GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Tuesday 31 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 TEN)

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

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

THE CORONER: Mr Sadd, I understand that you have an application this morning?

MR. SADD: In fact, sir, it is not that way around. As I understand it, Mr Townsend wants some passages from Nurse Hamblin's statement in relation to Mr Wilson's case to be redacted, and it is simply my response to that application. I think that is the way around. If it helps Mr. Townsend, I can just remind you, sir, of the passages that he wants taken out, and I understand that he gave his reasons for doing so, but I am more than happy for those to be rehearsed again this morning, if that would help you.

THE CORONER: Let me just identify those.

MR SADD: The first statement is that date of the 11 June 2005, and the second statement is that dated 30 September 2005.

THE CORONER: Yes. I have got those.

MR SADD: I am sure I will be corrected if I get it wrong; the passages that Mr Townsend would like edited are at page 3 of the June statement, and it is the penultimate paragraph, and I suspect, consistent with that, Mr Townsend would say that it is the paragraph just above that. In other words, the two paragraphs that have the spell summary.

THE CORONER: Yes, the spell summary. The difficulty, I think, we have with that is that it is written up after the event.

MR SADD: But, sir, it is not written up after the event. As the context of Nurse Hamblin's statement makes clear, it is a live document that is compiled during the course of the individual's stay, and the reason I say that is because we have very carefully placed in Nurse Hamblin's statement the context of her tenses, and I know that sounds an odd phrase to use, but if we address that issue straight away, those two paragraphs at page 3 are to be taken out, in line with the third paragraph from the bottom of page 4 coming out and my submissions on those, sir, are simply this; you need to read in there, or one needs to read, I should say, pages 3 and 4 entirely in context, and you will see at page 4 in the paragraph beginning, "At this stage."

THE CORONER: Yes?

MR SADD: It is a passage that, unfortunately, and I think inadvertently, I took Professor Black to without this issue having been sorted, and I have already apologised to Mr Townsend, but I certainly did not do it deliberately, but the passage, as it were, has gone in the evidence, but, simply reading, sir:

> "At this stage, normally the Ward Clerk at Dryad would ring the transferring ward to obtain a more detailed diagnosis of the patient awaiting transfer. This procedure made sure that we had a suitable bed available, and any other equipment that was needed. On referring to the notes of this patient, 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."

That statement is entirely ambiguous, sir, because --

THE CORONER: I am sorry, is entirely what?

MR SADD: Ambiguous, because what you do not know is whether Nurse Hamblin is referring to the spell record. What appears to be suggested is that she is referring to the records on transfer, and that that paragraph is to be read in the context of the paragraph just above, where she is talking about the process on admission, and her memory of what was her reaction in this particular case, and it is interesting to read, sir, that you would not have the choice of the word, "Prognosis", in the context of a document written after the event, and after Mr. Wilson's death. The word would be entirely superfluous, and therefore, on that basis, and that ambiguity, there is no justification for that paragraph coming out.

THE CORONER: I think one of the objections was, "The prognosis I made", because I am not sure she was making any prognosis at all. I do not think that was part of her job. I think that was one of the objections that was made.

Now, I think if it is reference to a note on admission, if it is going back to that and it refers to the prognosis that he came in with -- sorry, that is not very good English, but he has admitted the Dryad -- the notes that are written up at that point would, presumably, contain the word, "Prognosis". I mean, I do not know. You would look at it. I mean, if that is what Hamblin is saying, then I could accept that, but --

MR SADD: But, sir, she cannot be putting -- the interpretation that you put sir, if I may say so, is not one that is available on the sentence that she has recorded there.

THE CORONER: "At this stage normally the Ward Clerk at Dryad would ring the transferring ward to obtain a more detailed diagnosis of the 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, this patient, Robert Wilson, I noted that he had multiple organ failure. The prognosis I made ..."

I mean, she has got (Inaudible) hasn't she:

> "... was that he was being admitted for terminal care at Dryad Ward".

MR SADD: And that is the way should be read, sir. There is no basis, as I say, for that to be extracted in that context, and so one would make the normal points which are perhaps a cliché, but clichés are there because they tell truths, as it were. This is a statement that she would have read, presumably, a statement that she would have signed, and a statement that she had the opportunity to qualify, or clarify any ambiguity that she may have felt was contained in that statement, and no such qualification is provided in the second statement that she gives. Indeed, sir, when you turn to that second statement, and the passage that Mr. Townsend would like redacted, that is at page 5, if I can take you to the second statement dated September 2005 --

THE CORONER: Before we get to that one, we need to look at page 3, the first statement, do we not? Because if what is said about the Spell Summary, and what I understand about

the Spell Summary is incorrect, then that would cause me to have a different view of the final paragraph on page 5 of the second statement.

MR SADD: Sir, no it would not, is my submission, because what you have on the final paragraph on page 5 is, again, her view of Mr Wilson's state of health on admission.

THE CORONER: Well, can I be clear when the Spell Summary is written up?

MR LEIPER: Afterwards is my understanding. It is not a contemporaneous document.

THE CORONER: Because the difficulty you have got with that is on admission, I understood that he was admitted for terminal care because of multi-organ failure, because I see that from the spell summary. Well, she is looking at it after the event, isn't she? She has the problem I have got.

MR SADD: But, sir, read what she says at page 3 of the first statement, and the reference to the Spell Summary.

THE CORONER: "Notes which outline the diagnosis ..."

MR SADD: No, sir, just before that:

> "The Spell Summary is typed on the day or day after admission".

THE CORONER: Sorry, you were on the second statement?

MR SADD: No, it is my fault, sir. I am chopping and changing. I am going back to the first.

MR TOWNSEND: Could I invite you, sir, to read the previous paragraph as well?

THE CORONER: Of which statement?

A SPEAKER: Sorry, of the first. I apologise.

MR SADD: Sorry, sir, I apologise. I will read it out to you to save time. Page 3. Third paragraph up:

> "The Spell Summary is the discharge notes which outline the diagnosis, treatment and follow-up, if necessary, for the patient. This is ultimately sent to medical records at GWMH and then on to clinical coding either at QA or St Mary's hospital. The Spell Summary is typed on the day or day after admission which not only details the patient's personal details, but the diagnosis and the relevant medical code showing the patient's medical history. It is also based on the transfer letter which accompanies the patient. The transfer letter appears to be missing from Mr Wilson's medical notes."

THE CORONER: So, it is a contemporaneous document?

MR SADD: That is what you are being told in that paragraph.

THE CORONER: And that is what you would tell me?

MR SADD: And that is what I would tell you.

THE CORONER: Who is going to tell me anything different? Who is going to tell me it is not a contemporaneous document?

MR TOWNSEND: Dr Barton.

THE CORONER: Then that is an evidential point, isn't it? I am just wondering chronologically how we deal with it.

MR SADD: Well, sir, Dr Barton, as I understand it, and subject to what Mr Jenkins might say to you, sir, is giving evidence on Friday, and it is a point that could be dealt with at that stage, if you thought that was appropriate.

THE CORONER: What I will do is I will take the evidence as it is, subject to any further representations that are made, and if Dr Barton wants to deal with that and can deal with that, then she can do that on Friday. Is that a reasonable way to deal with that?

A SPEAKER: Sir, I see the force in that. My concern is simply this; it leaves the Evidence that the witness, who cannot attend, is unhappy about it on the record. Can I just invite the Court in considering which way to rule, to –

MR SADD: Sir, I haven't finished. May I just finish?

THE CORONER: Oh, I apologise. I thought I had asked you, but I am sorry, Mr Sadd. I didn't mean any discourtesy.

MR SADD: No, and nor did Mr. Townsend, but it is just that I am small and get hidden.

Sir, to reinforce the point that I make in favour of the passages being left in, I would invite you, then, to turn to page 5 of the first statement, so you have looked at 3 and 4, and then we turn to page 5, please, and you see there her comment. That is, sorry, I should say Nurse Hamblin's comment, four or five paragraphs down beginning with the words, "The diagnosis is also based on the transfer letter which accompanies the patient". The reason I take you to that passage and Mr. Townsend to that passage is that it is all of apiece with her account of what happens on transfer, and on admission, and it is all of apiece with her generic statements with her familiarity with the system on Dryad Ward, the length of time that she has been on Dryad Ward, and what would happen in actual fact on Dryad Ward, and how that applied to a particular individual.

So, if there is ambiguity, it ought not to be resolved against Mr Wilson, but it ought to be resolved in the context of allowing those passages left in to the statement.

THE CORONER: Right.

MR SADD: It is for that reason, sir, we also say, and I think it just helps Mr. Townsend if he knows my submissions in their entirety, at page 11 of the first statement, the first sentence there, I will remind you of that:

"The practice for administering diamorphine to control pain was to double the dosage".

Again, I am told that that should come out because it is taken out of context. The difficulty we have with that argument is the same difficulty we have with arguments altogether, is that this witness, by the time she is being interviewed, is well aware of the context in which she is being interviewed, has had the ability to qualify those statements, and, indeed, in September, three months later, provides a second statement. No qualification is given to that, and it should say, in her statement. There is no need for it to come out.

THE CORONER: Well, I think the difficulty we had with that was that it is a fairly prejudicial statement in the absence of the maker, as it were. I think you need to persuade me, I think. I hear what you say.

MR SADD: Sir, it is not so prejudicial when seen in the context, for instance, of the evidence that the jury will have heard from Professor Black, and his review of the prescription charts for the individuals that he was asked to look at, and you will recollect that in the context of that evidence he frequently refers to his expert surprise at the increase in the dosage, and that that increase, on occasion, has been doubled. That, indeed, is confirmed by Nurse Hamblin's comment. So, it is not simply a sentence left in the ether without any support, it is actually backed up by the existing medical records.

THE CORONER: What Black says, and the records that were contemporaneous then.

MR SADD: Sir, I will now give Mr Townsend -- I will give way, as it were. I am sorry that I stood up and interrupted.

THE CORONER: Please do not apologise. Mr Townsend?

MR TOWNSEND: I will now obliterate Mr Sadd.

I can deal, I hope, with my comments in relation to Mr Sadd fairly briefly, and I do not wish to repeat what I said yesterday, but --

THE CORONER: Well, Mr Sadd was not here to hear them yesterday.

MR TOWNSEND: I did relay to him over the telephone yesterday and this morning a summary of what I had said yesterday.

Can I put it in this way; the position is unsatisfactory, perhaps from everybody's point of view, including my clients, when a witness cannot attend. The evidence that Mr Sadd wishes to place before the inquest in reality is evidence that also comes from other sources. For example, matters such as doubling the dose. The witness statements that you are proposing to read, sir, under Rule 37 have, in my submission, to be taken very firmly in context. This witness was making, as you are aware, a number of witness statements in relation to a number of patients at the time to police officers. In relation to the case of Mr Wilson we are talking about witness statements, the written statements, she was making some seven years after the event. It would therefore, in those circumstances, not, in my submission, be at all surprising if there are things within those numerous witness

statements, including these ones, that she would wish to qualify if she had come to give evidence. It is almost inevitable. She has no recollection of the patient.

THE CORONER: That is the problem that we dealt with yesterday, effectively.

MR TOWNSEND: Yes. She is doing her best.

B THE CORONER: Yes.

MR TOWNSEND: But there is a potential injustice to her, and, indeed, a danger of the jury receiving evidence out of context if the passages that I have suggested are not removed from the statement, and, as I emphasise, the effect of their removal is not to prevent Mr Wilson, through Mr Sadd, putting forward, for example, the doubling of the dosage, or matters of that sort, because that is already there.

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THE CORONER: When would he do that? That is the difficulty, is it not? If this witness is not here, none of you is going to address me or the jury on the facts.

MR TOWNSEND: No.

D THE CORONER: Therefore, whatever it is, I need to pick it up, and I am the one that needs to talk to the jury about it, and I think the answer is for this evidence to go in and for me to urge the jury to accept caution, first of all, under Rule 37, and particularly to address this point. I think that is the way to handle it. I have great difficulty in admitting any statement under Rule 37 and then doctoring it. Do you see what I mean?

MR TOWNSEND: I appreciate that initial reluctance.

E THE CORONER: The evidence under Rule 37 is what the witness's statement is, is it not?

MR TOWNSEND: Yes.

THE CORONER: I mean, that is what is being admitted, as in the Diana and Dodi ruling on Rule 37. I mean, that is where the authority has come from now, is it not?

F MR TOWNSEND: Yes. Well, sir, if you are minded to take that course, plainly I do not wish to jump the gun, and it is premature at this stage, but I would be inviting you to consider carefully reminding the jury in relation to this particular witness that she is unwell, unable to attend, and unable to make any clarifications or corrections that she might wish to make.

THE CORONER: I think that is going to have to be her evidence throughout, is it not, because that is the basis upon which we -- I have admitted it, is purely for that reason. She was a very significant witness.

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MR TOWNSEND: Sir, yes.

THE CORONER: One of the most significant witnesses. No disrespect to anyone else, but, you know, that is where we are all coming from, is it not?

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MR TOWNSEND: Yes. Well, sir, it is finally, of course, a matter, of course, for the Tribunal, but those are my submissions.

THE CORONER: Right. Then let me adduce it, and I need to address it specifically in my summing-up to the jury. I have made a note to do that.

MR TOWNSEND: Sir, while I am on my feet, and I hesitate to delay matters further, there are a couple of matters that I would wish to raise with the Court in relation to Mrs Devine and the evidence that is going to be given in relation to her.

THE CORONER: Right.

MR TOWNSEND: I can summarise those fairly briefly. In addition to the evidence that is being given about matters that occurred at the Gosport War Memorial Hospital, Code A statement goes into some detail as to what happened at Queen Alexandra Hospital, and, indeed, sir, you were proposing to read, under Rule 37, the statement of Nurse Beane.

THE CORONER: Yes.

MR TOWNSEND: -- which deals with, at some length, a number of complaints that Code A had made about the handling of her mother's affairs at the Queen Alexandra Hospital, matters such as which relatives were being talked to at that stage, and so on and so forth.

THE CORONER: Yes.

MR TOWNSEND: Now, in my submission, that evidence simply does not --

THE CORONER: The Beane evidence?

MR TOWNSEND: The Beane evidence simply does not assist, and, indeed, what Code A says about her complaints in relation to Queen Alexandra simply does not assist in relation to the events that occurred at Gosport.

MR LEIPER: Sir, could I , in the interests of brevity, make it clear that Code A in the course of giving her evidence this morning, does not propose to dwell on any concerns she may have had in relation to treatment of her mother while at Queen Alexandra.

THE CORONER: Right. Do I then remove Beane?

MR LEIPER: That may well be the case. I will formally --

THE CORONER: Well, that would seem to make sense. The difficulty I had when I was preparing this was actually looking at Code A and saying, you know, what actually is her complaint? Where are we up to? It seemed unreasonable if she wanted to raise the matter then for me to the to allow the Beane statement to go in, because clearly that confirmed what she was saying, but if we can get rid of that, that is fine. No problem with that at all.

MR TOWNSEND: Sir, I am most grateful for that indication. There is also, and I simply

flag it, I think Mr Leiper finished making his submissions and there is no danger of my obliterating him in any event.

MR LEIPER: Not a hope!

