a matter for the jury.

THE CORONER: Yes. As I will direct them, but it really is something that is worthy of note, that this was a lady who was in hospital. That is the point that is being made.

MR LEIPER: You also say that she had a possibility of delirium, of rapidly progressing demented illness. The delirium was never diagnosed. So far as her psychiatrist was concerned, who was responsible for her mental health on 18 November, it was appropriate for her to be transferred to the Mulberry Ward, yes?
A I think what the psychiatrist saw was in terms of managing her symptoms the overwhelming problem at that stage was managing her mental symptoms, and that is far easier to manage on a psychiatric ward.

Q You also say that, in your report, the blood test sent on 9 November would not have been sent unless there was a significant change in her condition. That is at paragraph 6.11 of your report.
A Yes.

Q Elsie Devine had been having monthly blood tests from the beginning of the year.
A She had been seen in many different out-patients, but it is, in my experience, very unusual for blood tests to be sent from a community hospital unless there is a specific question being asked at that time. You do not do routine blood tests.

Q There was a suspected infection?
A So that would be one of the possibilities why it was sent, so there was a change - something was going on which led to a blood test being done and a urine test. I do not know what it was because I could see not find the medical note relating to it.

Q No, but ---
A That was a marker for me that somebody must have seen this patient and got worried about something.

Q Okay. She had blood tests, as I say, on a monthly basis between January and June of 1991. Then she was having them thereafter.
A I have just said ---

THE CORONER: Are you saying this is one of the routine blood tests?

MR LEIPER: Yes. 7 September, 13 October, 22 October; all blood tests taken and none of them suggested that she was terminally ill, did they?
A No. What they did document was progression of her renal failure, but I would think it

was most unlikely this was some form of routine blood test?

Q Let us deal with this progressive renal failure. It is undoubtedly the case that between 9 November 1999 and 16 November there was a marked increase in her creatinine level?
A Yes.

Q What you have said to the jury, and as I understand it, it is an important part of your diagnosis, your conclusions in relation to her cause of death, is that there was a progressive marked decline over a period of six weeks which ultimately resulted in her death. Yes? Your words to the jury.
A Yes.
Q That progressive, marked decline, as I understand it, is based on these blood tests that you refer to?
A That is evidence, yes.

Q Shall we look at the blood tests for the six weeks beforehand? If you begin by looking at page 355. Do you have page 355 there?
A Yes.

Q Do you see the entry for 7 September?
A Yes.

Q What is that entry for the creatinine level?
A It is 203.

THE CORONER: Somebody has highlighted mine in pink. Yours, I suspect?
A Yes.

Q 203. What was her creatinine level on 9 November? Do you remember?
A You show me.

Q It is page 347.
A 200.
Q Rather than there being a marked, an indication of there being progressive kidney failure, you get a quite different picture, do you not? If the recording on 9 November was, in fact, lower than the reading on 7 September. Do you accept that?
A I accept that there is very little difference in the creatinine between those two readings. That does not mean that you do not get variation on a downward pattern. Similarly, she might have been more dehydrated when she was admitted to the hospital, and then had some rehydration in the hospital, which would have led to a partial improvement, and then it deteriorates again. So, no, it is not --

Q This is all speculation.
A You have asked me for an explanation and I am giving you an explanation.

Q Okay, and what I want to explore with the jury is whether there is any justification for the explanation you have given. You have told this jury, on oath, that there was a marked deterioration in her condition over the six weeks before her death. All right? The creatinine level on 7 September is 203?
A Correct.

Q Okay. Her creatinine level on 18 October is 201.
A Correct.

Q Her creatinine level on 21 October is 161.
A Correct.

B Q That is on page 347.
A Correct.

Q That would suggest that her kidney function was improving?
A So on 21 October it was 161. On 9 November it was 200 and, hang on, on 16 November it was 360. 21 October it says 161 here on page 347?

C Q Yes.
A On 9 November 200?

Q Yes.
A And on 16 November 360.

MR LEIPER: Yes.

D

THE CORONER: So from 21 October onwards there is a marked deterioration; is that what we are saying?
MR LEIPER: What I want to understand from Professor Black is that on 7 September you have a reading of 203. On 18 October you have a reading of 201, and there is then a dip, and then I go back to a reading of 200 on 9 November. What I want to just get you to confirm is there may have been some misunderstanding on your part in relation to these creatinine
E results. One cannot infer from those creatinine results where there are admitted fluctuations a gradual decline in her renal function prior to 9 November.
A Well, no, because, as I said in my history when I first started, I started with a creatinine of 90 back in 1988 to 140 in the summer, to 160, to 200 here in November, to 360 by the middle of November. So there are clearly variations around that; I completely accept that, I completely accept that, but from going from 90 to 360 over that period of time was a big change. Going from around 200, during her early part admission, to 360 was a big
F change.

Q But it was not a pattern of progressive deterioration because on 7 September, as you have confirmed, it is at 203, which is, in fact, a higher level than the entry on 9 November.
A I would see the overall disease as being a progressive disease with variation, like confusion does. It can have variation.

G Q The increase between 200 and 360, between 9 and 16 November, coincides with the time when Elsie Devine was receiving the antibiotic trimethroprim does it not?
A Oh, indeed.

Q You will be aware that where somebody has trimethoprim it may cause a significant reversible increase in serum creatinine.
A In my experience that is a very, very rare side effect. I have never seen it and
H trimethoprim is a drug that is often used in people with renal impairment.

MR LEIPER: All right. Can I hand up, in that case, the product information leaflet from ** alporin? If you can give a copy to the coroner as well. (document handed).

THE CORONER: Is this one of the drug charts that is saying: "whatever happens, do not take this drug"?

B MR LEIPER: Yes. If you go to page 3 of that, do you see under the heading "precautions"?
A Yes.

Q It says: "use with caution in the following circumstances." The second bullet point, perhaps you would read that out for the jury?
A It says: "Patients with severely impaired renal function, creatinine clearance less than ten ml per minute".

C

Q I am so sorry, page 3 under the heading "precautions"?
A Oh right, okay. "In subjects receiving a single dose of 100 mg of trimethoprim, the urinary concentration ---

Q No, I am so sorry, on page 3?
A Yes.

D

THE CORONER: Impaired Renal function.

MR LEIPER: Under the heading "precautions"?
A Oh, precautions, I apologise. Yes. "May cause a significant reversible increase in serum creatinine. Tubular secretion of creatinine is impaired by trimethoprim" - I am sorry - "is inhibited by trimethoprim. It should not be given in severe impairment unless blood
E concentrations can be monitored."

Q In the first instance, it suggests that that drug, that antibiotic, should not be given in cases of severe renal impairment. Yes?
A That is what it says.

Q So that would suggest that on 9 November, when Elsie Devine was commenced on
F this antibiotic, if it was given properly, she was not in severe impairment?
A I do not think I know - I do not think - was a blood test done, I have to ask that, on 9 November?

Q Yes, it was.
A It was, sorry.

G Q And the creatinine level is 200.
A Yes, that is absolutely right, yes.

THE CORONER: That is the one we have at page ---
A Yes, we have got that, yes.

MR LEIPER: If it was being given appropriately it would suggest that, as at that date, she
H was not in severe impairment?

A That would be the assumption from this document, yes.
Q I handed up, if one reads the drugs chart, so that everyone can see precisely when it was that the trimethoprim was given, and it was given from 11 November until 15 November.
A Yes.

Q Yes? 11-15 November?
A Yes.

B

Q It is on 16 November that you get the raised creatinine level?
A I accept that.

Q According to the product information for the drug, that increase in creatinine level may be attributable to the administration of that drug. Do you accept that?
A I do accept that.

C

Q Does it not follow that you cannot infer severe renal impairment from the raised creatinine level of 360 on 16 November?
A No. She clearly had severe renal impairment with a creatinine of 360, but you raise an issue as to whether or not the prescription of trimethoprim accelerated that process.
Q But it could have been reversible, could it not?
A We do not know. The trimethoprim was stopped, was it not? So it was stopped.

D

Q But what the product information says is that, "may cause a significant reversible in serum creatinine".
A So if, you are quite right, that if the trimethoprim had caused some of that deterioration then it could equally be reversible. I cannot disagree with that.

Q If there was acute renal failure, her condition could have been treated by a simple
E measure such as stopping diuretics or the use of intravenous fluids and/or other antibiotics. Do you accept that?
A No. You have suggested - it depends what you say is the cause of her deterioration. I have not seen any evidence given that it was because she was acutely dehydrated. If it was due to the trimethoprim in part then it was stopped.

Q Hold on. You are assuming that there was this significant deterioration in her physical
F condition?
A No, I have said there is a significant deterioration in her mental state and in her renal function.

Q All right, but your conclusion that there is a significant impairment of her renal function is based on these creatinine results?
A Correct, yes.

G

Q The creatinine level may be explicable to the administration of the trimethoprim?
A It may be, in part, explicable.

Q If it is, that would not indicate that this was, as you have told the jury, a case of irreversible kidney failure which resulted in her death?
A No. I would say that it may have been - it may have been - if it was the cause a dip on
H what I believe to be a chronic irreversible problem with her kidneys because we have the

evidence going back over many months and the evidence of the renal position.

Q At paragraph 6.4 of your report, you say that a patient that is already frail and running with a creatinine level of 200 can have a rapid decline?
A Correct.

Q Given the contents of the medical records, given the account that the jury will hear about her relatives' view of her on the 18th, given the psychiatric review which records her physical condition being stable, there is no evidence of a rapid decline associated with impaired kidney function, is there?
A I disagree. I think there is evidence of decline of both her renal function, as documented in the notes, and of her mental state. It is the evidence that I have seen in the notes.

Q But if someone is dying from kidney failure, that would manifest itself in their, presumably, being prostrate, presumably lying down and feeling extremely unwell?
A That can be symptoms, yes, but I think we have talked about their being a systemic illness which is affecting the brain as well as the kidneys. You are seeing different manifestations of it. Similarly, people can die very suddenly with renal failure because the cause of death is often a raised potassium which causes an arrhythmia. I am just saying that that is why they can deteriorate very quickly.

Q That is not what you have told the jury has been the cause of death here. You have told the jury that there was progressive renal decline which happened over six weeks which ultimately resulted in her death?
A Over probably nine months I am talking about.

Q I am just quoting your words. Six weeks is what you said.
A That was the terminal of admission. Yes, that was six weeks, the terminal admission.

THE CORONER: Presumably it is not a condition that you just flick on like a switch, it is an progressive condition, whatever one says or does about it?
A That is the evidence as I have seen it in the notes.

MR LEIPER: But, as I say, if someone was dying from kidney failure, the likelihood is that that would manifest itself by their lying down and complaining of feeling extremely unwell.
A I think that is a very complex question actually and I think because of the obvious various ways things can manifest. Of course you are correct that some people may have a very slow course and may get anaemic, breathless, feeling more tired, but I think we saw here - we see the decline documented in the blood tests and we see the problems of the mental function. We see both issues happening together. I think it is very difficult, because we talked before about the management of the detail in the notes, to be able to add much to that. I think I am getting into the grounds of speculation beyond that.