MR TOWNSEND: It is the other way around. In relation to Code A evidence, she does also deal with what I might describe as general complaints in relation to Gosport War Memorial Hospital, and, indeed, information that she says that Mrs Devine passed on to her. I would ask the Tribunal to deal with that matter very cautiously, and to ensure that Code A evidence is essentially centred on her own observations.

THE CORONER: Yes.

MR TOWNSEND: For example, Mrs Devine might have said things.

THE CORONER: What is the quality -- what is the status of that evidence when things are said to her by somebody that is now dead?

MR TOWNSEND: Somebody who is now dead, and I mean this in no disrespectful way, we know that Mrs Devine was troubled in certain ways, as it manifested by her behaviour during that time. We have no idea where the truth lies, and I would invite the Tribunal to be very cautious about admitting general evidence.

THE CORONER: I think that is right, but I am not going to shut Code A out when she tries to tell me what her mother had told her. I really do not want to do that.

MR TOWNSEND: Well, sir, I understand that concern, and I understand that she will wish to say things, but it is important in my submission that evidence is not elicited which no-one is really in a very direct position to challenge. General assertions.

THE CORONER: Yes, but if somebody who is in Mrs Devine's position, is making statements, those statements are either true or they are false. If they are false, they may be as a result of the condition from which she suffers. I do not want to put to Code A the fact that those statements were not made, because I have no reason to suspect that they were not. There is no problem with that. So, I think I am going to ask Code A to say what she has got to say, and take it from there.

MR TOWNSEND: Sir, yes. I simply raise this question: if those reported statements go before the jury, in my submission it is difficult to see how they can assist the jury in relation to the relatively narrow issues that the jury have to decide.

THE CORONER: I disagree. I disagree very fundamentally with you because I think they are indicative of a situation in which Mrs Devine was at that time.

MR TOWNSEND: Well, they may be, yes.

THE CORONER: Well, yes. Either they are true, and if they are not true, then one has to look at the interpretation from somebody who is no longer with us.

MR TOWNSEND: Sir, I have made my submissions.

THE CORONER: All right. I have got that. Thank you. Mr Sadd?

MR SADD: Sir, one housekeeping point, and it is with me being present here today, is the issue of Professor Baker's report. His report only occurs in Mr Wilson's case.

THE CORONER: Yes.

MR SADD: And I know it is one that you want read.

THE CORONER: Yes.

MR SADD: And what I am not clear about yet is how you intend reading it, and it is whether -- I am just flagging it up now because it is just –

THE CORONER: Do you want me to do that now? If I do that first, would that be helpful?

MR SADD: That would help. I am conscious of Code A being here and giving evidence today, and it is a nerve-wracking process.

THE CORONER: Well, Professor Baker will be what? Twenty minutes?

MR SADD: Sir, yes. It is quite a long report.

THE CORONER: If I read quickly?

MR SADD: It is 18 pages of report, some of which is a medical record which we would say you do not need to read out.

THE CORONER: No. I think that is right.

MR SADD: It is really from page 9, and his summary.

THE CORONER: Does anybody have any observations if I take that for Mr Sadd's sake? Is that all right? Are you going to hold on for -- yes? All right. Could we get the jury in, then, please?

(In the presence of the jury)

Do you want me to take from page 9, Mr Sadd?

MR SADD: Sir, I was going to suggest, if I may, that --

THE CORONER: Page 3?

MR SADD: You read page 3 and then go to page 9, please.

THE CORONER: Good.

MR SADD: I think the jury would need to know, as I am sure you were going to include, Professor Baker's expertise.

THE CORONER: Yes.

MR SADD: Thank you very much, sir.

THE CORONER: Is that all right?

(In the presence of the jury)

THE CORONER: Good morning, ladies and gentlemen. Welcome back. Slight change to the housekeeping. I am going to read to you. This is a statement of Professor Baker. He deals with Mr Wilson. Remember Mr Wilson? Professor Baker is a doctor, head of the Department of Health Sciences, University of Leicester. Principal research interest: quality of care, including methods of improving professional performance, patient experience of care and patient safety. He has published around 130 peer-reviewed articles. He looked at the case papers of Mr Wilson, and he says:

> "I have studied copies of the records provided to me by Hampshire Constabulary in order to consider three issues; certified cause of death, prescription of opiates and sedatives and whether Mr Wilson fell into the category of patients who might have left hospital alive. With respect to death certification, I have concluded that the certificate was inaccurate, in that Mr Wilson did not have renal failure and had liver dysfunction but not failure. He probably did have heart failure, although I believe the initiation of opiate medication was an important factor in bleeding to death. With respect to the prescription of opiate drugs, I have concluded on the evidence available to me that the initiation of opiate medication on transfer to Dryad Ward was inappropriate. I have also concluded that the starting dose was too high. The prescription of Hyoscine and Midazolam was justified by the use of opiates.
>
> With respect to leaving hospital alive, I have concluded that Mr Wilson was in the category of patient who might have left hospital alive if he had not been commenced on opiate medication on transfer to Dryad Ward."

So, fairly significant, okay? He says:

> "The technical background and examination of the facts in issue".

First of all, the certified cause of death:

> "In this case was the certified cause of death supported by medical history of the patient? Certified cause of death was:
>
> 1(a) congestive cardiac failure;
> 1(b) renal failure; and
> 2) liver failure".

The certifying doctor was Dr E J Peters:

> "Looking at the question of liver failure, Mr Wilson was known to have a poorly functioning liver. The primary diagnosis relating to his admission between 17th

February, 1997 and the 12th of March 1997 was alcoholic liver disease, and at that time he had abnormal Liver Function Tests, including low albumen level and an ultrasound had shown a small liver, possibly cirrhotic, with marked ascites. His liver function was also impaired at the time of admission in September 1998. Jaundice does not seem to have been remarked upon in the notes relating to this admission. The working diagnosis during the admission in Queen Alexandra Hospital was active alcoholic hepatitis. A handwritten entry in the record dated 13th October, 1998 records the results of blood tests taken on 12th October. At that time, the bilirubin had fallen to 48 micromols ..."

Whatever it was, there were only 48 of them:

" ...and the ASTs, 37..."

International units? Is that the IUR:

"... although the alkaline phosphate was 181 international units per litre. I would tend to interpret these results as indicating some improvement. The notes do not record a diagnosis of liver failure, although this diagnosis is mentioned on blood test forms, the liver function tests, while abnormal, are not sufficiently abnormal to suggest fulminant liver failure. Diuretics can precipitate hepatic encephalopathy in patients with cirrhosis, but the hepatic encephalopathy was not diagnosed and the records do not include mention of the size of encephalopathy. Mr Wilson was noted to have some depression and mildly impaired short-term memory when assessed by Dr Lusznat, the consultant in old age psychiatry, on 8th October 1998".

If you remember, we read her statement:

"... and the nursing records indicate that he was sleeping, had poor speech on 29th September 1998, but these features were not sufficiently consistent, progressive, or severe to suggest hepatic encephalopathy. The course of Mr Wilson's final illness was rather gradual, if limited progress on a transfer to Dryad Ward which tends to rule out the progressive development of encephalopathy due to liver failure".

Renal failure is the kidneys:

"Mr. Wilson also had renal dysfunction. His creatinine reached 246... [whatever they are units]... and his urea, 17.8 millimols per litre on 25th of September, 1998, but there was some improvement over the following days. On the 30th September 1998, his creatinine was 165 micromols ...[whatever they are]... and his urea, 14.4 millimols per litre, and by the 5th of October, his creatinine had fallen to 97 and his urea to 7.5. The results on the 5th of October were within the normal range and remained so on the 7th of October 1998 and the 13th of October 1998. The improvement in renal function appears to have occurred following the temporary withdrawal of diuretics and the institution of intravenous fluids on 28 September, 1998.

Congestive cardiac failure. A note on admission to Dryad Ward records the problem of alcohol problems, recurrent oedema and CCF..."

The congestive cardiac failure:

"Heart failure is a syndrome rather than a specific disease. That is, it is a collection of symptoms and signs which can be caused by several different diseases. Congestive cardiac failure is a term that is less commonly used today. It can mean different things to doctors and may indicate right ventricular failure to some doctors, left ventricular failure to others, or failure of both ventricles to others. Mr Wilson had ankle, leg, and sacral oedema which may have been explained by right heart failure, low albumen level. Secondly, the alcoholic liver disease and the poor nutrition would have played a role in causing the oedema, although he did not have a raised jugular venous pressure when admitted to QA He did have crackles in the lung bases, especially in the left, and this might have been a feature of left heart failure.

Diagnosis of cardiac failure on clinical grounds alone is difficult. The notes indicate that Mr Wilson suffers from retention of fluid leading to swelling of his arms and legs. Potential explanations for failure in Mr Wilson's case include ischemic heart disease and alcohol induced cardiomyopathy. He was treated with high doses of diuretics at his admission in 1997, specifically Spironolactone 100mg daily, and Frusemide 80mg daily. During the admission in 1997 his weight declined from around 103 kilograms to 93 kilograms, suggesting that the diuretics had produced a satisfactory diuresis. In contrast, in 1998, his weight rose from 103 kilograms on 27 September, to 114 kilograms on 14th October despite continued treatment with diuretics. This suggests that his cardiovascular status may have declined between the admissions in 1997 and 1998. The medical notes on transfer to Dryad on 14 September 1998 do not mention the need for additional treatment of congestive cardiac failure.

Diuretics were continued and Oramorph 10mg was prescribed, doses being given that day at 14.45 pm and 23.45 pm. However, there was no mention of pain at all in the medical records, and therefore the indications for Oramorph are unclear. Oramorph 10mg four-hourly was commenced on 15th October 1998, the first dose being given at 10 am, six doses being given up to 1400 hours on the 16th of October. Mr Wilson was seen the next morning by Dr Natham as he had declined overnight with shortness of breath. On examination he was reported as bubbling, had a weak pulse, unresponsive to spoken orders, and had oedema plus plus in the arms and legs. The possibility of a signed myocardial infraction was raised although not investigated, and the history of reduced liver function noted. The dose of Frusemide was doubled. These notes indicate that Mr Natham thought that the congestive failure was an important factor in explaining Mr Wilson's condition. However, the fact that the deterioration coincided with the regular administration of Oramorph points to an alternative explanation, namely that the side effects of opiate medication, side effects which would include sedation leading to lack of responsiveness and reduced ability to expectorate which could explain the bubbling respiration.

In the afternoon of 16th October the nursing staff noted that Mr Wilson was very bubbly and that diamorphine by syringe driver had been commenced. The dose began at 16.10 and the prescription was written by Dr Barton. The bubbly chest may have been explained by morphine. Hyoscine was also prescribed by syringe driver, Midazolam being added on 16th October, the dose of diamorphine being increased to 40mg on 17th October, and on 18th October, to 60mg.

The prescription of opiates and sedatives. In the case of Mr Wilson, was his prescribing in accordance with his clinical need? Mr Wilson was receiving soluble paracetamol four times a day from 13th September 1998 until the morning of 14th October, prior to his transfer to Dryad Ward. He received 2.5mg to 5mg of morphine on 23rd to 24th September, and 2.5mg on 3rd October, and 5th October. He had also received Codydramol until the paracetamol had been started. Although he did have pain throughout his stay at QA, it appears to have been reasonably well-controlled by 13th October. The nursing record indicates that he had no complaints about pain on 30th October 1998, nor on the morning of 14th October. Neither the medical or nursing records from Dryad Ward mention an increase in pain later on 14th October, although the nursing notes on 15th October state that the Oramorph was for pain in the arm. On the information contained in the records, therefore, the commencement of Oramorph was not adequately justified. The commencement of subcutaneous diamorphine on 16th October followed a decline of Mr Wilson's condition, the cause of which was not clear. The nursing records mention that the reason for commencing the diamorphine by syringe driver was explained to the family but the reason itself is not recorded in the records. An alternative approach to the decline on 16th October would have been to stop the Oramorph and to see whether Mr Wilson improved. For some reason which cannot be found in the records, it had been concluded that Mr Wilson was not going to recover and that terminal care was the appropriate course of action. Hyoscine was also prescribed and I assume the intention was to control secretions. The dose of Hyoscine was increased in accordance with the problems caused by the secretions which were recorded as, 'Copious', on 17th October. The dose of diamorphine was increased, and Midazolam was added, although the records do not explain the reason for these prescribing decisions.

Leaving hospital alive..."

MR JENKINS: Well, he deals with other patients and I do not know that that is --

THE CORONER: Does he? Does he not deal with --

MR. SADD: Sir, it occurs to me that -- sorry to interrupt -- but if you were to read from four lines up from the bottom of that page?

THE CORONER: Yes.

MR. SADD: Can I just confirm with Mr Jenkins that he is happy with that?

MR JENKINS: Yes. That is fine.

THE CORONER:

"When Mr. Wilson was transferred from QA to Dryad Ward he was in need of nursing and medical care and at risk of falling until fully mobilised. A short term in a long-term NHS bed was viewed as appropriate was regarded as appropriate when he was reviewed on the ward round on 13th October. He appeared to be making some progress with improved renal function, less pain, and improvement in some of the measures of liver function. He still had significant problems however, including difficulty in moving and oedema. Nevertheless the QA hospital records do

not indicate that death was expected in the near future. With appropriate care, gradual mobilization was anticipated, yet shortly after admission to Dryad Ward, he was commenced on regular Oramorph.

Opinion. Certified cause of death. In this case was the certified cause of death supported by the medical history of the patient? In my opinion, Mr. Wilson had liver dysfunction but not full-blown failure. His liver dysfunction did not cause death. In the presence of other life-threatening conditions, the liver dysfunction may impair the ability to recover, and it would have been reasonable to mention on the death certificate that Mr Wilson had chronic liver disease. The cause of his liver disease – alcohol – was not mentioned in the certificate. Mr Wilson did not have renal failure. He did have abnormal blood test results after his admission to hospital. These improved with rehydration. Mr Wilson probably did have cardiac failure. There may have been other conditions as well. Hemoglobin estimations during his admission to Queen Alexandra Hospital had indicated mild anaemia. If this condition had deteriorated, the heart condition would also have looked worse. However, I think this was rather unlikely since he was being closely observed in QA and signs of increasing anaemia would almost certainly have been recognized. Evidence of bleeding would have been noted had it occurred. There is no convincing evidence in the records to confirm the diagnosis of myocardial infarction, such as history of chest pain, raised cardiac enzymes or ECG evidence."

(Inaudible). No ECG:

"One could also speculate about possible occurrence of some unsuspected condition. However, despite all these speculations, it has to be acknowledged that his decline was associated with the regular administration of morphine, and was responded to by administration of diamorphine by syringe driver. The reason for commencing Oramorph is not recorded in the medical notes. In particular, the reason for not using a non-opiate drug for pain relief are not given. Even if Mr Wilson did have pain from the fracture that was not controlled by paracetamol, regular doses of 10mg of oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed to adequately reduced the pain, a low dose of morphine, 2.5mg to 5mg, as had been used in the early days of this admission, might have been reasonable, although Mr Wilson did have congestive cardiac failure therefore his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of Oramorph on 14th October 1998."

MR. SADD: Sir, if it helps --

THE CORONER: I think that paragraph is probably more of interest to me than of anyone Else:

"Prescription of opiates and sedatives. In the case of Mr Wilson, was his prescribing in accordance with his clinical need? The records do not contain information to explain why opiates were commenced. On the basis of the records alone, therefore, the prescribing of opiates was not indicated. The sedative Midazolam was prescribed to accompany the diamorphine in the syringe driver, although the reason for the addition of Midazolam is not given in the medical or nursing records.