Q You also refer to falling haemoglobin levels.
A Yes.

Q On 22 October 1999, her haemoglobin was recorded as 9.5?
A Yes.

Q On 9 November, her haemoglobin is recorded as 9.9. So it appears as though there has been an increase there?
A I think you will find, if you take evidence from haematologists, that such variation is very common. Both of those are low.

Q As I understand it, you have relied on that as evidence of there being a continuing deterioration?
A I think ---

Q That was the reason why you out it in your report.
A No. I think that is a marker of renal disease. Someone with progressive renal disease will get, I probably used the word, I cannot find it here, normal (inaudible)? They will get a chronic anaemia. It is a marker of a progressive - it is a marker of renal disease, sorry, not (inaudible), it is a mark of renal disease, usually chronic. Does not happen acutely.

Q The jury will hear evidence from Professor Wilcock in due course which is to the effect that, in his view, it is not, her symptoms are not consistent with there being this progressive renal decline that you say was the cause of death. He says that one would expect to see a more graduated approach. Yes?
A I have not heard his evidence.

Q You have told, I think we are to accept, that so far as the administration of opiates were concerned they were substantially in excess of what you would have expected to see on 18 or 19 November.
A Without justification I agree.

Q You confirmed yesterday that in patients who are agitated or confused it can be appropriate to prescribe chlorpromazine.
A Agreed.

Q Alternatively midazolam?
A Agreed.

Q If it was Chlorpromazine the maximum dose for elderly frail people you said was between 12 and a half mg and 25 mg?
A I think that is the evidence from the BNF, was it not?

THE CORONER: I cannot remember. It came from somewhere, did it not?

MR LEIPER: You agreed with it yesterday. Do you agree with it now?
A If that was the evidence on the BNF, of course I agree with it.

Q The evidence from the BNF, as we discussed yesterday, said that there should be a reduction in the recommended dose for elderly people. Yes?
A Yes.

Q It was for that reason that you told the jury that 12.5 mg to 25 mg was the appropriate dose of chlorpromazine?
A Happy if that is what the record is.
Q So far as starting doses for midazolam are concerned, you have suggested that 20 mg

is the ordinary starting dose?
A Yes. I think that there is reasonable evidence that you should use smaller doses in elder people.

Q What you told the jury yesterday is that when you are treating a patient for agitation you would either use chlorpromazine or you would use midazolam. You would not use them both at the same time?
A That is, yes, you would certainly start with one or the other. I mean, I think, clearly, if you get a very difficult problem, you may have to add drugs.

Q But in order to assess whether or not one or other of those had worked you would have to wait for at least two or three hours before you can write that that was the conclusion?
A I think that is fair.

Q It would be unsafe to administer them both at the same time.
A You certainly increase the risk to the patient, yes.

THE CORONER: I think you said exactly when you started doing that.
A I said I would not start doing - I would not start by giving both simultaneously, no.

MR LEIPER: Nor would you do it within the space of three hours. You would certainly leave it three hours before?
A I would just ignore -- I cannot think of a reason why I would not wait three house, yes, I think that is fair.

Q Thank you. On 19 November, at 8.30 in the morning, Elsie Devine was administered 50 mg of chlorpromazine. Yes?
A Yes.

Q You accept that as a fact.
A Absolutely.

Q From the clinical records?
A Yes.

Q So it appears that she received between two and four times what your recommended dose would be of chlorpromazine?
A I think there would have to be good justification for that, yes.

Q Between two and four times your recommended dose?
A Yes.

Q Less than an hour later, she was given 40 mg of midazolam. Yes?
A Yes.

THE CORONER: It is in a syringe driver, so it is not given. It is started.
A Yes, it is started in the syringe driver, I agree. It started in the syringe driver, yes.

Q Thank you. Which I think you say is two times the recommended dose?
A Well, as you know, the recommended dose is between 40 to -- is between 20 and 80 in

the BNF, although I think for most older people you would use a much lower dose.

Q Presumably the effects of overdoses are cumulative. If you have too much diamorphine and too much chlorpromazine and too much midazolam, all those things can increase the risk of death to the patient. You accept that?
A All those can increase the risk of side effects, I agree.

Q And death, depending on the amount, yes?
A Depending on the amount, yes.

Q If it is correct that she was given between two and four times the recommended dose of chlorpromazine on the morning of the 19th, and if she was given approximately two times the recommended starting dose of midazolam on the 19th, she has, well, at least four times the amount of the recommended doses of drugs appropriate for dealing with agitation.

THE CORONER: That is not quite right, but I take what you say.
A I certainly accept the fact that she is on two drugs simultaneously, both of which at higher doses than one would apparently conventionally start at, yes. We accept that.

MR LEIPER: This is at the time when the Fentanyl is likely to be reaching its maximum effect: 24 hours?
A This is the time that there was the three-hour overlap, yes.

Q You accept that the 40 mg of diamorphine are four times the recommended dose of morphine that is indicated?
A I certainly accept it. It is above the normal starting dose, yes.

Q So far as the Fentanyl is concerned, that is something which you suggest we get expert evidence on?
A To know how much was actually around for those three hours, yes, I would.

Q The following day, 20 November, Elsie Devine was visited by Code A at 9 o'clock in the morning. The jury will hear evidence in due course from Code A and her evidence is that at 9 o'clock in the morning on 20 November Elsie Devine "appeared to stop breathing for long periods and would then suddenly take a very deep breath". That, as you explained to the Court yesterday, is a classic example of respiratory depression secondary to an opiate overdose?
A I certainly accept that those symptoms could be due to that, yes.

Q And it was as a result of those symptoms that Elsie Devine died.
A (inaudible).

Questioned by MR JENKINS

MR JENKINS: Can I ask some questions? So far as trimethoprim is concerned, was that given at the Queen Alexander Hospital in October?
A I do not know. You would have to tell me that.

Q We will deal with the records (inaudible). Can I just ask about if someone were to be given an overdose of opiate?
A Yes.

MR JENKINS: I asked you yesterday. If you were to give somebody an overdose, you and I dealt yesterday with the mechanism of death. It would be a respiratory death. Yes?
A Yes.

Q Again, one side effect of opiates, strong opiates to those who are not tolerant or not in pain or not in discomfort it may be or will be that it will affect the breathing centre in the B brain and the message to the lungs will not get through?
A Yes.

Q If a patient gets a huge overdose, or significant overdose, then the message to the lungs will not get through. It will be a respiratory death at the time of peak concentration.
A That would be the time of highest risk, yes.

C Q You do not stop breathing today and die two days later, do you?
A No, that would not be the -- I can see no logic to that, no.

THE CORONER: Can I stop you. We are going to change these now.

MR JENKINS: I am going to ask you to look at these charts if you would not mind, Professor Black. If you could pass them. (document handed). I think a prescription for D trimethoprim was written up at the beginning of December. November?
A On 11 November at 8 o'clock in the morning and 6.00 in the evening, yes.

Q Was never given trimethoprim?
A Well, strangely enough, in the photocopy I have in my notes the page before 277, which is not numbered strangely enough, must be 276, I thought if you take that out ---

E THE CORONER: I do not have a page 276.
A The notes can be tricky. It is not numbered, but it is the note before page 277.

THE CORONER: Hang on. Yes, I have.
A I thought, my reading of it was that the trimethoprim was given from the 11th to the 15th, but now that might mean that there is a page missing.

F THE CORONER: There is the record.
A Sir, there were five days, but, of course, we cannot see what drugs they were. That is exactly what I have, sir.

THE CORONER: Yes it does.
A Ah, right. So it was given from the 11th.

G MR JENKINS: I am suggesting as well that it was given in the Queen Alexander Hospital in October?
A Certainly she received antibiotics. I did not record in my report which it was, but I would be happy to look at evidence. It would not surprise me. It is what people routinely get given. If I can give that back to someone safely. (document handed).

MR JENKINS: I will not waste time. I will come back to it. So far as your report is H concerned, did you reach this conclusion: "Mrs Devine presents an example of the most

complex and challenging problems in geriatric medicine"?
A I think that is true.

Q This included progressive medical physical problems causing major clinical and behavioural and management problems to all the care staff she came into contact with?
A That is true.

B Q You deal in your report with various aspects of her treatment, including the decision to start Mrs Devine on a Fentanyl (inaudible) on or around 18 November 1999. The clinical entry that we have for that date by a psychiatrist, Dr Taylor, who has been brought in from the elderly mental health team to examine Mrs Devine you have already read to us, but on 18 November Dr Taylor writes: "This lady has deteriorated, has become more restless and aggressive again. She is refusing medication and not eating well."
A I think I read that out, yes.

C Q You did. I think the history that one has over the preceding month or so, both at Gosport and elsewhere, at the Queen Alexander Hospital, was that Mrs Devine, on occasion, was being aggressive, confused, turfing other patients out of bed; matters of that nature?
A That is what the notes say.

D Q That is what you are commenting on, at least in part, by saying she presents one of the most difficult problems to deal with?
A Very challenging behaviour for all the staff.

Q If you were to try and give an injection to a lady who is restless, aggressive and refusing medication, you risk there being a problem?
A You are quite right. Giving medication to people in that circumstance is extremely difficult, and getting their consent as well is difficult.

E Q To walk around with a needle, itself, carries health risks, for the patients as well as the staff. Fentanyl can be used as a patch?
A It is a patch, yes, I think.

Q Which gives a slow release of medication?
A That is correct.
F Q Over a period of time?
A That is correct.

Q What you said is that it is not written up in the medical records why it was that Fentanyl was decided upon?
A Certainly correct.

G Q What would you have done?
A I think that you need expert mental health nursing and that, to be frank, people who are very confused are much better managed in a nursing, in that sort of environment, and you would bring a specialist mental health nurse to the ward. At that stage I think I would have given them an injection. I would have probably used haloperidol. That is how I would managed it, but I feel that she certainly would have needed support. No matter how much supporting nursing you are giving, if you have a ward with lots of other ill patients you have
H to deal with the underlying distress and the problems.

Q You were asked about Fentanyl and you were given the manufacturer's documentation.
A Yes.

Q One would normally look at the British National Formulary I think if one was a doctor?
A Exactly right.

Q The manufacturer's documentation may have put a number of cautions and concerns to protect the manufacturer from being sued?
A That is absolutely standard practice for all drugs.

Q I am going to ask you to look at the British National Formulary rather than the manufacturer's literature. For duragesic, which is a Fentanyl patch, this is a 2006 volume, I do not know if that makes any difference. I have highlighted various passages for duragesic and I think the BNF, unlike the manufacturer's documentation, does contemplate giving a Fentanyl patch to patients who have not previously received opiate medication, yes?
A I have so say at the top of the page under "Fentanyl" it does say, "indications, breakthrough pain in patients already receiving opioid therapy for chronic cancer pain, chronic intractable pain, other indications", and then it refers you to 15.1, 4.3 so I would have to go and find 15.1. We would have to follow the audit trail through is what I am saying.

Q I understand. If you want to do that, do it?
A It is up to you.

THE CORONER: Is it going to produce a result for us?

MR JENKINS: I do not know. If the Professor wants to do it he can do it. I am just going to ask him the passages under "dose". The ones you have marked says: "Patients who have not previously received a strong opioid analgesic, initial dose 125 microgrammes per hour, patch replaced after 72 hours". The second one you have marked says: "When starting evaluation, the analgesic effect should not be made before the system has been worn for 24 hours, (to allow for the gradual increase in plasma Fentanyl concentration) previous analgesic therapy should be phased out gradually from time of first patch application."

Q Can we take those one at a time? What it says is patients who have not previously received an opiate, what is suggested by way of dose is a 25 mcg patch?
A Exactly what it says.

Q That is what was provided here?
A This is what the patient received.

Q So if one were to look at the BNF, and consider that Fentanyl was appropriate for a patient who had not received opiates before, the BNF is suggesting the 25 microgrammes.
A That is exactly what it says.

Q What Mrs Devine was given?
A Yes.

Q Yes. The second passage that I have highlighted and that you have read out says that

evaluation of the effect should not be made until the patch has been worn for 24 hours.
A Yes.

Q That is what happened here. The patch was worn for just over a day, 27 hours?
A 27 hours, I think.

Q So that is what happened here?
B A The patient received the patch for 27 hours, yes.

Q Indeed. If another form of medication was started at about that time one would anticipate that the doctor is considering the effect or evaluating the effect of the Fentanyl patch after 24 hours?
A That is a possible interpretation, yes.

C Q What you have also read is the caution on the next page dealing with the effect of Fentanyl and how long it lasts.
A Mm hmm.

Q I think what is talked about is that the Fentanyl will remain in the system for up to 22 hours?
A "Important: it may take 22 hours or longer for the plasma Fentanyl concentration to
D decrease by 50%. Replacing opioid therapy should be initiated at a low dose increasing gradually."

Q So the recommendation is if you are to start some other form of analgesia, like an opiate, start low and raise, if necessary, as the Fentanyl leaves the body?
A That is correct.

E Q Right. Can we come back to questions of concentration of drugs in the body? If one were to produce a chart showing the concentration on the vertical axis and time, let us do it for you that way, but that way for the jury, on the horizontal axis, one could chart the probable concentrations of drug in the body?
A Yes. I am certain that a pharmacologist expert would be able to do that for you.

Q Things that are relevant will be, firstly, the way in which the drug gets into the
F bloodstream?
A Yes.

Q If the drug is administered straight into a vein, intravenous injection, it is immediately available throughout the body and is pumped around every second?
A Yes.

G Q As the blood is pumped around the body. If the drug is given as an intra-muscular injection, because muscles are well supplied with blood vessels, the drug is available fairly quickly in the system, but not as quickly as an intravenous injection?
A Agreed.

Q Another route would be a subcutaneous administration, which is slower again?
A Agreed.

H

Q It may be less effective in elderly patients where the tissues are, perhaps, less well supplied with blood vessels?
A It is possible.

Q There are obviously other routes of administration. Some will be swallowing a tablet and the tablet will be absorbed in the intestine or the gut and that becomes available through the bloodstream at a more gradual rate. With a patch or with modified release drugs those will release drugs into the system at a gradual rate over time. Another thing that one has to consider is the half life of the drug, How long the drug stays effective in the system. Some will be very quick, and others, Fentanyl as well, will be more longer acting.
A Correct.

Q Thank you. What was suggested to you by Mr Leiper was that if a patient received a higher dose than they should get of an opiate they might die several days later. That is in, pharmacological terms, that is nonsense?
A Well, as I explained, the three hours when there would appear to have been a very peak dose would have been your highest risk.

Q Yes. At the time of Mrs Devine dying, the Fentanyl would have been out of her system, using the half life on the advice of the BNF?
A That is what I would understand from reading the BNF there, yes.

Q So any concerns as to a time when Mrs Devine might have been put at risk by excessive opiates, if there were any, that time is long passed at e time Mrs Devine died?
A It seems to me that the peak time of risk is that three-hour period.

Q What you said in your report is that Mrs Devine received good palliation of her symptoms, you say she appeared to receive good palliation of her symptoms in relation to the medication that was provided to her?
A I think it says: "She is reported to be comfortable and without distress".

Q You have seen the report of Dr Dudley who, rather than Doctor or Professor Wilcock?

THE CORONER: No, he has not.

MR JENKINS: Dr Dudley is a consultant nephrologist specialises in kidneys.
A Yes, they do.

Q He is based in the Bristol. He was asked to write a report and I just want to read several passages to you and ask if you agree with him. The jury will hear this in due course. He talks about progressively deteriorating renal function. He says: "She was treated appropriately in the terminal phase of her illness with strong opioids to ensure comfort and calm to enable nursing care and to maintain her dignity." Let me read that again. "She was treated appropriately in the terminal phase of her illness with strong opioids to ensure comfort and calm to enable nursing care and to maintain her dignity." Do you agree with that?
A I remain concerned about the dose levels that were given. I would want to see and hear the justification for that. That is what I cannot tell from the notes, sir. That is why I would have difficulty agreeing with that statement without hearing the evidence. That is presumably what the jury will hear.

Q He says, and to those who have the report, at paragraph 8.5, he was asked the question, "Would the acute confusional state be untypical of someone dying of renal failure", and his comment is, "Death from renal failure is usually characterised by increasing drowsiness leading to coma. However, in a proportion of patients, renal failure is characterised by an acute confusional state and such an observation will not be untypical in a patient with terminal renal failure, particularly when a previous chronic confusional state exists."
A I would certainly agree with that.

Q Thank you.

THE CORONER: How much longer are you going to be, Mr Jenkins?

MR JENKINS: I am going to be five or ten minutes.

THE CORONER: Do you want to do that now then, rather than ---

MR JENKINS: Certainly, yes. Let me give his last comment in his report. He was asked to comment on the use of strong opioids to calm, keep comfortable and enable nursing care in someone dying of renal failure who is not in obvious pain. Yes? His comment: "Strong opioids are commonly used in the terminal care of patients dying with renal failure who are agitated and restless to ensure comfort and calm, to enable nursing care and to maintain dignity." Would you agree with that?
A He is an expert and will see many more people dying of renal failure than I ever will, so I would bow to that expert opinion.

Q You viewed Mrs Devine's death as inevitable because of her kidney failure?
A That is the evidence I have given.

Q Can I take you to your report at paragraph 6.15. Paragraph 6.15, this is a report from 2005. You may have updated it since?
A Yes, but I have the similar paragraph.

Q And you must tell us how.
A Yes.

Q But you said that it was your opinion certainly by 19 November this lady was terminally ill and it was a reasonable decision to come to this conclusion?
A Yes.

Q Yes?
A Yes.

Q I break off. 18th November was the day when she was seen by the psychiatrist, deteriorated, become restless and aggressive again, refusing medication. That day given the Fentanyl patch. It is there for 24 hours. By the 19th, the syringe driver is commenced?
A Correct.

Q And you say of that day, "Certainly by the 19th the lady was terminally ill, it was a reasonable decision to come to that conclusion".

A Yes.

Q "Equally", you say, "not all clinicians will come to exactly the same conclusion and some might have referred her back to the District General Hospital."
A Unfortunately, in my latest version I did add a sentence between those two sentences.

Q Ah, right.
B A The sentence was: "However, it is possible that her more rapid deterioration was due to the use of Fentanyl on top of her other medical problems."

Q I understand. You say: "However, on balance, I believe that many clinicians will come to the same conclusion after a month in hospital".
A That is my view.

C Q The same conclusion meaning the same one that was apparently reached by Dr Barton?
A That is correct.

Q Yes? You go on: "Having made the decision that the lady was terminally ill the next decision was whether or not to offer palliative care".
A Correct.
D

Q "Mrs Devine was reported as extremely restless and aggressive and in some distress."
A Correct.

Q You say: "In my view, it would now be inappropriate not to provide high quality palliative care".
A I have written it this time as: "It would now be appropriate to provide her high quality
E palliative care".

Q But your opinion in January 2005 was that it would be inappropriate not to provide high quality care?
A I have just re-written it to be the same end point.
Q I choose to emphasise the earlier report; you will understand why.
A Okay.
F

Q You then go on: "She is then written up diamorphine and midazolam by subcutaneous infusion and the Fentanyl patch prescribed the previous day is removed. There was a three-hour overlap in the prescription of these drugs, but this is unlikely to have had a major clinical effect."
A Because I can find no evidence that it did in the notes.

G Q You and I have discussed the fact that the death was some days down the line?
A 58 hours I think, yes.

Q Yes. There is also a discussion regarding her status with a member of her family. I think Mrs Devine's Code A was involved quite heavily at that point. I think the Code A was to become involved, Code A who is in court, was to become involved for the first time when her mother was at Gosport on the 19th. Discussion regarding her status with a member
H of her family. There appears to be no dissent as to the appropriateness of her proposed care

either from the nurses or the family?
A So I wrote the notes.

MR JENKINS: Yes. Thank you very much.

THE CORONER: Is anyone else going to have anything for Professor Black? Then let us break for lunch and we will come back and deal with Gregory and then Spurgeon. I sincerely hope, said he, looking at the assembled company, that we can finish this afternoon. I am quite happy to sit on, but not for very much longer. Yes?

UNIDENTIFIED FEMALE SPEAKER: Sorry, as we are moving on after lunch from my grandmother I would just like to make a point.

THE CORONER: I do not think you can. I think if you want to do that if you speak to Mr Leiper because what I am not prepared to take is comments I said to Mr Farthing the other day, I do not want gratuitous comments from the floor. If there is question for the doctor, then fine. If you speak to Mr Leiper then we can pick it up from there. All right?

UNIDENTIFIED FEMALE SPEAKER: No, that is fine.

(The Luncheon Adjournment)

(In the absence of the jury)

THE CORONER: Back with us, Mr Wilson. Everything all right?

MR WILSON: Yes, thank you very much.

THE CORONER: We will have the jury, please, unless anybody wants to say anything before they come in?

(In the presence of the jury)

THE CORONER: Are we ready? Mr Leiper, a point that was going to be taken before lunch, anything on that or not?

MR LEIPER: Thank you very much, no.

THE CORONER: Thanks very much indeed. Can we look at Gregory then, please. Sheila Gregory.
A Sheila Gregory, who I think was 91 years old when she was admitted for her final illness. She had a past history of chronic obstructive airways, chronic bronchitis, some damage to her lungs over many years. Then in 1995, so I think about three or four years before this admission, she was clearly documented to have some quite severe heart failure and ** valvin disease of the heart, as I mentioned yesterday, the prognostic significance of having proven heart disease. She has an episode of diplopia, that is double vision which may have been due to a small stroke, and also was seen by a psychiatrist, a psycho geriatrician who thought that she might have early dementia, but I think no more came to that.