"The Palliative Care Handbook, fourth edition, published by the Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust and The Rounds Portsmouth Area Hospice in 1998 reproduces the World Health Organisation analgesic ladder in which step 1, mild pain, involves the use of non-opioids, such as paracetamol; step 2, moderate pain, weak opioids such as co-codamol, codium paracetamol, and step 3, severe pain, strong opioids such as morphine. In Mr Wilson's case, medication for pain moved from step 1 to step 3 without any explanation. Hyoscine hydrocromide 0.4mg to 2.4mg over 24 hours by syringe driver is recommended in the handbook for reducing secretions and is noted to be an excellent sedative. Midazolam5mg -60mg over 24 hours is described as a sedative, higher doses to be used only for terminal sedation. The handbook also indicates that a total daily dose of 30mg of morphine would be equivalent to 10mg of diamorphine by syringe driver in 24 hours. The handbook recommends starting morphine at a low dose and increase gradually according to need. This policy was applied in Queen Alexandra Hospital when occasional low, 2.5mg -5mg doses of diamorphine, were needed early in Mr Wilson's admission. On Dryad Ward, however, the starting dose was 10mg. On 15th October 1998, he had three doses of 10mg and one at 10 pm of 20mg. The time of this dose appears to be 2200 hours in the prescription record, but is given as 2400 hours in the nursing record. This is a significant amount of opiate, more than would have been indicated, even if step 2 of the WHO analgesic ladder had been tried first, and I would have expected sedation and drowsiness to occur.

By September 1998, copy of the British National Formulary notes that morphine may precipitate coma in hepatic impairment, reduce dose or avoid, but many such patients tolerate morphine well, reduce dose or avoid in renal impairment. It also states that in palliative care these cautions should not necessarily be a deterrent to the use of opioids. The use of Hyoscine to reduce secretions is common practice. Opiates can suppress the cough reflex which reduces the ability to clear the secretions. It also occurs in people who are too weak to expectorate effectively. Midazolam, a benzodiazapine sedative, can be added to Hyoscine if repeated administration of Hyoscine leads to an agitated or confused state.

MR JENKINS: Sir, I think you then move on to the third line on the next page.

THE CORONER: "In judging whether Mr Wilson might, if Oramorph had not been initiated on transfer to Dryad Ward, eventually have left Gosport War Memorial Hospital, several qualifications must be made. I am reliant on the hospital records only. Records are often incomplete, and I have not sought or obtained any information directly from the doctors, nurses or other staff or relatives who were involved in caring for Mr Wilson in the last days of his life. It is also difficult to predict with certainty the course of recovery that a patient will follow, especially when the patient is elderly and has a complex mix of several serious clinical problems, as did Mr Wilson. In addition to deterioration of existing conditions, new and unexpected problems can arise, including, for example, myocardial infarction ..."

You may remember that reference was made to the possibility of myocardial infarction in this case:

"It was also impossible to be certain about the degree of recovery, and whether the

patient would have been fit for discharge to their own home, or whether residential or nursing accommodation would be required. Bearing these qualifications in mind, in my opinion, Mr Wilson did fall into the category of patients who might have left hospital alive if the Oramorph had not been commenced on transfer to Dryad Ward".

All right. Anything arising from that?

A SPEAKER: Did the increase in other drugs combat the symptoms --

THE CORONER: You will need to interpret that evidence in the light of whatever else you hear. That will be part of your deliberations. A fairly significant part.

MR TOWNSEND: Sir, might I raise one point in qualification? You referred, in reading the report of Professor Baker, to Dr Lusznat, who is the consultant in old age psychiatry, and said that you had read Dr Lusznat's statement. I am not sure if that is correct.

THE CORONER: Do I not have that correct? I am just wishing my life away? All right then. Sorry. Then it will be read.

Anything arising? No? Then thank you. We you going to start with Victoria Packman, please?

VICTORIA PACKMAN, sworn
Questioned by THE CORONER

THE CORONER: Thank you. Victoria Jane Packman?
A Yes.

THE CORONER: You have waited a long time for this, have you not?
A Yes.

THE CORONER: Everybody refers to you as "Vicky"?
A They do.

THE CORONER: So, you are Mr Packman's daughter?
A Yes.

THE CORONER: He was known as "Dad" to you, though.
A Dad, among other things.

THE CORONER: On a good day or a bad day? All right. You used to work in the insurance business but gave up round about 1983 and became a taxi driver?
A Yes.

THE CORONER: He started his own taxi business with a friend and you worked as a driver?
A Yes.

THE CORONER: Carried on the business until around 1998, 1999 when he retired and did not work again. Weight increased rapidly, and for the last few years of his life he was virtually house bound. Legs and feet were extremely swollen. Because of his great

size he found it extremely difficult to get around:

"He never spoke to me about any health problems, and I never asked him."

So, what about the last couple of years? Do you want to tell me in your own words?
A Yes. I have got a few things to say.

B THE CORONER: Go on, then.

A My father was born in a small Derbyshire village. He was the third of four children, the other three being girls who are all still alive. The whole family were well-built. After leaving school he went into local government in Chesterfield where he met my mother in the Borough Treasuries Department in 1948. This was followed by two years' national service in the RAF, and then he began a career in insurance. Mum and dad were married in
C 1956 and moved to Nottingham at first for six or seven years, and then onto a job in London and a house in Kent. My brother, Mark, was born in 1964 and two years later I arrived. My father was, by this time, a fire and burglary surveyor, and we moved with his firm down to Portsmouth and we had a house in Emsworth. During all this time he was a fit man. He played tennis, table tennis, ran the line for football matches at my brother's football team and was Chairman of the Nautical Training Corps, TSU, in Emsworth. He also took a very keen interest in classical music.

D

Then everything seemed to change when he went with the Nautical Training Corps on annual camp to the New Forrest where, in the course of playing rounders, he put his foot down a rabbit hole and badly twisted his knee. This knee problem was to plague him for the rest of his life. Then, in 1982/1983 he lost his job and things took a turn for the worse. Dad decided he wanted to drive a taxi, and on having a medical examination he was found to have high blood pressure.

E

For many years, dad had been putting on weight slowly but surely. He tried driving a taxi for someone else, and even started his own taxi business. This wasn't a success. He carried on until 1988, 1989, then retired and did not work again. During this time, his main solace was his music. He joined the U3A, the University of the Third Age, hosted music mornings at home. His weight increased rapidly and his legs were very swollen. He walked with the aid
F of a stick.

During the last five years or so of his life, his legs were weeping with the oedema, and this gradually worsened. The District Nurse would call three times a week to change his dressings.

In 1999, my mother was diagnosed with the possible reoccurrence of breast cancer. She was due to go in QA for a biopsy on 5th August. I left for work at 6 o'clock in the morning. Mum
G was still at home and dad was upstairs. Mum was taken to QA by a friend. After returning from work, approximately 11 o'clock at night, I did not see my dad. He was in the bathroom, which was on the first floor. On 6th August I left for work without seeing my dad, returning early. Dad was in the bathroom. I spoke to him through the door, and he assured me that he was all right. At this point, the District Nurse called to change dad's dressings. I explained that he was in the bathroom and he would be down shortly. We waited for some time, and I told him that the nurse had other appointments, and he said
H he would not be long. Eventually, the nurse went upstairs to speak to him and went into the

bathroom. When she came downstairs she said dad had to go to hospital. An ambulance was called. They were not able to get dad out of the room owing to his size and the lack of space. A second ambulance was called to help get him out of the room and down the stairs.

Dad was taken to the A&E at QA I followed in my car because I had to pick my mother up and told her she didn't have far to walk because dad was downstairs. I took her down to see him. We were not told the reason for his admission by anyone. Dad was taken to Ann Ward and I took my mum home.

Mum visited dad every day. If I was not working I went as well. He made good progress. He had injections of antibiotics and his legs dried up. He seemed much better. He was given paracetamol when needed, but declined quite often and Gaviscon for indigestion which he suffered most of his life.

THE CORONER: By this stage are you aware of why dad was admitted?
A Just his legs had seized up and he just couldn't get himself up and ...

THE CORONER: Right.
A I remember he looked the best he had done for years. He was eating and drinking properly and quite able to do things for himself. He was happy and chatty and keen to go home. Because of dad's lack of mobility around the house, mum and I were told he would be going to Gosport War Memorial Hospital for rehabilitation and remobilisation. Whilst he was there, the Social Services were going to put up handrails for him to get around. We were never told anything different from this. Everyone seemed very positive.

Dad was in QA for approximately two weeks when he was moved to Gosport. When mum and I visited him there he was sat up in bed looking very well and very cheerful. He was in a room on his own three or four days away from the nursing station. He was eating and drinking properly and was in good spirits. He never complained of being in pain, nor did he show any signs that he was in pain. Friends of the family visited him each day. On 26 August mum received a 'phone call saying that he had had a suspected heart attack. When mum and her friends arrived at the hospital they found that dad had said he had had a really bad case of indigestion and not given any Gaviscon as in the QA

Dr. Barton called mum into her room and told her very bluntly that he was going to die. His sister came in to see him, and didn't think this was a possibility, saying, "Oh, Mick's not dying". Within three or four days after being admitted at Gosport, dad suddenly appeared to be what I would call, "Spaced out". His eyes were glazed, his head would nod about, he was propped up on pillows. I believe he was catheterised. He appeared very sleepy but was able to talk to us. He was, however, unable to hold a cup or pick anything up in order to eat. Mum and I would hold a cup with a straw for him to drink and feed him grapes.

The change was dramatic. He became progressively worse. He became a vegetable and just slept. We visited on Tuesday 31st, and he drifted in and out of consciousness. There was no facial recognition of who we were. On 1st September we visited as it was the last time mum would see him before her operation. He was completely out of it. By this I mean he did not move or stir.

Thursday, 2nd September, I visited him alone as mum had been admitted to QA for her operation. I sat by his bed for between three and four hours. He did not move. No-one came in to his room to check on him and no-one spoke to me about him.

Friday, 3rd September, my dad died. Reverend Margaret Sherwin, a family friend, was with him when he died. She informed my mother and the hospital rang my brother. The death certificate was myocardial infarction. At no time did we have any consultation with either the nursing staff or the doctor, other than when we were told he was dying. It wasn't until we received the medical notes and Professor Black's review that we were even aware of the gastrointestinal bleed. Having found that out after nine years it was not a heart attack that caused his death, it was a great shock.

THE CORONER: Have you anything else to add?
A It's about time.

THE CORONER: Well, yes, that is probably right. Okay. Anybody have any questions?

MR LEIPER: Nothing arises, sir.

MS BALLARD: Nothing, sir.

THE CORONER: Mr. Jenkins?

Questioned by MR JENKINS

MR JENKINS: You know I ask questions on behalf of --
A Yes.

Q You have just told us about Professor Black's report. Can I just remind you and the jury too of what he told us? He said that in relation to someone with your father's history and medical problems, at page 15 of his report, he says that your father was transferred to the Gosport War Memorial Hospital on 23rd August.
A Yes.

Q The prognosis for a patient with gross obesity, who was catheterised, and who has recent deep and complex pressure sores, was terrible:

> "In my experience...[he said]... such patients almost invariably deteriorate, despite the best efforts of staff and die in hospital".

A Yes.

Q Were you told anything like that at the Queen Alexandra Hospital?
A No. We weren't told anything like that at Gosport either, until the 26th.

Q I understand. I think it is right that your father was a huge man.
A Yes. Yes.

Q You have told us that it needed two ambulance crews, four people, to get him out of the house.

A It wasn't the fact that he was that big, it was the fact that the space in the bathroom wasn't enough to get under his arms to lift him out.

Q But it was also getting him down the stairs.
A Yes. Yes.

Q I think he had had sores on his legs for a very long time?
A Yes.

Q And they would weep. That is what needed the nurses to come and --
A Yes. He got an infection in there, basically.

Q I understand. I do not know if you will have seen them, but were you aware that at the Queen Alexandra Hospital, he developed some fairly nasty bed sores?
A On his feet. Other than that, yes, we knew about those.

Q Now, a decision was taken, I think, that nothing more could be done for him at the Queen Alexandra, and so he was transferred to the War Memorial hospital, as we have heard, in August.
A Yes.

Q What we have heard from Professor Black is that it was his view that it was a gastrointestinal bleed that your father had a few days into the admission.
A Yes.

Q Massive blood loss.
A Yes.

THE CORONER: Well, everybody says that. It is the same as everybody says someone was, "Rushed to hospital". He has got a gastrointestinal bleed. I do not know how you quantify them. It is a GI bleed.

MR SADD: It was a further bleed and he had had one in Queen Alexandra Hospital.
A Assumed.

Q That was the view of the Queen Alexandra, that he had had a bleed there. You know Dr Barton's note was that she thought it was a myocardial infarction, a heart attack, or a gastrointestinal bleed. That is what she thought when she assessed him after this event had taken place.
A Yes.

Q You know Professor Black's view in relation to the subsequent management was that it was within the boundaries of a reasonable clinical decision to provide symptomatic care only at that stage, after this event, whether it was a heart attack or a gastrointestinal bleed. Given his condition, and the prognosis, it was reasonable just to provide relief for pain and any symptoms he may have had.
A We were not aware that he was in any pain. The night he was said to have a myocardial infarction he was sat up quite happy saying that he had a bad case of indigestion.

Q Yes. You are not disputing Professor Black's view --

A No.

Q -- that he was seriously ill, are you?
A Oh, yes. Yes.

Q You are not disputing that?
A No.

B

Q We know that, in Professor Black's view, diamorphine, in addition to being prescribed for pain, but it is commonly used to manage the stress and restlessness of terminal illness. Your father was prescribed diamorphine.
A Yes. He was prescribed diamorphine after it was said he had had a heart attack.

Q We know that your father was reviewed by Dr. Reid, the consultant?
C A Uh-huh.

Q We will hear from him, I anticipate, but from Professor Black's view, Dr Reid was happy with the management, and his review on the same day, the dosage of pain relief, diamorphine, was increased, because, again, this is Professor Black's view, the previous dose was not controlling your father's symptoms. I am offering you this because firstly I want to remind the jury of the history of your father – there are a number of cases to juggle -- but also
D to give you the chance to respond.
A Yes, but when Mr Reid assessed him, it was too late to have done anything about a gastro bleed anyway, so he was virtually at the end of his life.

Q So far as the bleed was concerned, you know Dr Barton's entry in the note?
A But it was never followed up.

E Q Well, your father was not well enough to be transferred.
A But it also states, in Dr Black's statement, that if that had happened at home he would have been moved by ambulance.

Q Yes, but --

THE CORONER: I think there is a problem in that Professor Black took the view that
F whatever dad wasn't fit to be moved.
A No, he wasn't. Either way there was a possibility he was going to die, and like one of the jury Members asked the other day, with that 1% possibility of him surviving, was it worth the risk. We weren't consulted on it so we didn't get a say.

THE CORONER: Sorry, Mr. Jenkins.

G MR JENKINS: That is all right. Again, so far as the pain relief was concerned, Professor Black's view was that there was no evidence of any side effects, that from the records that he had seen, your father's symptoms were relatively well-controlled.
A I cannot comment on that because the last three or four days that we saw him he was not conscious.