In December 1998 she was obviously admitted very severely ill to the Haslar hospital with left ventricular failure. Indeed, on the blood tests available in the notes she was extremely lucky to survive, in my view. She was very seriously ill at that time, but she does survive. There is nothing else in the notes until August 1999 when she comes in with acute fractured neck of femur. She never makes a good recovery after the operation. Again, I discussed yesterday the prognosis and the complications that frequently occur after what may be a successful operation for a fractured neck of femur. She has a swollen leg. She is constantly confused, so quite likely delirium, acute confusion on top of maybe this early dementia that was mentioned by the psycho geriatrician. She has diarrhoea. She is doubly incontinent and has an in-dwelling catheter, so lots of problems going on. Increasingly unlikely that she is going to make a good outcome and return to her own home. I think she is seen by a consultant who says he will transfer her to Gosport and says "will get home?" so, again, already I think in the mind of the consultant was: is this a problem that this is somebody who is not going to leave hospital. She gets transferred on 3 September. She is highly dependent, a Barthel of 3 to 4, that is virtually totally dependent is recorded, and shortly after that has another neurological event that, again, is thought to have been a small stroke. Then really we have two months when she is reviewed regularly and makes no progress. Document: "poor appetite, agitation, confusion, remains catheterised, fecal incontinence, no improvement in mobility".

THE CORONER: I think there was real difficulty with the actual healing of the femur, was there not? Did you pick that up in the notes?

A Not on this case. There is another one that has a big problem with that.

Q Ah, right, then I am getting confused. I am sorry.

A So I think by this stage there is absolutely no doubt this is not a lady who is going to recover, to rehabilitate and leave hospital. She has been left with severe disability. Then something happens and something starts going wrong in November. There is an episode of vomiting on 1 November. On the 15th, she is clearly noted to be less well. An examination is recorded but there is no real conclusion. The nursing Kardex now says that she is distressed and breathless and a decision is made to start oral opioids to make her comfortable and to deal with her breathlessness. She is, on the 19th, the nursing Kardex reports her poorly. On the 22nd further decline is noted, and again she is examined and a record in the notes that she is breathless and her chest is clear and that she is in fast atrial fibrillation, this very fast heart rate. I think it may be relevant that the examination says that her chest is clear. Then, she had been receiving, as I understood it from the notes, around 20 mg of oral morphine a day for the last -- from the 15th -- I will have to double check that -- and then at this point she is started on a diamorphine syringe driver with 20 mg of diamorphine. She continues to deteriorate and dies on the 22nd. I think this lady had long-standing severe illness. I do not think she recovered from her operation and I think it is actually quite likely that the agonal event was a multiple or a pulmonary emboli, one or more of that, as it is a well-recognised complication of stroke disease. People are immobile. She is recorded as having a swollen leg. All of those are reasons for her to have pulmonary emboli.

THE CORONER: It was just the one leg, was it not?

A It was the one leg, sorry, the one leg. Clots going from that leg to the chest would cause breathlessness, it would cause uncontrolled atrial fibrillation and it would give you a clear chest when you examined it. So I think that her terminal event was a pulmonary embolism. That is probably what I would put on the death certificate under 1(a) and under 2 I would certainly put cardiac failure. I would put ischemic cerebrovascular disease and I

would put fractured neck of femur.

Q Sorry, what was the second?
A Sorry, I said cardiac failure, ischemic cerebrovascular disease and fractured neck of femur.

Q I would normally put a repair date on there but it is not significant in this case, is it? If you have a repair I would normally put a repair date on, but it does not matter. Right. The progress that you see in her then, nothing remarkable?
A This is --

Q Slow?
A Slow decline following the fall and the operation. I think that is a not uncommon picture at the end of people's lives.

Q The opiates that were administered latterly, did you have any comment on those or any observations on those?
A She was clearly breathless and distressed. As far as I can see, she was started on around 20 mg of oral morphine a day, which is certainly within the range that we have been talking about. When she is converted after a period of further decline to the syringe driver she is on 20 mg a day. It could be at the upper limit of normal, and clearly there would need to be justification, but I do not think that is exceptional, in my view.

THE CORONER: Any questions? Mr Leiper, is there anything you want to ask?

MR LEIPER: Not at this stage, sir.

THE CORONER: Mr Jenkins?

MR JENKINS: No, thank you.

THE CORONER: Mr Sadd? Those of us that deal with this business, it is a very well-trodden path, albeit a slow one.
Right. Thank you. Then can we look at Mr Wilson?
A Mm.

Q 74 year old?
A Yes, who comes to the A and E department on 21 September 1998 with a fracture of the left femoral head, his upper arm, here, and the second part of a tuberosity, which is a bit that is on the side that muscles attach to.

Q Got to be painful?
A There is no doubt at all that is a very painful fracture. Unless you are able to pin it, it will continue to move and to grate, so that is why the immediate decision in A and E was that it would be ideal to do an operation in order to pin it and then to go from there now. The background to Mr Wilson is that he had well-documented severe alcoholic liver disease, which has been documented back to 1994, although in 1997 there was an admission to hospital which demonstrated the damage to the liver and some of the complications. I think it might be just worth spending a few minutes on what cirrhosis of the liver is and the potential

complications. If you take alcohol to excess over a long period of time, although there are other causes but his disease was thought to be due to alcohol, you will get damage to the liver. It is called cirrhosis and essentially it is a process of inflammation, damage and scarring, repeated scarring, repeated scarring, so that the liver starts to fail. The number of liver cells, and the liver of course is about looking after the body, controlling the chemicals in the body, getting rid of toxic chemicals so that the kidneys can then excrete it in the urine. Liver also produces a number of very important proteins that are essential for life. So it has a very complex metabolic role. It is a bit like a factory. If you get damage, firstly, you may get direct problems with that. For example, you may stop making albumin or reduce making albumin, which is the protein that holds fluid in the circulation. So if you have a low albumin you may start accumulating fluid, salt and water and getting swelling in your abdomen, getting swelling of your legs. You may stop producing vital proteins to help the blood clot, but there are also side effects from the fact that much of the blood from the abdomen flows through the liver so that the toxins can be removed. That blood is finding that it cannot get through because of all this damage. It is like a sort of blockage in the pipe, so you get expansion of those blood vessels behind. So you can get very big veins which can bleed. You also get an enlarged spleen because the blood backs up into the spleen. It also makes it, again, more likely to get fluid in the abdomen. High pressure in the body will lead to fluid in the abdomen which is called ascites. The other serious problem is that because toxins may not be removed by the liver, you may start getting what is called hepatic encepatholopathy, which is confusion, coma, restlessness and coma that can lead to death because chemicals are not being removed from the body. If enough of those build up you will go into coma and it is one of the reasons that people die of the complications of alcoholic liver disease. Certainly in 1997 they have a scan of the liver showing it has cirrhosis. The albumin, that thing I said, was very low. The tests of his liver showed that he is not excreting. It is a chemical called bilirubin so he is not able to excrete that so it is high in the blood so he would have been jaundiced and he has ascites, this is this fluid in the abdomen. So lots of evidence in 1997 that he was having serious problems with this liver disease. When he comes to A and E he is offered the operation and he refuses, but he is kept in for observation, obviously because it is painful and he does not look very well at all and it is absolutely appropriate. The next day, he is not so well and he is vomiting. It is now decided that he is too ill to have the operation that they were prepared to operate on the night before. They do the blood tests that show problems with his platelet count, which is something to do with clotting. That is, again, related to the albumin. His haemoglobin falls, so maybe he has had a little bleed somewhere as well. That would be a possible precipitant to the hepatic encepatholopathy or a mild form of it that I have mentioned. He has impaired renal function. Again, that is a side effect of severe alcoholic liver disease. So he is vomiting. Why is he vomiting? There are possible reasons. He was given some morphine after he comes to A and E for his pain in the arm; very severe pain, very appropriate management. So we have heard before that morphine can cause vomiting, so that may well have been a cause. He is also now having his alcohol has been withdrawn for 24 hours. That is another reason why he may well be vomiting. So his condition clearly deteriorates over the first two or three days. He is not fit enough for the operation. He is not eating. He is obviously in pain. He communicates poorly with the nursing staff. He is restless, and his arm becomes very swollen, and, as I said, did receive several doses. In fact, things get so bad that the view is that he is not going to be fit to go home even if we can sort out the arm. He is catheterised, he is faecally incontinent, so people are starting to talk about a nursing home, assuming he leaves hospital. Then, as that conversation goes on, he starts to improve, becomes more alert. The notes say he becomes more adamant in his opinions, so he is able to -- his cerebral function starts to improve. He is reviewed by a psycho geriatrician because, of course, of all the problems that there had been

several days before with the confusion and restless and agitation, who says: well, it may be a bit of dementia, may be alcohol, it is not very clear. He also notes that his speech was slurred and that he had been sleepy and withdrawn at night, but never mind. He continues to improve. In fact, he improves so much that Social Services say that he is now too fit for a nursing home, but he is still getting pain in his arm. His weight, which was 103 kilograms when he comes in, by 14 October is 114 kilograms. He has gained 11 kilograms in weight. Now, that is not food. That is water. Salt and water. So just imagine that in terms of bottles from the shop: 11 litres of water. He has become very oedematous in his legs and no doubt his ascites would have been more. So although his mental state has improved, his functional state has improved, he clearly has severe liver disease and he is now fluid over-loaded, as we would say. He has almost certainly 12, maybe even more, litres of fluid on board that really should not be there. Clearly, it is going to severely restrict his recovery. So it is a complex problem. The arm is unresolved. He has pain. He is known to have alcoholic liver disease and he is now salt and water over-loaded. Having said that, there is no doubt that the pain after the doses of morphine, of which I think he received five in total during the whole of his stay in the Queen Alexander Hospital, which were either mostly 2.5 and one 5 mg dose, he is receiving regular paracetamol and intermittent codeine. He has been given regular oral, fairly mind, analgesia with some codeine. While there are a number of comments about pain, that is how he has actually been managed. I think I will just stop there just for one second.
I think I just wanted to reflect on what I think happened when he first came into hospital. I think he had an episode of what we call hepatic encepatholopathy, which is a change in the mental state that goes with liver failure. There were a number of precipitants, potential precipitants for that. He was clearly in pain. He had received some doses of morphine which are certainly a recognised precipitant. He may have had a small gastro intestinal bleed. He probably had alcohol withdrawal and was then started on I think he was started on chlordiazepoxide, which is a sedative drug which is often used in patients with alcohol withdrawal. The fact was that he went downhill and then he started to improve. If my assumption is right, any, or all of those, except the pain, could have changed in order that it allowed his functional state to improve. I think that if we are at this state what needs to be done is, the critical issue is to improve his overall medical condition, to try and stabilise the liver disease, to try and deal with the fluid overload, which would probably involve diuretics, that is tablets which make you pass more urine. It would involve daily weights so that you can document how things are going. You would hope that over a period of time you would improve, you would stabilise his liver function, you would improve his overall physical status so that you could get to a position where he could have an anaesthetic, because quite clearly he was not fit for an anaesthetic in order to deal with the pain in the arm, but you would still have to deal with the pain in his arm.

THE CORONER: Yes. That is not going to go away, is it?
A That is not going to go away until he has had an operation. I think the issue is going to be how to deal with the pain in the arm. However, from the Queen Alexander notes, they were managing it with regular paracetamol and intermittent codeine phosphate prior to his admission to Gosport. When he gets to Gosport, he is not written up for his paracetamol; I do not know why. He is not written up for the codeine phosphate that he was receiving intermittently, PRM, at the Queen Alexander. He is written up for oral morphine, 2-5 mls of 10 mg and 5 mls four-hourly. Shortly after he arrives at Gosport, he is given 10 mg at 2.45. He receives another 10 mg at 23.45. I find it difficult, from the notes, to understand why he was not written up for the analgesia that he was receiving in Gosport. I can find no evidence to say why he was given strong opioids without that oral analgesia being written up and tried. As we have seen, he did need a small number of doses at a lower dose of a strong opioid

early in his admission at the Queen Elizabeth Hospital. He then starts on -- I want to get this absolutely right -- on 15 October he receives 10 mg of oral morphine at 10 o'clock, at 2 o'clock at 6 o'clock and 20 at 10 o'clock at night. So he receives, to my calculation, 50 mg of oral morphine on the 15th.

THE CORONER: Give me those amounts again. 50 mg of 10?
A At 10 o'clock in the morning he receives 10.

Q Sorry, 10?
A At 2 o'clock he receives 10. At 6 o'clock he receives 10. At 10 o'clock he receives 20; all on the 15th. On the 16th, the next thing in the medical notes after his admission on the 14th says that: "He had declined overnight with shortness of breath. He has got weak pulse. He is unresponsive to spoken orders and there is oedema++ ", that means lots of oedema, "in both his arms and his legs." It is written that he has query silent MI, that means that he had a silent heart attack, query liver function. The treatment it suggests was to increase his frusemide, that is the diuretic that he was on, orally active diuretics. I also saw evidence from a Gillian Kimberley that "he looked dreadful and was incomprehensible at lunchtime on 15th October".

Q Sorry, the doses you have just given me were given on the 16th, were they?
A The doses of the oramorph I gave you were the doses on the 15th.

Q 10, 10, 10?
A And 20. That is my reading of the notes; happy to be corrected if I am wrong, I am sure I will be. I think he had 50 mg in total. So the medical notes on the 16th, so after the day when he had the 50 mg says that he has been very unwell, he has declined overnight and is short of breath and has this gross oedema, this gross fluid. There is evidence that he at least semi-conscious at times. Then on the 16th I believe he has 10 mg at 6.00, he has 10 mg at 10 and 10 mg at 2.00 in the afternoon. Then a diamorphine pump is started at 4.10 in the afternoon with 20 mg in of diamorphine and 20 mg of midazolam. The next medical notes on the 19th which states he has been comfortable at night and he is rapidly deteriorating. We have comments in the nursing Kardex about a bubbly chest late on 16 October and hyoscine is added on the 17th because of oropharyngeal secretions and the copious amounts of fluid are being suctioned.

Q Is it the 19th?
A Sorry?

Q What date?
A It says: "Copious amounts of fluids are being suctioned on the 17th. He further deteriorates on the 18th and continues to require regular suction", and I can reference that statement to page 266.

Q Sorry, I think we just got out of order because we had the comfortable night on the 19th.
A Yes.

Q Go back to the hyoscine.
A You are quite right. I jumped from the medical notes, where there is this gap, and then went back to what the nursing notes say on that day.

Q It says he died on the 18th.
A Oh well, I apologise. Can I review the medical notes then? 179. Do you have them? It would be better if I double check that.

MR SADD: It is a reference to the 17th you are quoting.

B THE CORONER: 17, what, sorry?

MR SADD: 179. It is an easy mistake for Professor Black to have made because what is meant to be a "7" looks like a "9". It is a very poorly written in note. Where it says comfortable night. Do you have that?
A Yes. You are quite right. I do apologise. The next note was on the 17th and I misread it as the 19th. "Comfortable night but rapid deterioration." So he has rapidly deteriorated
C between the 16th and the 17th and then he dies on the 18th.

THE CORONER: Right.
A I think my concern is understanding his rapid deterioration after admission to Gosport. I think that he gets rapid complications from his liver disease in two ways. Firstly, I think he
D develops hepatic encephalopathy and I think this was again, as you know I have already suggested that he had it early in his condition, and he now gets it again. That is the reason for his unresponsiveness. I also think that he gets -- he obviously is in severe fluid overload and that begins to affect his chest as well. I think that he eventually dies of the complications of his alcoholic liver disease, in particular his hepatic encephalopathy. The problem is that it is well-documented in the notes that, as I said earlier, that morphine can be one precipitant. There are many possible precipitants, but it can be one precipitant of someone going into hepatic encephalopathy. In using, on the 15th, 50 mg of oral morphine there has to be very
E clear justification that the use of that drug outweighs the potential side effects. Having liver disease makes you more likely to have those side effects because the metabolism of morphine is unpredictable. You may get significantly higher doses going to the brain, so you might not only get the direct effect of morphine, but you also have the potential, if it does affect the liver, and precipitates the hepatic encephalopathy, you also have that effect. So books, as we mentioned yesterday, textbooks always advise a clinician to take a great care when prescribing morphine, or diamorphine, in patients with severe liver disease. I think it is an
F issue as to the reason for the prescription and whether all the risks and potential down sides were understood. Equally, I cannot see any way that I can see "this was the only cause" or "the cause". It is possible that he might have had another gastro intestinal haemorrhage, which has not become obvious by the time he dies, but that, in itself, it does not have to be a very big one to precipitate hepatic encepatholopathy. It could have been that he was developing a chest infection on top of that fluid that we have mentioned in his lungs. It could have been and that is the problem I have in -- I am relatively confident that he died -- I am
G confident he died of alcoholic liver disease. I am relatively confident (inaudible) hepatic encephalopathy and that he had fluid in his chest. I am just not able to decide, from the notes, whether the treatment he received made that more likely or not.

Q So the condition from which he dies is the alcoholic liver disease?
A The complications of alcoholic liver disease, yes.

H Q Well, yes, but if you are going to say that you would want to specify what they were.

A And, you know ---

Q In that ---
A Yes, you are right. You could write it two ways. One would be hepatic encepatholopathy secondary to alcoholic liver disease. The other could be just alcoholic liver disease.

B Q I would be more comfortable with the alcoholic liver disease because of how specific you are then becoming in a terminal event that may or may not be there. Do you need to do that?
A No, I do not think you need to do that. I would not have a problem with that.

THE CORONER: Thank you. Mr Leiper? I am sorry, it is you, Mr Sadd, I am terribly sorry. I have just got used to looking at Mr Leiper.

C

Questioned by MR SADD

MR SADD: Professor Black, what you cannot exclude as a result of your evidence is that Mr Wilson may well have died as a result of a coma induced by the prescription of oramorph; that coma a result of his existing physical state, that is the serious alcoholic hepatitis that he had, and that coma was induced by the choice of medication at that stage which leads to his
D death. You cannot exclude the possibility?
A I think I have said that very clearly that I cannot exclude it.

Q Thank you. You refer in your evidence, just now, to the fact that there has to be, in a situation as presented by Mr Wilson's statement on 15th October, very clear justification for the use of oramorph?
A I agree.

E

Q Did you find that justification in the notes?
A No, I did not find clear justification in the notes.

Q Does it follow from that that in the context of there being clear justification you would have sought that or advice ought to have been sought about the prescription of that medication?
F A I think that a clinician should have put the justification in the notes; that would be normal expected practice.

Q Can we, please, look at the state, although you have already done so, Professor Black, and I imagine you are getting pretty weary by now, but if you will bear with me.
A No. It is an important case.

G Q Can we look at the state of Mr Wilson's health on his transfer on 13 October?
A Yes.

Q Perhaps the best description of that is provided in the clinical notes at page 21 of those notes, which you very fairly summarised, the entry half way down the page.

THE CORONER: If he does not, he will in a minute.
H A I have a reference in my notes that Social Services say he no longer fits their criteria

for a nursing home and should now receive further rehabilitation. That is my reference, 21. Is that the point?

Q "Social work assessment undertaken. Mr Wilson's needs indicate nursing home placement upon discharge." Homes booklet?
A That is what ---

Q That is a DHSS claim pack given to client. Do you want to have a look at that?

MR SADD: I am concerned, Professor Black, with the entry against the date 13 October 1998 and I will read it to you to save you time.
A This is from the social worker, is it?

Q It is from the social worker, but it is summarising the review by the medical team. Do you have that?
A Yes. I have it here, yes.

Q "Continues to require special medical nursing care as oedematous (?) limbs at high risk of break down. Right foot already about to break down. This is due to oedema secondary to cardiac failure and low protein. Also, high risk of self neglect and injury if starts to take alcohol again. Need to have 24-hour hospital care until heal arm."
A I think we have described that situation, yes.

Q If we go to page 36 of the notes, starting at the entry, this is in the nursing records, starting at the entry 12 October 1998, I think it is right to say that up until about 8 October Mr Wilson had been very reluctant to eat. There had been grave concern about his nutritional intake. In fact, a nutritionist had been involved in his case; that is right is it not? Can you remember that?
A I am very happy with that statement.

Q In line with what you have described to the jury a moment ago, we have an apparent change in his demeanour. We note that on 12 October 1998: "Good breakfast taken. Remains in a lot of pain when being cared for. Hygiene needs met. States that night staff washed lower half, refused to be weighed and night-time or overnight no complaints nor was he drinking well. Arm, hands and feet remain swollen. Very uncomfortable. He is restless overnight, sometimes (inaudible)." On the 13th, as you have quoted, Professor Black: "The weight has gone up to 114.4 kilos. Refused to change. Left arm supported on a pillow. Wash given. (inaudible) applied to right foot legs elevated on a stool. In a good mood this AM." Then for discharge to ward. Then we look over the page because it reads on: "Discharge to Dryad ward tomorrow. Has remained on his bed all PM. No complaints of any pain. Passing urine independently using a bottle. Bowels last open on the 10th. On the morning of his discharge, Robert had a peaceful night, slept well, no complaints of pain." So far so good in the sense of the record I am giving you is one that you have already seen and understand.
A Yes.

Q Is it fair to summarise that position, notwithstanding the increase in fluid in his limbs, that his sense of wellbeing in himself has improved from a low point, which involved an assessment, or a mini medical assessment by the geriatric psychiatrist?
A Yes. I think what has clearly improved is his cerebral status. I am not convinced that

his cardiac, fluid, balance, liver things have improved, but there is no doubt that there has been a significant improvement in his mental status and functioning.

Q The decision to transfer him to Dryad is on the basis of his receiving continuing care. Is that how you understand it?
A I think it is on the basis of hoping to stabilise his medical condition to a point at which they can fix the arm.

Q Thank you.
A He will be fit for an anaesthesia, anaesthetic.

Q If we go, please, to page 179 of the notes, and the entry there at the top is Dr Barton writing previous history fracture of (inaudible) and alcoholic problems, recurrence of oedema, CCF, that is cardiac congested failure, is that right?
A That is correct.

Q "Needs help in all daily needs. Hoisting, continent and Barthel score of 7. Lives with wife in, I think that is Sainsbury Green or (inaudible) Green.

THE CORONER: (inaudible) it should be.

MR SADD: Thank you. "Plan is gentle mobilisation."
A That is what I think it says, yes.