Q He was dying.

H

A He was dying, yes, but also the last time my mother saw him before he died he wasn't even aware we were there.

MR JENKINS: Yes. Thank you.

THE CORONER: Yes. Ladies and gentlemen, is there anything you want to ask? Good. Then thank you very much indeed.

I am sorry, Mr. Leiper. It is normally Mr Sadd I ignore.

Questioned by MR LEIPER

MR LIEPER: I apologise for detaining you in the witness box.
A That is all right. I'll run later.

Q Because you call him (?) he was at the Gosport War Memorial Hospital for a period of about ten days?
A Yes.

Q And it was put to you by my learned friend Mr. Jenkins that the reason why he was transferred was that there was nothing more that could be done for him at the QA. The reason why he was transferred was for the purpose of rehabilitation?
A Rehabilitation and remobilisation, we were told.

Q I just remind the jury as to your impression of how he was when he went to the Gosport War Memorial Hospital?
A He was fine. The day before when he was still at QA, he was chatty, cheerful, looking forward to going home, he looked the best he had done for years. He went to Gosport, we visited him on the first day he was there, and he really -- he just seemed full of beans. Then, three days later, just away with the fairies.

Q While he had been at the QA, had you been aware of his experiencing any pain?
A No.

Q He had not made any complaint to you?
A No.

Q While he was at the Gosport War Memorial Hospital, did he ever complain to you of experiencing pain?
A No.

Q At no stage?
A No.

THE CORONER: Well, he had had the indigestion, had he not?.
A Yes. At the QA he was treated with Gaviscon for it and he was fine. He did not get that at Gosport.

THE CORONER: So, you said he had not had any pain but indigestion?
A Yes.

MR LEIPER: You were fully expecting him to return home?
A Yes. So were Social Services otherwise they wouldn't have been coming round to put the bars in.

Q We have been told that there was evidence of a rectal bleed on 25 August.
A Yes.

THE CORONER: Did you say a rectal bleed or a GI bleed?

MR LEIPER: Well, sorry, blood coming from the rectum. Were you ever informed of that?
A No.

THE CORONER: What was the date of that?

MR LEIPER: 25th of August. We have been told that there was some unusual blood tests which came through, tests which showed a marked fall in haemoglobin. Were you ever informed of that?
A No.

Q Was any member of your family ever informed of that?
A No.

Q We have been told that after 26th August there is a substantial amount of evidence that he continued to pass blood rectally, and there were black faeces. Were you ever informed of that?
A No.

Q Was there ever any discussion between you and your mother and anybody at the Gosport War Memorial Hospital in relation to the possibility of his being transferred for acute treatment in another hospital?
A No. We had no consultation with them at all.

Q Was there ever any discussion, either with yourself or your mother, and anybody at the Gosport War Memorial Hospital as to why it was that he was being commenced on diamorphine and diazolam?
A No. The only consultation was the night that Dr Barton spoke to my mother and said that he was dying.

Q You have been referred to a number of passages in Professor Black's report. Do you remember this, that he said that on 26th August, when your father was identified as being seriously ill, examination was either not undertaken or recorded in the notes, an investigation which is performed is never looked at or commented on. Do you remember him saying that?
A Yes.

Q He also said that a difficult clinical decision is made without appropriate involvement with senior medical opinion. Do you remember him saying that?
A Yes.

Q He also said that a higher than conventional starting dose of diamorphine was used without any justification being made from the notes. Do you remember him saying that?
A Yes.

Q You have been reminded of Mr Black's view in relation to the course of your father's death.
A Yes.

Q You will also be familiar with Mr Wilcox's view in relation to the cause of your father's death.

THE CORONER: Wilcox is still to come.

MR LEIPER: Professor Wilcox's view, which you will be fully familiar with, is that:

> "In my opinion it is the inappropriate management of Mr Packman's gastrointestinal haemorrhage, together with his exposure to unjustified and inappropriate doses of diamorphine and Midazolam that contributed more than minimally, negligible, or (Inaudible) to his death."

That is something that you were aware of?
A Yes.

THE CORONER: Can I caution you all about the use of certain words in this court? You will know that I am a court of record.

MR LEIPER: Yes.

THE CORONER: You will know that I cannot apportion blame, there is no question of that, and therefore if you are referring to these, would you please exercise caution in the words that you use?

MR JENKINS: Well, can I also ask what the question is going to be?

THE CORONER: I have no idea. I am waiting with baited breath.

MR LEIPER: Sir, the exercise I was doing was similar to the exercise that my learned friend --

MR JENKINS: I was reminding of the jury of the evidence they have heard. You cannot do that with Wilcox, whether he is a doctor or a professor.

MR LEIPER: Well, I was reminding this witness of the evidence that she has read.

I have no further questions. Thank you.

THE CORONER: All right. Thank you. Is that it, then? That is it. Thank you very much indeed. I am grateful.
A Thank you.

THE CORONER: Now, would it be helpful to have five minutes, and then we will get to you, honestly.

A SPEAKER: That is all right. I've waited a long time. Five minutes does not make any difference.

(The Court was adjourned for a short time)

THE CORONER: Code A

Code A sworn

Questioned by THE CORONER

THE CORONER: Thank you. Code A
A That's right.

THE CORONER: How do you want to deal with this? Do you want to talk to me about mum?
A I am going to, yes.

THE CORONER: Okay.
A Thank you.

THE CORONER: Can you make sure you keep your voice up?
A Yes. My mother, "Elsie" as she was known, was one of five children. She left school at 14 and entered service. She worked for admirals and captains; started work in the kitchen. It was soon noted that she had a talent for cooking, and she followed that path of cooking for the rest of her life. She married my father at the age of 26, and had Code A Code A and Code A. It came as a terrible shock. My father said it was a good one.

During my younger years, my mum worked for a captain in the navy in Alverstoke, Gosport, housekeeping, cooking and catering for large dinner parties. She worked with them for some fifteen years and they had become close friends of the family. I used to go there during my school holidays and play in the garden, and help my mother in the house. She carried on with her cooking and cleaning throughout her working life, and also did a lot of entertaining at home. It was well noted in her circle of friends and family that she was a fantastic cook, and there was always something on the table, if anyone visited.

Mum eventually retired at 60. Both my parents were very sporty and avid cyclists. They belonged to the Gosport Cycling Club. At some stage dad was the Secretary. We always had bicycles as children. We never had a car. We used to cycle everywhere. They owned a boat, and they loved fishing. As children, we used to go with them to the Isle of Wight for holidays in the boat and spent considerable time living on it.

They encouraged us to do everything. Code A and I learned to play the piano as my mother did. We were encouraged to play tennis, and we were given tennis lessons. I was also given horse-riding lessons. They were very keen for us to get out and do things like that. We were a very close-knit family.

My father died in 1979 Code A He was not a smoker. Neither was my mother. I came home to be with dad. At that time Code A I was home for the whole period that he was seriously ill, and that was six weeks.

After he passed away Code A Six months later we had planned to come home for Christmas, and we had a Christmas family gathering whenever we could. We saw that mum was lost without dad. She had lost her sparkle. They didn't own their own house, but the garden was very large, and my dad was very, very keen gardener. Everything seemed to be falling apart for her, so I suggested that she moved from their rented accommodation and that she came to live in our family home in Alverstock. I said, "It will be a fresh start, mum. New things to look forward to, close to the beach", which she often liked to go to, and also close to my husband's family who also lived in Alverstock. She got a little Yorkshire Terrier. She decided she would move in with us.

She got a little Yorkshire Terrier and everything was perfect. Code A schooled in England. They returned to boarding school, and during their exceats they used to go home to see their Gran. They were thoroughly spoilt by her, and she was like a second mum. The three of them were exceptionally close. She would fill their tuck boxes with things that probably I wouldn't agree with.

She became slightly deaf, which progressed over the years, and she only had 30% hearing in one ear. At first, she was given an NHS hearing aid. It didn't have the latest technology, so eventually we bought a private one for her from Dolland & Aitchison. Code A noted that she also was hard of hearing with the television, always had to be up louder than anyone else, so she got a TV aid for her via Social Services. I do not know if you know about those things. It is an earpiece that goes to the television and it makes things a lot easier. We do not have to all have to listen to --

THE CORONER: So it means the neighbours do not have to share it?
A Exactly. My mother had a bad knee for years. The joint wasn't straight, and I think it was from an injury years ago, and by 1986 she stopped riding her bicycle. It had gone well over. I would have liked her to have had a knee replacement, but she declined, and she got a knee brace instead. At this time we moved to Fareham, and eventually she was registered partially disabled because of her knee.

In December 1998 she was recommended, I noted on the medical file, for a knee replacement, and I think the consultant's words were, "Sooner rather than later". Eyesight deteriorated, and she would say, "I ought to get my eyes re-tested", which she did, and she was diagnosed with cataracts. The first one was done privately because of the length of the waiting list, and the second one was done six months later on the NHS.

Mum was not a frightened person or was easily phased, and we were subjected to two burglaries. After that, she told people that she didn't live alone, she lived with Code A who was away on holiday rather than lived alone, and she would always say that to us. "Don't tell people I live here on my own. You are just away on holiday, and I am looking after the house".

Mum also suffered water retention for years, and on the odd occasion she saw her GP ,eventually, and the last two years of her life, she was started on diuretics. She also had an

underactive thyroid. Code A lived with her Gran on and off as I was still living Code A and in January 1999 she moved back to her grandmother after being Code A for a few months.

Code A that he was taking mum to the hospital for her fluid retention at the Queen Alexander. Code A said, "I will take over these visits and leave you with more free time". He lived in Gosport and we lived in Fareham.

B

In February 1999 Dr. Logan told my Code A that my mother had multiple myeloma. He wasn't particularly helpful, and he said to her, "I expect you are going to look it up on the Internet later". She said, "Yes, I will". Code A called me -- Code A – and told me my mother had multiple myeloma. I didn't know what that was, and she said, "Mum, it's bone cancer". I was horrified.

C

We returned to Code A in April 1999. My mother had been there for me all my life, and there was no way that through this difficult time I wasn't going to be there for her. In May 1999 I went with my mother to see Dr Cranfield who told me that she wasn't convinced about the diagnosis of multiple myeloma. I was shocked. She said, "We will do a bone marrow test", and during that visit she took a sample from my mother's hip. Mum was very brave, and didn't react. In fact, she put the doctor at ease, saying, "Don't worry. You get on and do what you have to do".

D

Dr. Cranfield commented to me, "What a lovely, brave lady your mother is". Mum also had a full body scan. Later, I was told by Dr. Cranfield there was no myeloma. I was delighted. Mum was then referred to Dr Stevens who changed mum's medication from the Frusemide to Frusemide and Amiloride, but she said, "You will have to finish the Frusemide first and then go to the doctor and collect the changed prescription later".

E

Mum went every six weeks or so, and I went with her. There were never great concerns raised. I knew she had a problem with her kidneys, but I saw no concerns by the doctors, so I did not have any either. It was always, "See you in a couple of months". If it was more urgent, then I thought we would be visiting more often. We went May, June, and July. She had her kidney function checked, and creatinine had been 200. In July that was, and neither of us, or the consultants, were concerned. It was a question of watch and wait. Dr Stevens said 150 was slightly above her normal age.

F

THE CORONER: Sorry, 150 was slightly above normal for her age?
A For her age. Yes. Slightly above normal for her age.

THE CORONER: And it was 200?
A No. She said at one stage -- no, she said 150 was slightly above normal for her age.

G

THE CORONER: So where does the 200 come from?
A The 200 comes when it was July. What I am trying to point out here is that 150 -- because she went to 200, and then she dropped again, my mother, to --

THE CORONER: So it comes back?
A It goes up and down.

H

THE CORONER: Right. During this time mum developed a skin ulcer on her bottom which she told me about. The day nurse visited twice and said that mum needed to move about more. I learned that I must not stop her from doing things around the house as she had always done. Basically, I fussed about her too much, and she wasn't getting enough exercise. The ulcer quickly healed within two weeks once she got back to being more mobile. She always blamed me for the ulcer that she had on her bottom.

B THE CORONER: Sorry? I lost that slightly.
A Sorry.

THE CORONER: Why was she immobile at that point?
A Because I was home, and I used to say to her, "You sit, mum, I will do it. You don't do that, mum, I will do it". I just basically fussed over her too much.

C THE CORONER: Okay.
A I hadn't seen her for a while, and I wanted to --

THE CORONER: Well, she is your mum, is she not?
A Yes. So, I am saying, you know, as one does.

THE CORONER: Yes. Do go on. I am sorry.
D A Yes. The ulcer quickly healed once she got back to being mobile, just as she had been used to before I returned home.

In June, Code A Code A However, it was inevitable. I cried every day. My mum used to get cross with me. She said, "Pull yourself together". I wouldn't get dressed in the mornings. She would get angry with me over that. I didn't
E bother to think about food. She said, "Come on. What are we having for lunch?" "Come on, what are we having for dinner?" Code A He said, "Stop crying. It's for losers. I am not going anywhere".

Things got better when Code A was a bone marrow match, and at the end of August, Code A came home on holiday, mainly because of Code A and we decided to have a family holiday because of the seriousness of Code A
F

I left meals I prepared in the deepfreeze for my mother, and Code A a family friend, would pop in to see that she was happy and okay and didn't need anything. On 9 October I was concerned about mum. She didn't seem herself --

THE CORONER: You were back from holiday by then?
A Yes. Sorry. Yes, the end of August. Now we are 9 October.
G

THE CORONER: Right.
A I was concerned about mum, as she didn't seem herself, and I asked my Code A to come to the house on the Friday evening. I had called him on two occasions. On both occasions he came up, and he really couldn't see anything wrong with my mum. On the second visit that evening, Code A and out of the blue Code A decided that she would not have my mother for the six weeks that I would be in Code A
H Code A something that had already been agreed upon. It caused a family argument. My

mother was upset about it all but she played it down.

On Saturday, 10th October I came downstairs at about 7.30 and found several cups of tea made over the kitchen tables, and biscuits on the floor. I went upstairs to see mum as she was usually up, but she was fast asleep. I thought, "How bizarre is this?" I went back downstairs, cleaned everything up, and at 8.30 I went back upstairs to my mother with a cup of tea. She clearly wasn't herself. She drank her cup of tea and she went out to the bathroom. I thought she was a long time, and so I went to check on mum. She was sitting on the toilet. She looked in pain. I asked her what was the matter. She said that it was burning. She was passing urine. I said, "Oh, you must have cystitis, and I will call the doctor". "No need to call the doctor and make a fuss. It is Saturday". I said, "No, mum, I am going to call the doctor".

She was admitted to the QA with a suspected urinary tract infection. I discussed with mum Code A and decided we would try closer to the time when she was to be released from the QA --

THE CORONER: So, she was in QA?
A Yes. Sorry. She was admitted to the Queen Alexander Hospital.

THE CORONER: What date was that?
A It was 9th October. Sorry, it was 10th October.

THE CORONER: So, it was actually the day that you were with her when she went to the lavatory?
A Yes. That's right. Yes. I discussed with Code A over the period of time, as he wasn't going to take his mother, about getting residential care, what were we going to do. My mother had had the whole family round her, was very concerned about Code A I didn't want her to be left on her own completely. I suggested Code A came up and lived in our house with Code A He was happy to do that, she wasn't. It was suggested then that my mother, when she was discharged from the QA, that she would go into St Christopher's Hospital in Fareham. This wasn't right for mum, I knew, and I said -- because her own mother had not had a good experience there, and she had this thing, my mother did, about St Christopher's.