Q Would you accept from me, although I am happy to go through the notes with you, that we know that on 12 and 13 October overnight he was given I think codeine phosphate?
A Yes. I think that was my evidence that he received single doses on those days.

Q But that the last prescription of morphine had been on 5 October?
A That is correct.

Q At that stage it was a relatively low dose of 2.5?
A That was correct.

Q Thank you. Would you also accept from me, but again you can go through the notes, that the complaints of pain in the arm, although it was assumed he was in pain, the complaints that he was recording were fewer as it led up to his transfer?
A I think that that is the evidence that you have just read out from the nursing Kardex.

Q Were you aware that at the time is the name Gillian Hamblin familiar to you?
A Gillian Hamblin? I have obviously read at some stage a Gillian Kimberley. Perhaps I have that wrong.

THE CORONER: That is the wife.
A That is the wife. So, is that a nurse?

MR SADD: I will tell you who she is. It was not designed to be a trick question. It is just whether or not you knew and I did not want to teach you something you already knew.
A I am aware now that there was a nurse called Gillian Hamblin.

Q She was the senior Sister at the time and a clinical manager on Dryad ward. She has provided a series of statements, which are going to be read in this inquiry, and I just want to read out to you from her statement dated 11 June 2005. It is page 4 of her statement and it reads as follows, she is referring to the checking in procedure to Dryad and she says as follows: "At this stage, normally the Ward Clerk at Dryad would ring the transferring ward to obtain a more detailed diagnosis of a patient awaiting transfer. This procedure made sure we had a suitable available bed and any other equipment that was needed. On referring to the notes of this patient, Robert Wilson, I noted that he had multi-organ failure. The prognosis that I made was that he was being admitted for terminal care at Dryad ward." In your review of the notes that you have seen, can I ask you two questions? First, is that conclusion justified?

A I couldn't justify that, no.

Q My second question is: does that conclusion inform the treatment that he did, in fact, receive from your perspective once he was on Dryad ward?

THE CORONER: I do not know, it is a recognised pattern of treatment that one would give in such circumstances. I think the question is it not?

MR SADD: Professor Black can still answer the questions I assure you.

THE CORONER: I am not suggesting he should not. What I am saying is: is it a recognised path? Is that what one might expect?

A I would expect somebody who was ill to be assessed by the doctor in charge of the case who would make the clinical decisions. I am sure they would discuss that with the nursing staff, but I do believe that the medical staff would be in charge of the medical care of this patient.

MR SADD: As far as you are concerned, your understanding of what you have read, and I appreciate entirely that this man was never a patient of yours and you have only been asked to look at things in retrospect, but on your view of it he was not being transferred for the terminal care?

A No, I do not think at this stage he was being transferred for terminal care.

Q Can we then look at the care that he, in fact, receives. On 14 October, as you have described, and we can go to the drug charts which are at page 258 of the medical records, they start at 258 I should say, once he is on Dryad.

A I have my own summary.

Q I tell you why I want you to look at it, Professor Black, and I am sorry about this is because I am slightly confused about an entry for which I need your assistance. That is specifically to 261 when we get to 15 October.

THE CORONER: Do you want to look at 258 or 261?

MR SADD: I want to run through from 258 first. As you have noted, paracetamol appears not to have been prescribed notwithstanding it is in the transfer letter. That is one of the medications he was on?

A He was originally -- in Queen Alexander, he was on regular paracetamol and receiving

multiple doses. On admission here it is written up on the "as required". So it is there, but it was never given.

Q I was going to say, but you mentioned that it was never written up. In fact, one can see that it was.
A It was.

Q I just wanted to help you correct that. As we know, it was never given, as you say?
A No. Absolutely.

Q Again, from your reading of the notes, did you come to any understanding of why that might have been the case?
A No, I did not.

Q You did not. We know that on admission on the 14th Mr Wilson, in the way that you have described, was prescribed oramorph starting at 14.45, 10 mg.
A Yes. I am just trying to find it on the Kardex. Yes. The problem with the Kardex is that they have crossed out the words "regular prescription" and put "PRN". It was an inappropriate way of using the prescription chart, but, yes, he is written up. It is written up under regular, crossed out "PRN", which means give it as required, and he receives 10 mg, as I said, at 2.45 and 11.45 in the evening.

Q Were you able to locate in the records any assessment to justify the change in the drug regime?
A No, I was not.

Q From what you have been able to read, does the change (inaudible) appear to you to have been clinically justified?
A I could not find evidence in the notes to explain to me why that decision was made.

Q Although you are now, as is the jury, well familiar with the justification for introduction of oramorph, what would you -- I suspect I might be stopped from allowing you to speculate -- but in the context of this man's problems, and they are problems that you have set out, what would you have expected to find to justify the introduction of oramorph?

THE CORONER: Can you see any reason at this point to introduce oramorph?
A I could find no reason in the notes to do so, documented. There may have been a reason, but if it was, it was not documented.

Q Was there any reason in this that would have been obvious to you that makes you think: ah, this looks like an oramorph case?
A Not that I have found in the notes.

MR SADD: I know you have been taken more than once to the Wessex Guidance and the analgesic lab?
A Yes.

Q This appears to have been a step 1 to a step 3 change?
A I think I made the point that he did appear to already be on regular paracetamol, step 1. He was having intermittent when needed codeine phosphate, step 2, and neither of those were

continued regularly, so the paracetamol was not continued regularly, and at this stage they went to step 3.

Q Was an examination, a full examination, called for on transfer to Dryad?
A I think that that would be normal procedure. I think it is important that you know what your baseline is, what the problems are with the patient, in order to document them so that if other doctors come and review the patient at a later stage they know what your findings were then, so that they can then see if there was a change. I think particularly when somebody clearly does have a serious and chronic disease, was grossly (inaudible) and so on, it would have been appropriate, normal practice.

MR SADD: Can we look, please, at the ---

THE CORONER: Have you finished with the drug charts?

MR SADD: No, I am going to come back to those because we are only on 14 at the moment, sir, so I am going to run different dates if that is all right, thank you.

THE CORONER: Yes.

MR SADD: If we go, please, to page 278 of the notes. What you will find there, Professor Black, is the nursing care plan on transfer to Dryad. If I can read out for 14 October: "Had to change Pegasus mattress because of fault". Pegasus mattress is for pressure sores; is that right?
A Yes.

Q "Bob was restless at times, used urinal with assistance as he wanted to stand. Oramorph 10 mg given for pain control." Then on 15 October 1998: "Settled and slept well". We know then that on the 14th that he is conscious because he wants to stand and is assisted to do so. Is there any reference on the 14th or 15th that you can find to his complaining of pain?
A Well, apart from the comment that on the 14th it says, "The oramorph was given for pain control". That is the only comment that I can see.

Q In terms of contrasting Mr Wilson's physical state by reference to his fracture on 14 October to that on 21/22 September when he was admitted, sorry to make you play these elastic games there, but going back to that date, is there anything that you have seen in the notes that suggests the physical pain in that arm had worsened?
A No.

THE CORONER: Can I stop you there because I think we need to sort the equipment again. (After a pause). Go on.

MR SADD: Professor Black, is there or are we entitled to conclude from the nursing care plan entry that I have read out that certainly in that brief entry we can assume that Mr Wilson was conscious?
A Yes, he was. He could get up to stand.

Q Looking at the clinical records for his time in Dryad, that is going back to page 179, can you identify an entry that covers any of the 24-hour period for the 15th?

A No.

Q Is that sheet, that record, is that one that the clinicians treating Mr Wilson would have completed?
A That is the medical notes. I did not find any other medical notes.

Q Thank you. We then turn to the 15th, and the prescription regime that is then introduced on the 15th. I will read out to you the nursing care plan for the 15th: "Settled and slept well. Oramorph 20 mg given at 12 midnight with good effect". Then it says: "Oramorph 10 mg given at 06.00 hours". If we look at the prescription details on page 261, there is no entry for them. There appears to have been maybe a mistake because under the comment for the 15th for 6 o'clock there is blank. Do you see that? It is entered for the 16th but not ---

THE CORONER: That is because on the 15th it was given at midnight and if it is given 10 mg at 6 o'clock that is going to be after midnight which will take you to the 16th.

MR SADD: Look in the box below.

THE CORONER: That is my understanding.

MR SADD: Sir, I just read the note from the 15th, and ---

THE CORONER: Yes, but the 15th says it was given at midnight, 20 mg given at midnight, and then 10 mg given at 06.00 hours, also after the midnight on the 15th. It is why nobody ever dies at midnight. Do you know that? The police are incapable of dealing with a death at midnight because they do not know whether it was the 15th or the 16th. There is not a date that goes with midnight. So you die at 11.59 or 00.01.
A Sir, I also found those notes difficult to get the chronology and have always gone by the drug chart chronology.

THE CORONER: I think that is how it appears, is it not?

MR SADD: That is my mistake, Professor Black, I am sorry.

THE CORONER: I do not think it is a mistake. It is just a misunderstanding of what it is. It is quite difficult.

MR SADD: Is there anything in the notes for the 15th, so in effect we are left with the nursing care plan that relates to pain or restlessness?
A The bits you showed me did not mention a pain.

Q Is there anything on the 15 or 16 October from the nursing care plan that indicates whether or not, first, Mr Wilson is conscious on the 15th?
A Sorry, you are going to have to take me back to the nursing care plan. I kept flicking through the pages.

Q I am so sorry. Page 278.
A Okay. Your question is, is there anything on the?

Q On the 15th in that entry that indicates whether or not Mr Wilson was conscious during that day.
A Well, "has difficulty in swallowing medications" and if you are unconscious then clearly you cannot even attempt to swallow medications.

Q So we can assume that he is conscious. On the 16th, between the night of the 15th/16th, he has what the doctor who examined him, Dr Knapman on the 16th considers to be, or suggests, that he has had a myocardial infarction, is that right? He has declined overnight with shortness of breath. Sorry, that is page 179.

THE CORONER: 179?
A The note says: "Declined overnight. Shortness of breath on examination. Bubbly and weak pulse. Unresponsive to spoken orders. Oedema++ in arms and legs, query silent MI, query liver function." That is what I read out earlier.

MR SADD: Can you exclude that overnight on the 15th, can you exclude the possibility that Mr Wilson went into coma as a consequence of the medication he had been given secondary to his hepatic liver disease?
A Can I exclude it? No.

Q Given what was known about Mr Wilson's condition, and if we assume, for a moment, that the prescription of oramorph was justified on the basis of pain, was the prescription at that level, in the light of his condition, justified?
A I think that, in the presence of severe liver disease, it would be normal practice to start with as low a dose as possible and then to work up.

Q We know that previous doses of morphine that he had received had been at 2.5?
A I think he had one dose at 5.

Q One is at 5. That is right, sorry. When he was initially admitted on the 21st.
A Yes.

Q Would it have been feasible to have started oramorph at those levels?
A It would have been completely feasible.

Q Do you think in the context of Mr Wilson's condition it would have been proper?
A I think, on the evidence I have, it might have been proper. Can I just clarify how that oramorph was given? Was it oral or was it by injection, and if so by which route?

THE CORONER: I am the one person in the room without records.
A Well, my records show that he was given intramuscular oramorph on these last two doses and it was written intravenous or subcutaneously up, originally I was not clear which route was actually given. Probably subcutaneously.

MR SADD: We know that on the 16th, as you have noted, a syringe driver was introduced just after 4 o'clock that day?
A Yes.

Q We also know from the nursing care plan, and I will not make you go to it, Professor Black, I promise. I am just going to read out to you what the nursing care plan

says: "Has been on a syringe driver", this is for 16 October, "has been on a syringe driver since 16.30. Diamorphine 20 mg and hyoscine 24 mg. A little bubbly at approximately 22.30 when repositioned/pad changed more secretions pharyngeal during the night, but Robert has not been distressed, appears comfortable." From that entry, do you understand the basis for the increase and the use of the syringe driver, the increase in diamorphine and the use of the syringe driver?

A I cannot find, certainly from the medical notes, a justification for those changes.

Q If Mr Wilson was, by then, in a coma what would have been the effect of the increase in the administration of morphine?

THE CORONER: Can we answer that or not? If he is in a coma would the increase in the dose of morphine affect the position?

A It might or it might not.

MR SADD: I suppose what I was trying to establish, Professor Black, it may be an unfair question, it may fall outside your expertise, is whether it would have meant that the coma would have been deepened?

A It might have meant that, but -- I do not see how you can say.

Q On the 17th, and again I am referring to the nursing care plan here, 17 October, hyoscine 05.15 hours increased to 600 mg as secretions increased. During the day diamorphine 40 mg and hyoscine increased to 800 mg. Midazolam, 20 mg added. Night-time noisy secretions but not distressing Robert. (inaudible) is required during the night. He appears comfortable. Hot at times." Again, on the basis of those entries, are you able to find a clinical justification for the further increase in the administration of morphine?

A No, I cannot.

Q If we go -- I know you do not have it, Professor Black, I am sorry to make you search around for something -- but I am going to go now back to nurse Hamblin's statement, which will be read eventually to the jury, and pages 7 and 8 of that statement. This is the statement dated, sir, 11 June 2005. To help you, Professor Black, what nurse Hamblin is recounting is her involvement in the care of Mr Wilson. She explains, looking at what went on on the 17th, she says: "The dose of hyoscine was increased to the cope with the increase of secretions on the chest which is recorded as per my entry on 17 October 1998. The diamorphine was increased because of pain." I am sorry to belabour the point, but have you been able to find any references to increased pain?

A No, I have not been able to find that.

Q She goes on to write for the afternoon of that day, explaining the increase in diamorphine 40 mg, she says: "This entry is self-explanatory. Mr Wilson's condition has continued to deteriorate. Neither I nor my staff have recorded the reason for the increase in diamorphine in the nursing notes. However, it would have been increased due to pain level not being controlled by the previous dose." In the context of Mr Wilson being in a coma, and falling into a coma over the 15th, over the night of the 15th/16th, on what basis could a member of staff justify increasing pain on the 17th if he remains in that coma?

A Well, it would have to be a hypothetical example I could give, but I think you would need evidence for that which I cannot give you. There is nothing in these notes to explain that to me. It does not mean there could not be an explanation. I cannot see it.

Q But it goes a little further than that, does it not, Professor Black, because I have taken you to the nursing care plan. We know that one of the indications of whether or not one should increase the morphine is if there is apparent distress on the part of the patient. We know, fortunately, that there are two entries in the nursing care plan, one on the 16th, "Robert has not been distressed, appears comfortable", and we know on the 17th, "appears comfortable, hot at times". "Noisy secretions but not distressing Robert. Appears comfortable. Hot at times." Would you accept from me that those appear to contraindicate the need to increase pain relieving dosages?
A Both of those would not give me a justification for increasing it.

Q If we read further on from nurse Hamblin's statement, at page 11, sir, the top line of that statement: "The practice for administering diamorphine to control pain was to double the dosage". In what way was the fact that diamorphine here I think was trebled in a 48 hour period. Would you agree with that, the administration of diamorphine?
A I think the conventional situation, as we discussed yesterday, would be to increase it by 50 per cent every 24 hours. That does not mean that you might not, in some patients, in some circumstances, feel that doubling it was right, or even that you do not have to reassess the patient more often.

THE CORONER: I think this is going back to the point that we have been labouring and that is that you would look for justification of that. That is what is missing, is it not, in so much of this. If you are going to double it, if you are going to increase it by more than the 50 per cent there should be, in the records, something to justify that. That is what you have been saying for two days now.

MR SADD: Can I take you to the conclusion of your report? The report that I have, Professor Black, is at the top of agreed version 2 of 19 November 2005. Do you have that?
A Well, I have my most recent version, so if you read out yours I can see if it varies at all.

THE CORONER: Which paragraph are you on?

MR SADD: I am about to tell you, sir, I am sorry. If we look at paragraph 7.3.

THE CORONER: "I believe that the prescription and total of 50 mg of oral morphine." Do you mean that?

MR SADD: That is the one. Can I read this out?
A Yes.

Q I will ask you the question that follows on from this?
A Yes.

Q. 7.3: "It is my belief that the prescription and the total of 50 mg of oral morphine on 15 October following the 20 mg that were given on 14 October was not an appropriate clinical response to the pain in Mr Wilson's left arm. In my view, this dose of analgesia formed a major contribution to the clinical deterioration that occurred over 15 and 16 October, in particular, his rapid mental state deterioration." You go on to say that this treatment "more than minimally contributed to the death of Mr Robert Wilson on 19 October 1998". Is that a view you still hold today?

A I think, in view of the evidence I have given here today, I would add the word "likely" in there. In this view, this dosage is "likely" to have formed a major contribution. I feel that my evidence here today adds that slight difference.

Q Sir, may I take instructions, please? You will be relieved to know I have finished, almost. (After a pause). Professor Black, thank you for your patience.

B MR LEIPER: May I ask a few questions about Mr Wilson?

THE CORONER: Of course.

Questioned by MR LEIPER

MR LEIPER: Can we just go over it again. He had a fall in late September 1998, was
C admitted to hospital?
A Yes.

Q He did not want to undergo an operation in relation to the forearm?
A On admission, but was prepared to the next day when they would not operate.

Q Understood. At the time he was admitted there was a significant history of chronic
D drinking which had led to liver disease?
A Correct.

Q Advanced liver disease?
A Advanced liver disease, correct.

Q There were major concerns about his poor nutritional intake, not just when he arrived
E in hospital, but the reports that were being received from his wife as to the fact that he would not eat often at home.
A Correct.

Q Meant that he was in poor shape?
A Correct.

F Q Nutrition is, obviously, important because it maintains the body and allows the tissues to remain healthy. If someone has poor nutrition, the chances of skin breakdown, pressure sores are significantly enhanced?
A Correct.

Q The nutritionists, the dietitians were involved in hospital and the view was being expressed that he was taking in less than half of what he should be taking?
G A I will accept that you have that evidence in the notes, yes.

Q If you want it, it is page 173. Is page 173. He has a poor nutritional intake and at best is managing less than 50 per cent in his nutritional requirements. In view of his poor intake whilst in hospital, and reported by his wife at home, nasogastric feeding, that may be the only method of (inaudible). That is in early October.
H A Yes.

Q But there were improvements, and particularly improvements in his mental state?
A Yes.

Q The psychiatrist was involved at some point.
A Yes.

Q There is a letter from Dr Lusznat, I think is her name, we have it in the medical records at page 117. She saw him in the middle of October. I am sorry. Her letter is dated the middle of October. She saw him on 8 October and talked about his history, including drinking pattern and family history. On page 118 she talks about his state of mind and said that he admitted that or was suggesting that there was no point in living. This is part of his state of mind at that stage?
A Mm hmm, yes.

MR LEIPER: She goes on to suggest that Mr Wilson would benefit from anti-depressant treatment. She started him on that. It is page 118?
A Yes, I am just going to it.

Q She says: "I have taken the liberty of starting (inaudible)", which I think is an antidepressant?
A Yes.

Q She said: "I do hope, of course, he tolerates it in view of his liver and renal failure", liver and kidneys?
A Yes.

Q Then the paragraph above, she suggests that it seems as though Mr Wilson may have developed an early dementia?
A Yes.

Q Perhaps alcohol related. Alternatively, this may be early Alzheimer's disease or vascular-type dementia. He is transferred to the Gosport War Memorial Hospital. You told us that he had a very significant fluid overload?
A Yes.

Q Does that suggest cardiac insufficiency?
A No. It gives -- people talk a bit a bit about cardiac failure. In fact, there is nothing wrong with his heart at all. It may give you similar symptoms because when you have heart disease you collect fluid in your lungs and that gives you breathlessness. When you have liver disease, you get fluid all over your body and that may include some in the lungs, giving you breathlessness. So I think people in the notes may be referring to cardiac failure, but I could find no evidence that he has a primary problem with his heart.

Q The suggestion from the psychiatrist is some form of dementia or problems?
A It is very common for people who have alcoholic liver disease to have a degree of alcoholic dementia as well.

Q Kidneys, liver?
A Yes.

Q A lot of fluid overload in the body?
A Yes.

Q Puts a great strain on the body?
A As we said right at the beginning, he has serious complications from his alcoholic liver disease.

B Q We know from the prescription sheets that Mr Wilson, once he was admitted to Gosport, was written up for various medications, including paracetamol, written up by Dr Barton, although that was never given?
A Correct, yes.

Q That was written up, page 258 if you want it, written up as an "as required" prescription, paracetamol. She wrote him up for a variety of other drugs. Perhaps I need not
C go through them all, but I think on the next page, page 260 if you have it, six other drugs, including the antidepressant, trazodone, multivitamins, frusemide, which I think is a diuretic?
A It is. Indeed. That is actually, sorry, let me just.

Q Page 260.
A Yes, that is correct. She has written up for -- I cannot read the dose, but I think -- you are quite right, she has written up frusemide, yes.

D

Q It is the nature of the drug that is important rather than the dose I think. On the next page she has written him up for other drugs, including oramorph.
A Yes.

Q I think on the last page of the prescription sheet she has written him up for oramorph and she has written up diamorphine as a PRN dose, as required?
E A Yes, the drug chart has regular prescription written out, PRN written there and has written diamorphine 2-200 mg (inaudible) 24 hours.

Q I think hyoscine and midazolam were also written up on the same PRN basis?
A Indeed.

Q We know that oramorph was given. There were complaints of pain and they are noted
F in the medical records but not regularly. It is noted that on 15 October, page 265 of the notes, he was commenced on oramorph for pain in the left arm. Does it help for me to give you page numbers?
A Yes, it does. That is exactly what it says, yes.

Q "Wife told condition is poor", I think?
A Yes.

G

Q What we have heard is that he deteriorated overnight, the night of the 15th. We have been referred to the entry, let you find the page, that oramorph was given at midnight to good effect. What inference should we draw from the words "to good effect"?
A I am not sure I can be certain.

H Q I am not asking for certainty, I am just asking for an inference.

A One inference might be that if the oral morphine was started for pain in the left arm as written in the nursing Kardex that the pain was no longer there.