I said to the nursing staff, and to a doctor who had called me on the telephone, that if my mother was happy to go to St Christopher's, then that would be fine. I didn't think she would be. Code A also agreed, and Code A thought perhaps the Gosport War Memorial Hospital was better, as it was more local for him.

On 19th October, my Code A Code A He was one of the oldest men ever to be offered this treatment, and we knew he was going to need a lot of support. Code A for six weeks so that we could be with him 24 hours a day.

On 21st October, my mum was discharged from the QA and would have been coming home, but as we weren't there, and he didn't want mum -- we didn't want mum to be on her own with all the worry of Code A she went to the Gosport War Memorial Hospital for respite where she was to be looked after until we could all be home together.

Code A told me the transfer went well. Mum had her own room, and was happy. Code A collected mother's clothes from home and took them to her. The next day, on 22nd, Code A left me with Code A Code A to visit mum. She was happy, but homesick. They took her a box of chocolates and shared a few.

B Code A continued to keep me informed of how mum was getting on, and at the same time checked on how Code A was doing. On 28th October I visited mum with Code A leaving Code A When we arrived, mum was in the lounge area chatting with Code A Code A a close friend who lived near by Gosport War Memorial Hospital. They were sitting in the lounge area. When Code A and I walked in, and mum saw us both, tears started rolling down her face. I said, "Oh, don't be silly", and we sat holding hands and both ended up crying.

C The bell went at about 5 o'clock, and I wondered what it was. Mum said, "Now you have to Leave so the patients can have their tea". I thought it was ridiculous, but mum didn't want any fuss. She said, "You get on back. I'll be fine".

On 4th November Code A visited again.

D THE CORONER: Sorry, what date?
A 4th November.

THE CORONER: Thank you.
A Code A visited again. Mum was fine, but, again, homesick.

On 11th November Code A and I visited, and mum was nowhere to be seen. Her clothes were
E neatly folded on the bed. The nurse noted that we were looking at the clothes and said, "That is strange". She said, "She often does that, love". I was puzzled. I said, "Perhaps she thinks she's coming home today", as she knew I was visiting. I asked where my mother was, and she said she was having a bath.

Half an hour or so later, mum came walking on her own down the corridor. At this point I was standing outside of the room where my mother was sleeping, the towel round her neck.
F Her hair was dripping wet, and no shoes on her feet, but she had a jumper and skirt, of course. The carer came to the bed and proceeded to put rollers in my mother's hair. I said to my mother, "Your hair's very short. I thought you were having your hair permed". My mum said, "Yes, but the lady who does it is on holiday. It's a right mess, isn't it". My mother was a very proud person.

We waited for the carer to finish, and we started to have our visit. We talked about Code A
G She said she prayed for him every night. I told her, "He will be home in two weeks, as will we", and we cried.

I knew she wasn't happy at the Gosport War Memorial, although she never told me, and, sadly, she never knew that Code A just like she always said he would. I planned to visit my mum on the 18th, but we had a logistic problem and we decided that we would visit on 21st. On 19th, Code A were in Fareham after a collection of a new
H car from Bruges. They would have visited their Gran, but visiting hours were not until

2 o'clock, and they wanted to get back to Hammersmith as they had been away for two days.

This has caused considerable distress, knowing now what was happening over the previous 24 hours.

No sooner had Code A arrived at Hammersmith, than my Code A called to say, "Mum has 36 hours to live", and was in Code A I was hysterical. I had Code A Code A The nurse told us to go immediately and not to worry about Code A They were taking great care of him, and in an emergency, "We will call you".

We got to the Gosport War Memorial Hospital arriving about 3 o'clock. We rang the bell to get access and Frieda Shaw, who I now know her name, let us in.
Nurse Frieda Shaw. I introduced myself and she said, "Yes, I know who you are", she said, "But your mum won't know you". I rushed along the corridor with Code A and I went into mum's room. I went straight to her bed, and took her hand from underneath the covers, and started shouting, "Mum, mum", hoping I could wake her. She was completely comatose. Frieda Shaw, standing there looking, repeated, "She won't know you, love". But she saw then my mum squeeze my hand, and said, "Oh, she knows you are here, love". I asked Frieda what had happened. She said, "I cannot comment. I have only just come on duty". She said, "Sometimes they can go on like that for weeks". She asked us if we would like a cup of tea, and we said, "Yes, please", and she left the room.

Code A was concerned at her comment, and she said to Code A and I , "How can Gran go on for weeks? There is no fluid drip. There is nothing. I don't understand her comment". Fifteen minutes later Frieda Shaw came back in, and I believe another carer was following her. We were never introduced – with the tea -- for which we thanked her.

Another two hours later she came back in again, and she said that the doctor was here to see us. We didn't request to see a doctor and we were surprised, but we understood it was probably to explain to us what had happened to our mother. Code A said to Code A and I, "You go with the doctor and I will stay here with Gran". As we exited the door, standing right in front of the door, we were faced with a female doctor who I now know to be Dr Barton. She was clutching a brief case in front of her with two hands, and Code A said, "Good evening". She did not reply, but rather turned tail down the corridor, uttering the words in an abrupt way, "Follow me". Code A looked at me and I at him and we raised our eyebrows at her abrupt manner. Frieda Shaw saw this.

THE CORONER: Mr Jenkins, this is not helping matters, necessarily. I understand your duty, but if it gets to the point where I have to do something about it I will, but I haven't got to that point.

MR JENKINS: The point is, if we were dealing with a statement, we all know what was going to be said. The way in which it is --

THE CORONER: It is all here.
A I am quite happy to answer any questions to Mr Jenkins.

MR JENKINS: I will deal with that.
A We followed in order to break the ice, and Code A said, "Are you on duty or have you

come especially?" And she replied, hostile, once more, "I have come especially", and Code A replied, "Thank you".

We followed Dr Barton into a room, more like a storage cupboard with chairs stacked in it. We sat down, and Frieda Shaw remained standing. Dr Barton said, "You know all about your mother's illness, don't you". I said, "Yes, but I cannot understand what's happened". She said, "Do you know that your mother has multiple myeloma?" I said my mother did not have multiple myeloma. I had a good rapport with Dr. Cranfield, and we spoke at great length regarding my mother's problem. She said, "Yes, I know. I have also been speaking with her". I had a good rapport with Dr Cranfield. Coincidentally, she was the same doctor that was looking after Code A

I asked Dr Barton, "When did you know about my mother's deterioration, and when was her last blood test? She said, "On Tuesday, but I did not want to worry you because you have enough on your plate with Code A and I shall be putting, 'Kidney failure', on the death certificate. I haven't discussed your mother's illness with Code A as he isn't medical, is he?". I said, "Well, no, he's not".

I was appalled at her attitude and shocked, that she knew my mother was dying and yet she hadn't told us. I was surprised about the statement about Code A

I remained calm, stood and thanked her, and returned to my mum's room. Code A followed closely behind. We didn't see Dr Barton again. I told Code A what we had been told. He was very angry. "I might not be medical, but give me a turbo engine and I'm your man". He asked which doctor it was, and I said I didn't know. I explained what she looked like. He said, "That's Dr Barton". Code A later bought up that statement at a meeting with the Trust, and also the fact that he had never met Jane Barton, even though he had requested an appointment via a nurse the week prior. At 11.30 pm we went home that evening.

On November 20th, we returned to mum's bedside at 9 am, and mum continued to squeeze my hand. I hoped that she knew that I was there and it wasn't just a reflex, as I have since been told. At 11 am Code A arrived and he was in and out all day with other members of the family. We all thought mum was going to pass away that day, because she was going for long periods without breathing, and then taking a very deep breath, as though struggling. It was awful to watch. Frieda Shaw came and told us that we would need to contact a funeral director and make arrangements. This was a real change from the previous day when she told us it could go on for weeks.

Pastor Mary, who had seen mum on several occasions, asked if we wanted to see her, and she visited us at about 3 o'clock. We spent the rest of the day with mum, and left at 11.30 in the evening. Code A said her goodbyes that evening. She didn't want to come back again and see her Gran in a worse state. She was too traumatised to say goodbye again.

November 21st, Code A and needed his family, and we knew we must return. Code A and I went in to see mum that morning. We stayed about two hours. Code A went and spoke to Frieda Shaw to inform her that we were returning to Hammersmith and to telephone us if there was any change and we would be back the following morning. I was crying uncontrollably, and Frieda said, "I am very sorry". Code A supported me, and we left. At 8.30 that night we received a telephone call from the Gosport War Memorial Hospital to say mum had died.

Code A collected the death certificate and took it to the Registrar. She would not accept the death certificate as a recognized cause of death. Code A went back to Dr Barton and waited some four hours, and Dr Barton finally saw Code A She did not acknowledge that he was even speaking to her, and just stared at him when he was explaining to her about the Registrar. She took the certificate out of his hands without saying a word. She added the words, "Chronic glomerulonephritis", and passed it back to Code A stating, "Your Code A isn't happy with us, is she". He replied, "I have no idea". He was surprised, as he didn't know why Dr Barton would say that. I was just as surprised when Code A told me later on the telephone. It did make me start to think that something was not in order.

THE CORONER: Can you try and cut the speculation a little bit and can we deal with --
A I am just saying as the story is, sir.

THE CORONER: I understand.
A And I am happy for, you know -- I am very sorry, but, you know --

THE CORONER: Do not apologise, please.
A It is just the way it happened.

THE CORONER: Yes. Okay.
A Over the course of the next week – again, I know what you mean, it is speculation -- I spoke a lot about my mum's death to the staff at Code A because we were all still --

THE CORONER: That is somewhere I am not going to go.
A I know. I am just going to say because to us, things were not right. I mean, Mr Jenkins spoke earlier, sir, about me reading my statement, and I am not doing so. I am just reading this, so in my statement were we going to be omitting some of this?

THE CORONER: We will omit evidence where you were being advised about the status of your mother's death by others.
A Okay.

THE CORONER: You can tell us what your concerns were.
A Okay.

THE CORONER: Does that make sense?
A I will try and put it in a different way.

THE CORONER: Okay.
A Thank you. We were very close to the hospital staff at Code A You can appreciate; Code A had 24/7 care, and they knew the trauma that I was under, the sudden death of my mother. So, we spoke about different things, and I told them that there was no drip up, and when I arrived she was in a coma.

Code A discovered the syringe driver on the Saturday at the hospital. My mother seemed to have pushed down in the bed, and he wanted to lift her up to make her more comfortable, and he noticed the syringe driver under my mum's pillow. We didn't even know

she was on a syringe driver. It wasn't the sort of syringe driver that Code A was having at Code A

THE CORONER: Did you see it?
A Yes.

THE CORONER: Or was it just what Code A told you?
A No. I'll get to it, shall I?

THE CORONER: Thanks.
A As he lifted his grandmother up and plumped up the pillows, he noticed this small device under the pillow and it ran down and into her back, into her shoulder. We didn't really know what it was, or that it contained morphine, and we never asked. We assumed that is what the procedure was. It was Code A that said, "I think this is a syringe driver". I also explained to the staff that my mother's kidneys were not good. Am I allowed to say that?

THE CORONER: Yes.
A She was on Frusemide Amiloride, and I probably understood that one day that is probably what she would die of -- her kidneys would not be functioning – but I also understood at that time that she would become very lethargic.

It was suggested to me, to alleviate my concerns, that when I returned back home with my husband, that I looked at my mother's medical file to put my mind at rest.

Code A returned home for the Christmas, and on 6th January I wrote to Max Millet --

THE CORONER: Can I ask you where we are going now? You remember when we discussed this – forgive us for a second – when we discussed this originally I was concerned that --
A I am not going into all that.

THE CORONER: Okay. We were looking at the current situation there and then.
A I am just talking about that I wrote to Max Millet and I wanted to view my mother's medical records, and this is me seeing it first hand.

THE CORONER: Right. Okay.
A Is that all right?

THE CORONER: That is fine.
A That is why I am not reading my statement.

THE CORONER: All right. Thank you.
A I wrote to Max Millet at the Portsmouth Healthcare Trust, raising my concerns, and were invited to visit the Gosport War Memorial Hospital, and take a view copies of various things. We were not allowed to have a full copy of the medical file. I didn't get a full copy of the medical file until 2002. I have a letter here stating why.

I was shocked to see the cocktail of drugs that my mother had been administered in the last four days of her life. My first concerns was the Fentanyl patch. Code A had been given this at Code A for the chronic pain he was in. I also witnessed the side

effects. I was also concerned regarding the nursing notes. Putting together the drugs and her care I noticed that she was bathed and her hair washed on the 15th, the 16th, and the 18th, the 18th of November being the very day that 25mg of Fentanyl had been administered to my mother for the alleged pain she was in. I knew Sandra had visited that day in the evening, in the afternoon, and you will hear a statement later.

In the evening my Code A was sitting with his mother in the lounge area. No-one informed this family regarding the Fentanyl patch. Nobody would have known. We couldn't see it.

THE CORONER: Well, presumably you didn't know, did you?
A No. You couldn't see it.

THE CORONER: You are saying it is not until you had seen the notes that you realised that that had been there?
A Exactly, and my mother would certainly not have known either.

I think it was 2002 I eventually got the full medical file. I noticed a letter suggesting that she was suffering from dementia. I was shocked, as was the rest of the family. I really couldn't understand. This was never discussed with any of the family, or, indeed, in the independent review, because if my mother was suffering from severe dementia, I think I would have known. Forgetful at times --

THE CORONER: Where does the, "Severe", come in?
A It is in a letter from the psychiatrist, then she says my mother was very deaf so she may not have heard. My mother sent us cards and letters which were not the pen of a demented lady.

THE CORONER: They were sent by mum?
A They were sent by my mother, and she had told us from the notebook.

THE CORONER: You have seen this. There certainly are copies available. We will get those to you. Have you got spare copies of these? I wonder if we could have those. (*Documents handed*) Thank you.
A I did take copies of them.

THE CORONER: I took lots of copies as well, after our conversation. Is it easier to read them?
A Yes. Shall I carry on?

THE CORONER: Yes. Go on.
A "Well, Code A and family, I am pleased to hear you are all right. I have been looking every day for news. It was great to hear everything is all right. Well, I have a lovely place to live in and they treat me as high as a queen. I have my own little flatlet with all my food. I have, they think the world of me (?). One thing, I am not allowed out on my own. Code A comes every day, and Code A bought me a pair of pink bedroom slippers. Code A bought me a pair of house slippers. They bath me. Friday week they are coming to perm my hair. I have had three doctors to see me. I feel lost without you all, but never mind. The important thing to me is that you are all all right. Nothing

else. I do not get up until 8.30, and one day they let me stay in until lunchtime, and all I did was watch the telly."

She had a private room when she went in, initially, and then -- this was after my last visit on the 11th. She may have written it the next day on the 12th:

"To Code A ..."

This is obviously a reference to my visit:

"Glad to hear you are both going on all right. Love mother, also Code A All's well here. Mother".

She often sent cards all the time to Code A at boarding school. It was a thing she did. I had more cards than anyone could think about. I find it difficult now to understand why Dr Barton commenced intense palliative care without discussing with me or my family first so that we could have the opportunity to be with our mother.