Q Yes. That is the natural inference, is it not? To good effect, meaning he was no longer complaining of pain or talking about it. The nurses have to ask him, "how are you doing". That is how they know it is to good effect, is it not?
A The nurses are looking after him 24 hours a day, yes.

Q We know that on the next day.
A I mean, I just make the point there, there was an assumption in your question that you have to be able to ask the patient. It is also relevant that you may be able to assess that somebody who cannot speak is in pain.

Q We know from page 179 that he declined overnight. There is a mention of shortness of breath. Page 179.

THE CORONER: Is that the 15th and the 16th? This is Dr Knapman?
A Yes, absolutely. He is writing on the 16th.

Q He suggests in his note and queries silent MI, myocardial infarction and heart attack?
A That is what he writes.

Q Query deterioration liver function. He is suggesting these as possible reasons for the deterioration?
A Yes.

Q We know what Dr Knapman, as to the prescriptions, because he is looking at the prescription sheets, we know that is he writing them?
A Yes.

Q Yes. He adds a prescription on page 261 at the bottom of the page.
A Yes. If I remember rightly he adds frusemide.

Q He does. It follows that Dr Knapman is handling the prescription sheet and writing on it? One would assume he knows what is being provided for the patient and indeed he is adjusting the medication?
A That would be a fair assumption.

Q One would assume that he knew what pain relief was being provided to the patient?
A That will be a fair assumption.

Q And this is after Dr Knapman visits that the syringe driver is started on the 16th?
A I think that is quite correct, yes.

Q I think Dr Barton does not see this patient again. So it is after Dr Knapman visits that the syringe driver is started. We then have referred to in the notes, on the 17th, page 265, the nursing record: "Slow deterioration. In already poor condition." Then on the following day, the 18th, a Dr Peters is there.
A Yes.

Q There is reference in the records by Dr Peters, page 179, and it is his entry. I think Dr Peters has undergone gender reassignment. He was a he at the time, is now a she. So on the 17th --

THE CORONER: Realignment?

MR LEIPER: Reassignment.

THE CORONER: Is it? I have not done it, you see, so ---

MR LEIPER: Dr Peters. 17th, we have his comfortable night but rapid deterioration?
A Correct.

Q We know that Dr Peters as well added to the prescription sheet. One inference from that is that Dr Peters, similarly, Dr Peters is adding hyoscine on the PRM.
A That is a fair assumption.

Q It is above Dr Peters' entry that the diamorphine had been written up and the entries have shown that the diamorphine has been given, and also the oramorph on the 14th. If Dr Peters had any concerns similar to Dr Knapman on what was being provided to the patient would you have expected them to have put a line through the medication that they thought might be inappropriate?
A I think if they thought the medication was inappropriate, then that would have been something to do.

THE CORONER: Yes. They had an opportunity to ---
A They had an opportunity to do that.

MR LEIPER: It goes further than that, does it not, because every nurse who was involved in the caring of a patient had their own professional obligations with regard to care given to patients?
A That is true.

Q Whilst they are not doctors, nurses may have a view on the medication that they are being asked to give to the patient?
A I think we talked yesterday about the importance of a multi-disciplinary approach when patients are coming to the end of their live and in ensuring they are on the right medication.

Q I understand. If diamorphine is written up as an "as required" medication, PRM, nursing staff must be giving information to the doctors or having a justification for providing the medication which is written up in that way?
A I certainly have difficulty with the way the diamorphine was written up "PRM".
MR LEIPER: Thank you very much.

THE CORONER: Anything else? No. Ladies and Gentlemen, anything you want to ask the doctor?

UNIDENTIFIED FEMALE SPEAKER: (inaudible) ideally you would have stabilised his

condition in order to give him the operation?
A Yes.

Q Do you, I do not know if you have mentioned anything suggesting that they were trying to do that (inaudible)?
A Well ---

B THE CORONER: Your voice just tailed away.

UNIDENTIFIED FEMALE SPEAKER: Sorry. Is there anything that you up picked up in the notes to suggest that they were actually trying to stabilise his condition like the encepatholopathy?
A Yes. I mean, clearly, when he was, as we just heard, when he was admitted all his drugs were written up, including the diuretics. I think that if the intention had been he was
C simply here for terminal care, as we see in other patients, it is usual to stop medication which is not needed and just give whatever is the minimum needed for symptomatic relief. He was written up for all the medication he was on.

MR SADD: May I take a point on that, please? In the light of the juror's question if we go to the prescription sheet and, Professor Black, page 260, please.
A Yes.
D

Q We can see there a reference to frusemide at the top?
A Yes.

Q Then we have references to multivitamins, et cetera?
A Yes.

E Q After 9 o'clock on 16 October.
A Yes.

Q Frusemide appears not to have been --
A Because it was re-written, was it not, by Dr Knapman on page 261.

Q And was it given?
F A Yes, it says it is given.

Q Was it given on the 17th?
A No, it was not given on the 17th. I am not clear if the patient could have taken tablets on the 17th.

G Q Understood. Looking then at, that was the second question I was going ask you, in fact, because if you had reached the stage where you had reached of being in the coma, what, of the drugs listed on 260, could he have been administered or could have been administered to him?
A If you are in a coma, then I accept that it will be difficult for you to take oral medication.

MR JENKINS: Is there any evidence from the nursing record that he was in a coma?
H A No.

Q Would you expect the nurses to write down, "he has been in a coma for the last 24 hours"?
A I would have to go back to the notes, but I have not seen it, I cannot think standing here.

THE CORONER: There is no reference that I have seen that says he is in a coma. I think the questions that are being put to you are: if he were in a coma, would he be able to.
A Clearly.

THE CORONER: We will go to Enid Spurgeon now.
A Can I just go to the loo?

THE CORONER: Yes, of course you can. Five minutes.

(A short adjournment)

THE CORONER: We will now deal with Enid Spurgeon.
A Enid Spurgeon I believe was 92 when she was admitted in March 1999 after a fall. She had had some previous problems documented in the notes. She had probably had a heart attack some years before. She had had depression and was probably developing early dementia and was being followed up by a community psychiatric nurse. She had previously had one fracture of the hip which did not need an operation and she also had a chronic bone disease called Paget's disease which causes slow remodelling and reshaping of bones, but unless you get a fracture it usually does not give you too much trouble.

She comes in and I have never been provided with the Haslar notes so all I have got is the handwritten one page summary at transfer to Gosport which states that she had a dynamic hip screw, which is the operation; that she could be mobilised from bed to chair with two nurses; that she was incontinent at night, has a small pressure sore on the back of her right leg that is swollen and the only medication she is on is paracetamol as required.

When she arrives at Dryad the medical notes say that she is not weight-bearing, so an immediate difference between what was being said in the Haslar transfer. She was not incontinent and the medical plan was to sort out analgesia.

I think that from the point that she was admitted to Gosport there are continual comments about pain in the hip and I have to say this is very difficult to reconcile with that one-page summary from Haslar. So what are the possibilities? She may have had continual pain in Haslar and just not been treated for it. She may have had treatment but they did not bother to write it up in the letter that transferred her. She might have had some disaster in the ambulance. People do dislocate hips that have recently been operated on at the time of an ambulance transfer which is possible. She might have been starting to have developed a wound infection. She might have had a – I am afraid I do not know is what I am immediately saying. I had difficulty reconciling those two notes.

Clearly, though it is not written in the medical notes apart from "sort out analgesia", it would appear from the nursing notes that she does have continual pain which does not settle and is interfering with attempts at rehabilitation.

She started on opioids analgesia starting with 10mg bd of morphine slow release and she would appear to have got a side effect from that of trouble with vomiting and the staff recognised that. They stopped the MST and start her on oral co-dydramol, so step two, so to speak, of that analgesic ladder, and her vomiting stops but her pain seems to continue so it started again. It would appear that she does not get vomiting this time and the MST is then increased to 20mg bd on 6 April.

B On the 7th she is now seen by a consultant who is concerned. He does not know why there is continued pain and arranges for an x-ray. Again, I have never seen the result of that x-ray, there is no evidence that it was ever done and no evidence that anybody ever looked at it to see if it was done or a report obtained, but the consultant seemed to think the likeliest thing is an infection and starts her on antibiotics.

C Clearly the pain must continue, despite the oral MST, and on I think it is 12 April a syringe driver is started instead. At that time she had been on 20mg bd of the morphine, which is 40mg in total and, as we discussed, and you can divide that certainly by three everyone agrees, it may be by two in some, but 15-20mg of diamorphine might have been the appropriate dose if you were simply converting at the same level and she is started on 80mg a day of diamorphine. I was not able to find the reason in the notes why that increased dose was given.

D Dr Reid then reviews her and he believes that she is on an excessive dose and reduces it to 40mg. However, the same day, later in the day if I have got the chronology right, the Midazolam that was in the pump was increased from 20 up to 40mg and again I was unable to find why the dose of Midazolam was increased very shortly after the dose of diamorphine was reduced. Then she subsequently dies on 13 April.

E So a very elderly lady. I think the likeliest thing was an infected wound but clearly on the balance of probabilities and no more than that and certainly secondary to a fractured neck of femur, but I am struggling to be certain what the medical condition was. There is no doubt though that she was not mobilised and she was not doing well and she was in continual pain.

THE CORONER: Do you know which hip it was – right or left?
A I am just checking. (Pause) Right.

F THE CORONER: On the balance of probabilities, 1(a) infected wound and 1(b) fractured right hip.
A Yes.

THE CORONER: Do we have a date for the operation?
A The notes that I saw were 20 March, i.e. the day after she was admitted to Haslar. That is just from that one page. We do not have the Haslar notes. They would have been
G very helpful.

THE CORONER: Do you have anything to add to that?
A No. It is a difficult story.

THE CORONER: It is incomplete, is it not?
A It is unsatisfactory.

H

THE CORONER: Do you have any idea what happened to the Haslar notes?

SPEAKER: I cannot understand why Professor Black never saw them.

THE CORONER: Is there anything you want to ask? (Pause) Ladies and gentlemen, anything? It is really quite sad there is nobody here for her either, is it not? It is one of those. If there is nothing else for Professor Black, thank you very much for the help you have been for the last couple of days. I will now leave you in peace. I will release you.

(The witness withdrew)

THE CORONER: Tomorrow. Mr Wilson, are you going to be fit for tomorrow?

MR WILSON: Yes.

THE CORONER: We will take you first and then Dr Barton if you are fit and well we will pick you up at that point.

MR JENKINS: Sir, what you have said in relation to Dr Barton, she will deal with four of the patients and deal with the others at a later stage in the evidence.

THE CORONER: Let's see how far we get with those. It is quite important that we take the same procedure and deal with each deceased individually and then we can pick up from there.

MR JENKINS: It would be usual whilst a witness is giving evidence for lawyers or anybody not to discuss the evidence they have given.

THE CORONER: I think I have got to make an exception for you. What I would prefer is if we are half way through a deceased I would say that must not be discussed, but as the team you will obviously need to talk to Dr Barton on other matters.

MR JENKINS: I think there may be a break of a week or so, but I raise it just so that people have the chance to make any observations.

THE CORONER: 10 o'clock tomorrow. Thank you for your help today.

(The court was adjourned to the following day)