THE CORONER: Thank you very much indeed. Ms Ballard?

MS BALLARD: No thank you, sir.

THE CORONER: Mr. Jenkins?

Questioned by MR JENKINS

MR JENKINS: Well, the fact is she discussed it with Code A and it is noted in the contemporaneous medical records. It was discussed with Code A It was discussed with the, Code A is what it says.

A Can you -- in the medical records?

Q Well, I am suggesting it is there.

A Okay. Okay, Mr Jenkins. Thank you.

Q Can we just deal with confusion?

A Yes.

Q Do you say your mother was not confused?

A Well, I can only say from what -- family visits, and I can only go by two cards and a letter she wrote to me, and visits and talking. I do not know. You tell me.

Q I will do.

A Thank you.

Q Here is an entry for 12th October, 1999. It is a review at the Queen Alexandra:

"Patient still very confused, very aggressive, refusing all medication. Threatening and physically harming staff".

What do you say about that?

A What I say about that is that when she went into the Queen Alexandra Hospital she was confused.

Q Aggressive?
A And maybe aggressive. I never witnessed that, but I will say to you, Mr Jenkins, that also can be caused by a urinary tract infection, and that is what the doctor told me.

B Q On 25th October she was described as, "Mildly confused". On 1st December, "Quite confused and disorientated".
A Excuse me, Mr Jenkins --

Q 1st November, I am sorry:

"Quite confused and disorientated".

C

15th November:

"Very aggressive at times. Very restless".

18th of November. This is from the psychiatrist:

D "This lady has deteriorated, has become more restless and aggressive. She is refusing medication and not eating well".
A Yes.

Q Do you say that is not accurate?
A I do.

E Q You do?
A Can I just go back to your first question, please?

Q You can.
A You spoke about Code A as you know, six months after my mother, and we had some 100 letters back and forth with the trust.

F Q Yes. I have got them all here.
A And meetings. Well, you will note from that letter, one of those letters, then, Mr Jenkins, the letter my brother wrote to Mr. Millet.

Q Well, we can talk about the way in which the Trust and the Chief Executive have dealt with things if you want to –
A I don't mind.

G

THE CORONER: I do not want to.

MR JENKINS: There were a series of meetings.
A That's right.

Q You complained about everything, Code A Is that fair? You complained about the Queen Alexandra before your mother went to Gosport?

H

A Do we want to talk about that?

Q No, we do not.
A Because I am quite happy to bring up that.

Q I just want to put things into –

B MR LEIPER: Sir, with respect to my learned friend, in light of our earlier discussions today I had understood that we were not going to be going into issues about concerns in relation to -

THE CORONER: No, definitely not. I really do want to confine this really to mum's death.
A Thank you.

MR JENKINS: I just want to put it in context, though.
C A Yes.

Q I don't want to go into the detail of the complaints that you had about the Queen Alexander, but it is just the fact that you complained about that hospital.
A Well, I am sorry, if you are going me that question, Mr Jenkins, then I am going to respond, because when I went in there I thought my mother was having the best care.

D THE CORONER: This is the QA, we are talking about?
A Yes. This is talking about the QA, a patient, not one, two patients --

THE CORONER: Well, no. No. I really am not going to go any further than that. Seriously, I am not. I need to limit this to mum's death, and that is actually the important thing, from my point of view.
A Well, I am sorry, sir, but Mr Jenkins is answering the questions and I am not being
E allowed to respond.

THE CORONER: But he's asking you about mum's death.
A No. No. He said --

THE CORONER: And the fact that you were uncomfortable with that.
A No. He was saying that I am a complainer, and I am not going down that road, because
F I am not. Far from it.

MR JENKINS: I think you complained about nursing staff speaking to Code A who was listed as your mother's next of kin. As a contact, rather, sorry.
A I was also a contact. I complained about, sorry?

Q You complained about the nursing staff in rather bitter terms, about them speaking to
G Code A about his mother's death?
A Well, that is pure hearsay.

Q I will read you the note and you can comment, "18th October, 1999." This is written by a nurse.
A That's right.

H

Q "Code A rang me and asked what was happening with her mother. Was very distressed and aggressive towards me verbally, asking how dare I speak to the Code A and make plans with him and not herself as 'he couldn't care where she went'. I tried to reassure her but she wouldn't listen to what I was saying. She does not want her mother to go to St Christopher's, full stop! She will be contacting the GP and the psychiatrist to see if they can get a bed at the Gosport War Memorial Hospital".

B Is that an accurate report of the conversation?
A No. It is not.

Q It is not?
A No. It is not her talking to Code A it is talking to Mrs Devine. I can also say there that she goes on to talk about Code A because of it and I cannot understand why that is on the nursing notes, because it is completely irrelevant to my
C mother's medical file.

THE CORONER: I am now confused.
A Yes.

THE CORONER: who was that conversation with?

D MR JENKINS: You are the Code A are you not?
A Yes, I am.

THE CORONER: Is that a conversation with you, or are you saying it is with your brother's wife?
A No. He's quoting something, a conversation, over the telephone that I had with a nurse who I didn't know at the time, her name.

E THE CORONER: But it is a conversation you had?
A Yes.

THE CORONER: Saying that you wanted mum to go to Gosport and not to St Christopher's? Is that the conversation we are talking about?
A If that is what he's saying. He's mum mumbling, and, I am sorry, can you talk slower,
F too?

MR JENKINS: I will not mumble. 18th October, 1999:

"Code A rang me and asked what was happening..."

A No. Code A did not ring. Code A did not ring.

G Q This did not happen?

MR LEIPER: Sorry, I do hesitate to interrupt my learned friend, but you have made it clear that matters which may or may not have happened at QA, and concerns that may have been expressed, have no relevance in relation to cause of death.

H

THE CORONER: Well, I think the problem I have got here is that we are looking at why mum goes to Gosport instead of St Christopher's, which I was taking as being the significant point here, as whether there was any conversation between the QA and Code A that would have informed her of her mother's condition. Sorry, that is circuitous, isn't it, but what Code A is saying is that she was not informed of mum's condition, there was no communication, or very little communication, that it was unsatisfactory.
A At Gosport War Memorial.

THE CORONER: Well, I think this point goes to QA, does it not?
A I need to have it in front of me, and I don't really understand where it is coming from.

MR JENKINS: I am just reading the notes.

THE CORONER: Are we talking about the level of communication? Is that what we are looking at?

MR JENKINS: We are looking at the evidence that this lady is someone who complains a lot.

THE CORONER: Well, I am not sure that is going to impress the jury or me in any way at all. I mean, I hear what Code A has said, and I take her evidence as she has given it. I do not think it is helpful to say if she is a complainer or not. What is that going to achieve?

MR JENKINS: Well, it is relevant, as well, to why it was that Mrs Devine went to the Gosport War Memorial, the suggestion is being made that it was because of this lady, the daughter. I am just saying that that is where she wanted to go.

THE CORONER: I think that is what she said in her evidence. I mean, that is what you said, isn't it, that the conversation --
A It was agreed, yes, that she would go.

THE CORONER: That there was no way that she was going to go to St Christopher's.
A She didn't want to go to St Christopher's.

MR JENKINS: I think you were also concerned about things that happened at Gosport. You did not like the rollers that were used in your mother's hair.
A No, and, again, that was brought up with the trust, and that was checked upon, and I had an apology for that.

Q And I think you did not like the practice that they had of asking relatives to leave at mealtimes.
A No. Well, we were traveling down from London, and I was only coming once a week, and I thought under the circumstances, if my mother was dying, someone would have told us, and allowed us to be with her 24/7.

Q I think you did not like someone turning the television off at some point?
A No. You are not going to go down that road. I am going to answer that.

THE CORONER: Please do.
A We were sitting with my mother, and we did not know what to talk about eventually, so my son turned on the television, and we talked to my mother what was going on on the television, talking through the news, or whatever programme was on. A nurse came in, two carers came in, and asked us to leave. They wanted to turn my mother, and as we walked out of the room, they turned the television off and glared at us in a very uncomfortable manner, and that is why that is in my statement. I found it very upsetting, as if they were implying that I was sitting in there watching a television when my mother was dying.

MR JENKINS: You did not really get down to see your mother until the 19th?
A No. That is true.

Q We have heard that you had other things on your mind.
A That's right, Mr Jenkins.

Q But up to that time, communication was with your brother?
A And me. Code A communicated -- my brother and I were very, very close.

Q That may be right.

THE CORONER: I think the channel of communication was essentially your brother, and he then shared it with you?
A My 'phone number was there. They could have called me any time.

THE CORONER: No. Can we go to the point? The channel of communication was your brother?
A That's correct.

THE CORONER: And he then shared the information with you so you were informed through him, but not directly from Gosport?
A That's correct.

MR JENKINS: You told us that, "No one informed this family of the use of the Fentanyl patch". that is not right. Your Code A was informed.
A Excuse me, it was put on on the 18th, so when was my brother told?

Q He was spoken to that day.
A What, on the 18th?

Q I think so.
A I do not think so, Mr. Jenkins. I think you need to check the file.

Q There we are, but I suggest the contemporaneous notes show that your Code A was told --
A Code A was not told.

Q -- about the condition and the prognosis.
A Code A was not told, and I would like to see the proof right now where he was.

Q Can you just tell us about the records that I have given you, about the confusion? Are you saying that those have been fabricated at some later stage?
A I am sorry, Mr Jenkins, but you have just asked that Code A was told, and I want that point to be clarified now. You said Code A was told on the 18th.

Q It will be clarified in due course.
A Oh good.

Q Can I come back to the confusion?
A Yes.

Q I have read to you a number of medical records talking about your mother being confused.
A Yes.

Q When do you say those entries were made? I have given you dates in October, November.
A Well, like the nursing notes, ten years ago, Mr Jenkins.

Q They were made contemporaneously? You will accept that?
A I am not going to accept it, no.

THE CORONER: Can I just say that, so far as I am concerned, the notes that we have been looking at, the notes that we have access to and of which I have the originals, I view as being the contemporaneous records of mum's time in Gosport.
A Yes. That's right.

THE CORONER: There is nothing that has swayed me to the contrary. That is what I am going to accept. Unless and until somebody can show me that these are not contemporaneous records --
A Are we talking about confusion now?

THE CORONER: Yes. It is in here.
A Yes. Can I just say on that point that the psychiatrist who did the test on my mother –

MR JENKINS: Dr Taylor?
A Hmm hmm.

THE CORONER: Can I also clarify something else, that if you disagree with what is being said --
A No, it is not --

THE CORONER: That is okay. I do not have a problem with that, but if you are going to say that the records are not the original records and they are falsified --
A No. They are the original records. They are not good records, but I would just like to say that if my mother was agitated and confused and aggressive, then why was she bathed and her hair washed the day that she was applied a Fentanyl patch? One is not allowed to ask questions, I realise that.

MR JENKINS: You are right. I am wrong about the date. It was 19th November, it says --
A Thank you, Mr. Jenkins.

Q Just listen to the entry, and I will try not to mumble:

"Son seen and aware of condition and diagnosis".

B That is 19th November. That is your Code A that is being referred to, is it not?
A That's right, and at that time, right when that entry was done, my brother telephoned me, but on 18th November, when the Fentanyl patch had already been applied, and as we have discussed, 135mg of diamorphine, nobody, nobody knew.

Q What we have heard was that on the previous day your mother was very confused and aggressive, was refusing medication. That is the psychiatrist's entry.
C A Yes.

Q She was a bit of a management problem.
A Yes, but she also told the psychiatrist that morning that she had a sore mouth.

Q How does that help us?
A Well, it helps you in the fact that --
D

Q Does it mean she wasn't aggressive?
A She didn't tell the psychiatrist that she was in severe pain.

Q Well, what we know --
A And she said she was happy.

E Q What we know from the British National Formulary is that if one is to use Fentanyl, then what is recommended as 25microgramme patch which is what was used.
A 135mg of diamorphine by the time she woke up that morning.

Q I am just talking about the Fentanyl patch. A 25 microgramme Fentanyl patch for someone who has not had opiates before is what is --
A For chronic contractible pain.
F

Q -- is what is suggested?
A For chronic contractible pain, which is what my husband was having.

Q We are not talking about your husband, we are talking about your mother.
A No, and I am telling you that that patch was for chronic contractible pain.

G Q Yes. You know that your mother's behaviour was such that it would have been dangerous to approach her with a syringe?
A Why not give her Oramorph? Why not give her --

Q Well, I wasn't going to argue the case with you, but you will recall --
A No, but you will see in time.

H

Q Let us do it now. Again, the psychiatrist, Dr Taylor, the very day that the Fentanyl patch was used, "She is refusing medication and not eating well". He says:

"She has deteriorated, become more restless and aggressive again".

What I suggested to Professor Black, and with which he agreed, was that to try and use a syringe would be dangerous, both for the staff, and potentially for your mother as well?
A I think there is also another entry to that which we clarified earlier on, sir.

Q If she is refusing medication, oral medication is not going to be very helpful.
A Do you remember? Which is additional to that, and Mr. Jenkins is only reading out one bit in the file.

Q Do not worry. You have your own evidence. You may read that out.
A That's right.

Q Can we come to Professor Black's view? He describes your mother as an example of the most complex and challenging problems in geriatric medicine. Do you agree with that?
A If that is his opinion.

Q You don't agree with it, do you.

MR LEIPER: Sir, with the greatest of respect to my learned friend, I am not sure whether this witness's view of that expert report really is evidence which assists this jury.

THE CORONER: I am sure it is not, but the difficulty is that Code A has made the assertion, and against that she has got an answer to it and wants to say --
A I said it is his opinion, and, surely, sir, that is correct. That is his opinion, well, you get lots and lots of opinions. Professor Black also said he could find no justification for the strong opiates.

THE CORONER: I don't need a rerun of Professor Black, if you like. I do not know where you are going with it, Mr Jenkins.
A But I am not an expert, and I do not think Mr Jenkins is either, in that field.

MR JENKINS: But I am entitled to ask questions, and I will do.
A And I am responding.

MR LEIPER: Well, with respect to my learned friend, he's absolutely entitled to ask questions which will elicit evidence which will be of assistance to the jury in their deliberations. Code A views as to Professor Black's report or Professor Woodcock's report is not evidence which is going to assist the jury in any material particular, and in those circumstances, I object to this line of cross-examination.

THE CORONER: They are very strong words for a coroner's court. I am not used to that kind of thing.

The answer to the question is that if we were to move forward, I have absolutely no difficulty with it. What I don't need is a rerun of Professor Black through the eyes of Code A if it is not going to be helpful, and if there is not a specific point that we are going to take. If it is

just a general rerun then no, let us not do that. I do not know where you are heading with this.

MR JENKINS: I just wanted to respond to the last comment that Code A made, which was that she finds it difficult to see how Dr Barton commenced palliative care in respect of her mother.
A Yes.

MR JENKINS: I wanted to remind Code A and the jury of the comment that Professor Black had made on exactly the same point.

THE CORONER: The, "most complex and challenging condition"?

MR JENKINS: Well, Professor Black, at page 18 of his report, paragraph 6.16 says, on 19 November:

> "Mrs Devine was reported as extremely restless and aggressive and in some distress. In my view it would now be inappropriate not to provide high quality palliative care".

THE CORONER: It is a rerun of Professor Black.

MR LEIPER: It is a rerun, and if and insofar as this is a productive exercise, I will have to do exactly the same thing with Professor Woodcock's report, and in my respectful submission it is not something which is going to assist this jury.

THE CORONER: Well, I think you are right.

MR LEIPER: Thank you.

MR JENKINS: Now, you are aware of the view of the nephrologist as well, are you not, Dr Dudley?
A Yes.

Q I hope we hear from him in some form or another.
A Yes.

Q But you will know that patients who may be in terminal renal failure, a confusional stage is a typical presentation?
A I do not know that, no.

Q That an appropriate form of treatment for patients in the terminal stage would be strong opiates, particularly those who are agitated and restless, to ensure comfort and calm to enable nursing care.

THE CORONER: I think that was the drug of choice, wasn't it, was how Professor Black referred to it.

MR JENKINS: Of course. Do you have concerns about that, that that should be the view expressed by the experts?
A I am no comment.

Q You are no comment?
A Yes.

THE CORONER: I think it is fair to say you cannot comment. Is that right?
A I cannot comment. Yes.

MR JENKINS: What was your reaction to the three independent reports that were commissioned, two of them inquiries, one of them an independent report --

THE CORONER: Well, I do not want to go there either. You know, I have been quite careful not to bring those in.

MR JENKINS: Well, they are being brought in, aren't they, by the witness?

THE CORONER: No, they haven't. Not at all. I think there has been inquiry, but have very, very particularly left those out of account. They are after the event. They are post facto judgments, and they are not matters that this jury will find helpful. It will be their judgment, at the end of the day.

MR JENKINS: I think they would, with respect, but you don't want them to go in, and in which case they shall not.

I think when you saw Dr Barton you went to a room to have a discussion about your mother?
A That's right. With Code A

Q You describe it like a storage cupboard with chairs stacked in it. I think there was some zimmer frames in as well.
A Well, when I walked in it was dark. Along the wall -- I can picture it. I can draw you the picture now -- there was chairs, there was a table, there was chairs stacked on it. I suppose the -- where we were seated there was just enough for a chair -- the chair in the row, Dr Barton sat there, I sat there, it was in a row like that. It wasn't a circle.

Q I am suggesting that was the only room there was.
A Well, I am just saying how it was. I mean, you know --

Q It didn't seem ideal, do you agree?
A No, it didn't seem ideal.

Q I think you said that your son went to Gosport on one occasion and you described it as Dr Barton keeping him waiting for four hours. Did you know then --
A No, not my son, it was my Code A No. He's a very busy man, and he said, "I had to wait four hours".

Q Did you know then that Dr Barton was only there for very limited periods of the day?
A Probably not.

Q Probably not?
A I know we never saw a doctor, and I know he requested to see one the week before.

MR JENKINS: Thank you very much.

THE CORONER: How long would you like, Mr Leiper?

MR LEIPER: I will be extremely brief.

THE CORONER: Excellent.

B

Questioned by MR LEIPER

MR LEIPER: Code A you have been asked about your recollection of the evidence of the psychiatrist's review which was conducted on 18th November. Is it your recollection that on 18th November the psychiatrist said:

C

> "Reviewed on ward, happy, no complaints, waiting for her Code A not obviously paranoid, says tablets make her mouth sore".

He concluded that the plan was to transfer to Mulberry Ward when a bed was available.
A Yes, I did read that, but we had no idea that my mother was going to Mulberry Ward. That is true, yes.

D

MR LEIPER: I have no further questions.

THE CORONER: Ladies and gentlemen? No? All right. Thanks very much indeed. Thank you very much indeed. We will break now and start at two o'clock with Mrs Briggs, then I will go to Dr Reid and continue Dr Reid tomorrow, if that is all right with everyone. All right. Thank you very much indeed.

E

(Luncheon adjournment)

(In the absence of the waiting jury)

THE CORONER: Ms Ballard?

F

MS BALLARD: Sir, I just wanted to briefly raise with you before proceeding this afternoon the manner in which you are intending to approach the evidence of Dr Reid.

THE CORONER: Yes?

MS BALLARD: He has produced statements in respect of two patients, being Mrs Devine and Mrs Gregory.

G

THE CORONER: Yes.

MS BALLARD: So far as the statement in respect of Mrs Devine goes -- there are two statements which he has written.

THE CORONER: Yes.

H

MS BALLARD: One can quite happily be put into a camp of being factual evidence detailing his specific involvement and his entries in the notes with respect to Mrs Devine.

THE CORONER: Yes.

MS BALLARD: The other statement, really, is his commentary and opinion on the prescriptions that were written up for Mrs Devine.

THE CORONER: They are two considerable statements, are they not?

MS BALLARD: They are not inconsiderable.

THE CORONER: One is sixteen pages -- they are both sixteen pages. Perhaps it is just coincidence.

MS BALLARD: No, sir. The first is 21 pages, and the second is 16 pages. I think there are copies in duplicate with different dates, so you may be referring to the second statement which is 16 pages long, being twice in your bundle.

THE CORONER: Forgive me whilst I just scan this. Yes. Why have I got one date of 4th October, 2004 and 26th November, 2004? A sixteen-page statement, plus the 21-page dated 26th November?

MS BALLARD: Sir, they are both identical. As I understand it, there are two statements dated 4th October, and there are two statements dated 24th November.

THE CORONER: I see. Right. Which one of those do you want me to take?

MS BALLARD: I am more than happy for you to take the entirety of the 21-page statement, which is factual evidence regarding Dr Reid's clinical involvement with Mrs Devine.

THE CORONER: Yes.

MS BALLARD: So far as the second statement goes, that is the sixteen-page statement, whilst it is entirely right, I submit to you, sir, for Dr. Reid to provide an opinion as to prescriptions which would have been written up for Mrs Devine, that would have been reviewed as part of his consultant ward round, this statement goes further than that.

THE CORONER: Yes.

MS BALLARD: You will know that the last occasion that Dr Reid sees Mrs Devine is on 15th November.

THE CORONER: Yes.

MS BALLARD: And at page 7 of that statement, sir, you will see that towards the bottom, starting -- in mine it is the fourth paragraph up --

THE CORONER: 18th November 1999?

MS BALLARD: Yes. From there on in, Dr Reid offers an opinion as to prescriptions about which he has no involvement.

THE CORONER: Yes.

MS BALLARD: And in the circumstances --

THE CORONER: You wouldn't call him as an expert.

MS BALLARD: -- we have Professor Black giving evidence, and who clearly has a dispassionate view. I am more than happy that those not are referred to.

THE CORONER: Let us take out page 7 onwards. Is there anything after that?

MS BALLARD: Well, it is not the entirety of page 7, sir. It is from 18th November 1999 onwards. Prior to that he's commenting on matters that he would have had knowledge of with his consultant ward rounds.

THE CORONER: Right. 8-16 then come out?

MS BALLARD: Yes. The bottom part of 7, and then 8-16. I am grateful.

THE CORONER: So that comes out in its entirety.

MS BALLARD: So, sir, they should be, in effect, one-and-a-half statements from Dr Reid with respect to Mrs Devine.

THE CORONER: Thank you.

MS BALLARD: With respect to two other patients that Dr Reid had involvement with, that is Mr. Packman and Mrs Spurgeon, he has not produced any witness statements in respect of those.

THE CORONER: No. He has not. I wondered what he was going to do with those.

MS BALLARD: Well, sir, can I suggest, and it is a matter entirely for you, but if I could identify for you the pages of his clinical entries and then when you ask him questions you can take him to those, and that is the extent of his knowledge, really, on those matters.

THE CORONER: Why don't you lead him through it?

MS BALLARD: Sir, yes --

THE CORONER: I have no objection to that. He's effectively yours, isn't he?

MS BALLARD: Well, he's yours.

THE CORONER: I know he's mine, but produced by you, is he not? On your authority?

MS BALLARD: Well, sir, strictly speaking he's produced by yourself. You have required him to assist you with your inquest.

THE CORONER: Yes.

MS BALLARD: I have no objection to doing that, sir. I am more than happy to give him the page references. It may seem odd to the jury to approach it in that way, but I am more than happy to be guided by you, sir.

THE CORONER: I do not know if he thinks differently. Tell me where I am going, then.

MS BALLARD: Page 24, with respect to the notes regarding Mrs Spurgeon. These are the Gosport notes. They are the two entries that he makes with regard to Mrs Spurgeon. The only other relevant entry is an entry on page 84 of the QA notes -- sorry, no, the Haslar notes -- and then with regard to Mr. Packman as identified by Professor Black, Dr Reid only saw Mr. Packman on the one occasion. That is at page 55.

THE CORONER: That is the Gosport notes?

MS BALLARD: Yes.

THE CORONER: It will take me a long time to understand any of this when I come to look at it later. Right. Have we got those pages of notes? I am grateful, sir. Mr Leiper?

MR LEIPER: Sir, just to save me getting to my feet in the course of this afternoon, can I just say that it seems that the approach adopted by Ms Ballard in relation to Dr Reid is entirely appropriate in the circumstances. It is not appropriate that he should be giving expert evidence. He's here to give evidence on matters of fact, and if there are questions which invite his opinion in relation to adequacy in relation to adequacy of steps done, that falls into the category of expert evidence, and if, sir, you would like him to go through chapter and verse as to why this is inappropriate in the course of this inquest, I will do so.

THE CORONER: I dare say that whoever is going to ask the questions would be far better asking it of Dr Woodcock unless that will present any problem. I mean, if you want to ask the question, let me know and I will vet it.

MR JENKINS: Well, I do want to ask him questions. Obviously, they are his patients and he knows what treatment is being provided to his patients in general terms.

THE CORONER: Is that what you could have done?

MR JENKINS: Well, I do not know, from what Mr. Leiper is saying, he does not want Dr Reid to be taken through individual prescriptions or administrations of medicine when Dr Reid wasn't there, and I am content with that.

THE CORONER: Well, he is the consultant in charge, is he not?

MR JENKINS: I agree with that, and I think what you have been told is that it is not proposed that Dr Reid should be asked to comment on individual doses that were --

THE CORONER: Surely, it is not comments on the treatment regime, then that would be valid, wouldn't it, because he's the guy at the end of the -- where the buck stops.

MR JENKINS: Well, that is my view.

THE CORONER: But I think if you are going to ask for an expert opinion from him I wouldn't want to do that, but if you wanted his comments on the treatment that was there, and the treatment that was administered, then I would take that.

MR LEIPER: Unless I misunderstand the position, it is appropriate that he should do that up until the end of his particular involvement with patient. The treatment thereafter --

THE CORONER: Yes, I think that's right.

MR LEIPER: The treatment given thereafter is not appropriate for him to --

THE CORONER: I do not think it would be helpful, would it?

MR LEIPER: Well, in my respectful submission it would be inadmissible.

THE CORONER: Oh. Now that is a difficult word for a coroner to come across as well. Not one that I am accustomed to, I have to say.

MR LEIPER: As I say, I do not know whether --

THE CORONER: The answer to your question is that nothing is inadmissible from my point of view. The only question in my mind is how much weight you attach to it, and it is almost a sliding scale, and I think the evidence that you are looking at would have fallen off the end of the scale, but the evidence that you are looking at, I think, is quite germane, because it is whilst he's the consultant in charge.

MR JENKINS: Well, what I also would like to ask Dr Reid is; what does he mean by all this?

THE CORONER: Well, it is a question of fact.

MR JENKINS: Absolutely.

THE CORONER: I do not think we are disagreeing, if that is any help.

MR LEIPER: Yes, and just for the sake of clarity, and there should be no uncertainty about this, so far as the propriety of the drug regime which was administered to Elsie Devine after 15th November is concerned, those are the pages that you have taken out of the statement, and that is the evidence that we object to. I am grateful.

THE CORONER: Right. Can we have the jury, please?

(In the presence of the jury)

THE CORONER: Are you restored to the rudest of rude health? Good. Let's deal with

Ms. Briggs, please.

Code A sworn
Questioned by THE CORONER

THE CORONER: Hello, Code A We have not met before, I believe. Code A
A Yes.

B

THE CORONER: Your relationship to Mrs Devine?
A Code A

THE CORONER: Code A
A Yes.

C

THE CORONER: Code A
A Yes.

THE CORONER: Tell me about your experiences with Elsie latterly, when she went to Gosport. Did you see her before she went to Gosport, when she was in hospital?
A Not when she was in QA, no.

D

THE CORONER: The first time you see her is at Gosport?
A Yes.

THE CORONER: When was that? Do you remember? You have got your statement there. You can refer to that.
A Yes. I visited her a few times before the last time I visited her. I went three or four times on my own. I went Code A and I went Code A on another day.

E

THE CORONER: Take me to the first visit that you have documented:

"Code A phones me to tell me that Elsie had been admitted into QA at the end of October or November 1999".

A Yes.

F

THE CORONER: " ...with a urinary tract infection. Code A understood that after the infection had cleared she would be allowed home".

A Yes.

THE CORONER: "At that stage Code A [we have heard from her]...with Code A Code A It was a difficult time for her. I believe there was no-one at home to look after Elsie and she was transferred to Gosport War Memorial Hospital".

G

A Yes.

THE CORONER: "Saw her several times in Gosport. Never saw her in her room, she was always in a communal room sitting in a chair".

H

A Yes.

THE CORONER: "Visited once with Code A three or four times on My own. Visited during the daytime. Whenever I saw Elsie she always seemed fine. She appeared to be no different than when she was at home. Always recognised me, Always talked. Never seemed to be any pain or distress. To me she seemed quit normal".

A Yes.

THE CORONER: "On each visit she told me she wanted to go home. I took this to be a good sign she was feeling fit and well".

Whenever she said she wanted to go home you told her that Code A wasn't at home, and she really could not go home until Code A was there.

A That's right.

THE CORONER: You weren't aware of any medical reason which would prevent her from going home; it was purely the fact that Code A was not there.

A Yes.

THE CORONER: You visited on Thursday, 18th November. Tell me in your own words about that visit.

A Well, I went in to see her in the afternoon, and the nurses had just washed her hair, and they brought her into the communal lounge. Her hair was still wet, and I said that I would dry her hair, which I did. I dried her hair. It didn't take long because her hair wasn't very thick, and then I asked the nurses if I could take her to have a cup of tea, which is just through into a little cafe place, and they said no, I couldn't take her. I couldn't understand why not, and so I went through and got the tea and brought it back, one for her and one for me. She drank it all right, nothing wrong. We chatted and reminisced, and she told the other ladies that were sitting in there, "Oh, this is Code A We used to have good times together", and we were all laughing and joking about the times we had, and then I got her to sign her pension book, because Code A bought it over the night before and said to me that, you know, she wanted her to sign it, and she signed it in her name, and she signed on the back for me to collect it for her. I stayed there for about an hour-and-a-half, and then I had to go to go to the Post Office to draw this money. That was the last time I saw her, and she was perfectly all right when I was there.

THE CORONER: That was 18 November?

A That was 18 November, yes.

THE CORONER: And the previous visits you had with her, they were perfectly normal? She was the normal self that you had known?

A Yes. She wasn't in any pain, she was always laughing and joking with me, talking about old times.

THE CORONER: Did she tell you why she was in Gosport? Did she tell you why she was in Gosport?

A No. I never asked her.

THE CORONER: All right. Thank you for that. Questions?

Questioned by MR JENKINS

MR JENKINS: Just A couple, Code A I think it is right that you Code A had Code A before the events we are talking about here in the late 1990s?
A Yes.

Q You very kindly visited Mrs Devine on a number of occasions. I take it you were not a point of contact for the nurses or the doctors, were you?
A No.

Q It would not have been your place, in a sense, to ask them what the position was?
A No.

Q Were you aware that Elsie had, in fact, been exhibiting signs of confusion and sometimes no doubt inadvertently aggression in the time prior to 18th November?
A No.

Q No-one mentioned that to you?
A No.

Q Thank you. Did you know what she was in the Queen Alexandra for?
A Yes. For a urinary infection.

Q Nothing else? Nobody told you about anything else?
A Pardon?

Q Nobody told you about anything else?
A No.

Q Who were you getting information from about --
A Code A

Q You weren't speaking to Code A at all?
A No, because she was busy at the hospital. Code A

Q Yes. Would you have 'phoned up the Queen Alexandra and been aggressive to nurses?
A No.

Q No?
A No.

Q It would not have been you, would it?
A No.

Q You would not have 'phoned up to say what is happening with your mother, would you?
A No.

Q She was not your mother.

A No.

Q You would not have said; how dare they speak to Code A Code A

A No.

Q Code A He was concerned about his mother, was he not?

B A Yes.

Q Thank you very much.

Questioned by MR LEIPER

MR LEIPER: On 18 November you said you talked about old times, especially

C past Christmases.

A Yes.

Q How would you describe Elsie Devine's demeanor?

A Same as she always was. She was always like that.

Q Always like that?

D A Happy and jolly and talking, especially with me about the times we had, because we used to spend a lot of time at my house.

Q When she was talking about times that you had had, did you notice any particular difficulties with her ability to recall times that you had had together?

A No.

E Q You were with her for a period of time. Approximately how long were you with her on 18th?

A About an hour-and-a-half.

Q In the course of that you asked her to sign a pensions book?

A Yes.

F Q Did that seem to be appropriate, given her mental presentation? Did you have any concerns about asking her to sign?

A Oh, no, because she signed it when Code A took it to her, and she couldn't go in that time, so that is why she asked me to take it, to get her to as -- you know it, so she just signed it. I just said, "Sign on the back", and she did. She knew where to sign.

Q She knew where to sign?

G A Yes, because she had done it before.

Q You didn't notice any sort of deterioration in her recollection of things which had happened in the past?

A No.

Q Did she present to you as being confused?

H A No. Definitely not. She wasn't in any pain, neither. Perfectly all right.

THE CORONER: She did not appear to be in any pain?
A No. No. She never told me she was in any pain.

MR LEIPER: Was she moving around in a way in which suggested she might be in pain?
A No. I dried her hair, and then she got up and was talking to a couple of ladies in the chair about me, and then she came back and sat down again.

Q Did she appear to be agitated?
A No. No.

Q So, from the respect of her mental health, so far as you were concerned, had there been any deterioration?
A No. Not that I could see.

Q So far as her physical health was concerned, did there appear as though there was any deterioration?
A No. That is why I was shocked when I got a 'phone call Friday night from Code A to say that she had to go and see her Code A

Q Friday is what date? Friday the -- you went to see her on 18th?
A Yes. 19th.

Q So, this was the following day?
A Yes, that Code A had 'phoned her saying that she had to go over to see Code A because she was dying, and I was shocked, because I had seen her on the Thursday, and she was perfectly okay. I couldn't understand.

Q Did anybody inform you that a Fentanyl patch had been administered?
A No.

Q Did anyone inform you that it was the view of those looking after her that she was in a state of terminal decline?
A No.

Q Thank you very much.

THE CORONER: Ladies and gentlemen? Anything?

Thank you very much indeed. I am very grateful. I will release you now. Dr Reid, please.

RICHARD IAN REID, sworn
Questioned by THE CORONER

THE CORONER: If you could identify yourself, please, and give me your professional qualifications?
A I am Richard Ian Reid, MB ChB, FRCP.

THE CORONER: Thank you. And your position with Gosport?
A I was consultant in geriatric medicine at that time, and that was a part time role.

THE CORONER: At what time?
A I was appointed to Portsmouth on 1 April 1998. I had dual responsibilities. I was the Medical Director of Portsmouth Healthcare Trust, which was normally half my allocated sessions for the week. For the other half of the sessions I was a consultant, and from somewhere in early 1999 I started working as a consultant in Gosport War Memorial Hospital.

THE CORONER: Forgive me whilst I just find -- right. Can we look at your dealings with Elsie Devine, please? Do you want to start there? How do you want to deal with this? Do you want to read through? Do you want to tell me about it informally, or how would you like to handle it?
A I would like to read through my statement.

THE CORONER: By all means please do.
A "I am the above named Richard Ian Reid and I reside at the overleaf address. My qualifications are MB ChB (Glasgow) FRCP (London). I am a consultant in the care of the elderly. I am employed by Portsmouth Healthcare Trust".

That was at the time the statement was made.

THE CORONER: Yes.
A "Although I am based at Queen Alexandra Hospital, I am often asked to give evidence on the treatment of elderly patients in other wards in hospital."

I beg your pardon. I am reading from an incorrect statement. I do beg your pardon.

THE CORONER: What about page 2 of the statement of 26th November?
A Yes. That's right. I beg your pardon.

THE CORONER: Go to page 2 of that, "My current role, which I began in April 1998", and take it from there.
A Right. The statement I have got here is 4th October, but I think it is the same statement as 26th November.

MS BALLARD: It is sir, yes, but it may be, for page number reference purposes, to refer to the same date as Dr Reid. It is just that they are slightly different. That is all, sir.

THE CORONER: Okay.
A I do apologise.

THE CORONER: I have got, "My current role which I began in April 1998". Have you got that?
A Yes. Yes:

"...as consultant in geriatric medicine, Medical Director of East Hampshire Primary Care Trust, formerly Portsmouth Healthcare Trust. I am based at the Queen Alexandra, Cosham. I have a full-time NHS contract which consists of eleven sessions per week. One session is three-and-a-half hours.

I have an on-call responsibility and work weekends, Saturday and Sunday, on roughly a one weekend in ten basis. I began the responsibility of looking after in-patients in Gosport War Memorial Hospital in either February or April of 1999. This continued for a period of about 12 months until about March 2000.

As consultant to Gosport War Memorial Hospital I had responsibility for the patients on Dryad Ward of the hospital. In this role I supervised the work of Dr Jane Barton, a local General Practitioner, who, in addition to working as a general practitioner, worked as a Clinical Assistant at Gosport War Memorial Hospital. In the absence of Dr Barton, I supervised the work of any locum or partners at a general practice covered her responsibilities for her. It was also my role to supervise the work of any specialist Registrar who was attached to me on Dryad Ward at Gosport War Memorial Hospital. I undertook a weekly ward round of Dryad Ward which I usually conducted on Monday afternoons.

THE CORONER: Can I just stop you just to say you refer to other people as being, "Locums". The locums, presumably, would be the partners in Dr Barton's firm?
A That's right.

THE CORONER: You also refer to Specialist Registrar.
A Yes.

THE CORONER: " ...attached to me on Dryad Ward". Did you have one? Intermittently? Few and far between?
A Yes. There wasn't always one round. They had to --

THE CORONER: Few and far between. Was it hen's teeth?
A No. It was a training post, so they would do spells of one particular aspect of geriatric medicine and then move on to another.

THE CORONER: Right. Do carry on, please.
A Right:

"I was accompanied on my ward round by the Clinical Assistant Dr Jane Barton every two weeks if she was available to do so. I also provided consultant cover to Daedalus Ward which is the other consultant-led ward at the War Memorial Hospital, when my colleague, Dr Alfie Lord, was on leave or unavailable. This was a reciprocal arrangement with Dr. Lord, would normally cover my leave periods or unavailability. In the event of myself or Dr. Lord being unavailable for long periods of time, then locum consultant cover would be sought. However, for short periods of absence then no locum cover was arranged.

If the Clinical Assistant, Dr Barton, was experiencing a particular problem regarding the management of a patient, then I would expect the Clinical Assistant to contact me to seek advice, or ask me to attend Dryad Ward to carry out an examination of the patient, or to see relatives who were concerned. If my advice was sought by the Clinical Assistant then I would expect a note to be made on the patient's clinical notes by the Clinical Assistant.

Dr Jane Barton is a very experienced doctor, and, as such, if there was a serious clinical problem relating to the treatment of a patient which would require her to seek such advice. If a problem arose requiring consultant input during any short-term availability of both myself and Dr. Lord, then I would expect the Clinical Assistant to contact the Elderly Medicine Officer at Queen Alexandra Hospital to obtain the required consultant input.

B

The clinical notes of a patient are where a record is kept of the clinical treatment of a patient. I would expect a note to be made on the clinical notes on a patient's admission to the hospital giving a brief history, and the results of any examination and treatment. I would also expect a prescription sheet to be commenced detailing any drugs prescribed on admission.

C

The clinical notes of a patient would then be maintained by the Clinical Assistant or doctor covering that responsibility, myself as consultant, with entries from other clinical staff and consulted with regard to the management of the patient. A nursing record is also commenced on admission of a patient which is maintained by the nursing staff.

D

During my ward round of Dryad Ward I would visit each patient, read their clinical notes, examine the prescription sheets and obtain additional information from the nursing staff provided from the nursing records. This information is usually verbally provided, and it would be unusual for me to read the nursing record of a patient. This information, together with the information I have obtained myself as a result of any examination I have made with the patient, would form the basis of any note that I made on a patient's clinical notes. If there is no marked change in a patient's condition, treatment and management, then I would not expect any entry to be made on the patient's clinical notes by the Clinical Assistant. However, I would make a note on the clinical notes of each patient I saw during the ward rounds.

E

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

F

I have been asked to detail my involvement in the care and treatment of Mrs Elsie Devine born on Code A who was admitted to Dryad Ward, Gosport War Memorial Hospital, on Thursday, 21 October, 1999, having been transferred there from the Queen Alexandra Hospital. Mrs Devine was a patient on Dryad Ward until her death on Sunday, 21 November 1999 at the age of 88".

THE CORONER: I do not think that is right, is it? The date of admission is not right.
A I beg your pardon. Mrs Devine was an in-patient until her death -- she was admitted to Dryad Ward on Thursday, 21st October.

G

THE CORONER: Yes.
A And she was an in-patient until she died on Sunday, 21st November:

"During this period, I was the consultant for Dryad Ward at Gosport War Memorial hospital. I first wish to state that I have no personal recollection of Mrs Elsie Devine

H

herself, and therefore this statement is being provided by referring to certain entries made by myself and others on Mrs Devine's medical notes, in particular entries made on her clinical notes and prescription sheets.

"By referring to Mrs Devine's medical notes, I can state that I saw her on three occasions. On each of the three occasions that I saw Mrs Devine it was as a result of my weekly ward round of Dryad Ward in Gosport War Memorial Hospital. The three occasions were as follows; Monday, 25 October 1999, Monday, 1 November, 1999, Monday, 15 November 1999.

"I have been shown a document bearing an exhibit label. This document I recognise as a speciality history sheet on which doctors record clinical notes in relation to a particular patient. The patient in the case of this document was Elsie Devine. The document is double-sided, notes are therefore recorded on both sides.

"My attention has been directed to an entry on the lower part of page 154 which commences with the date 25 October 1999. I recognise this writing as mine, and that the notes end with the signature that I recognise as my own. My note is preceded by a note dated 21 October 1999. The handwriting and signature at the end I recognise as that of Dr. Jane Barton, Clinical Assistant at Gosport War Memorial Hospital. These are the only two notes that appear on page 154.

"My note of 25 October would have been made during the course of my weekly visit to Gosport War Memorial Hospital and during my ward round on Dryad Ward. My note read as follows:

> '25 October 1999: Mobile unaided. Washes with supervision. Dresses herself. Continent -- mildly confused. Blood pressure 150/70. Normal chromic anaemia. Chronic renal failure. Was living with daughter and son-in-law. Believed son-in-law awaiting bone marrow transplant. Need to find out more regarding son-in-law, et cetera.'

The entry has then been signed by me using my normal signature. This note should be interpreted as follows: on Monday, 25th November I saw and had contact with the patient, Elsie Devine. It is possible that Dr Jane Barton was present. It is also possible that I carried out a physical examination of Elsie Devine. The main content would have been noted by me from reports made to me by the nursing staff and/or Dr Barton, if she were present.

'Mobile unaided'. This means that Mrs Devine was at that time walking without support, and that she, at that time, was probably safe walking on her own.

'Washes with supervision'. This probably meant that Mrs Devine was physically able to wash herself, but that, due to her confusion, she required some guidance and prompting to wash.

'Dresses herself', meant that Mrs Devine was, at this time, physically capable of dressing herself. I have made no record if she required any guidance with her dressing.

'Continent'. This probably meant that Mrs Devine was, at that time, continent regarding her urine, and was aware of the need and recognised the need to pass urine, also control her bladder until she passed urine.

'Mildly confused'. This probably means that at this time Mrs Devine's short-term memory was mildly impaired. She was confused as to the time of recent events, but was probably aware of her surroundings, ie. that she was in hospital.

Blood pressure 110/70 is a blood pressure which I would regard as being on the low side. However, provided that the patient appeared to be well in themselves, it would not be a cause for concern.

'Normal chromic anaemia' means that at that time Mrs Devine's red blood cells were low in number, and that these cells were low in colour when examined under the microscope.

'Chronic renal failure' is a reference to chronic renal failure being one of a number of causes of non-chronic anaemia.

These notes would have been completed by me during my afternoon ward round of Dryad Ward, Gosport War Memorial Hospital. This would have been the first occasion that I would have seen Elsie Devine as she was admitted to this hospital on 21st October, 1999.

The note is then completed with the brief social background which is self-explanatory as related to me by the nursing staff.

Prior to her admittance by hospital, Mrs Devine was living with her daughter and son-in-law in a home environment. It was believed that her son-in-law was himself in hospital awaiting a bone marrow transplant.

The notes of, 'Need to find out more re son-in-law', et cetera, is a note to say that more is needed to be found out about Mrs Devine's current home circumstances and if her daughter would be able to care for her mother following her husband's illness, or if residential or nursing home needed to be considered.

All the above would have been obtained from verbal reports of the nursing staff and from Mrs Devine's notes. I would not have relied on the patient, who was in a confused state, to provide such information.

The next note in the same document is dated 1st November, 1999, and has been written on the reverse side of this document, page 155. This note has been made by me and would have been written by me during my weekly ward round of Dryad Ward at Gosport War Memorial Hospital. I do not regard it as unusual that no note has been made on the clinical notes since 25th October, as there had been no major change in Mrs Devine's condition and treatment since that date.

I would have had access to all medical notes relating to Mrs Devine's condition and treatment, and in addition could possibly have had Dr Jane Barton in attendance, as

well as the nursing staff, from all of whom I could have taken verbal reports on which my note would have been based.

This should read as follows:

> '1st November, 1999: Physically independent, but needs supervision with washing and dressing and help with bathing. Continent. Quite confused and disorientated. For example, undresses during the day. Is unlikely to get much social support at home, therefore try to see home visit if functions any better in own home'.

This entry is then signed by me with my normal signature.

This note could be interpreted as follows:

'Physically independent', probably means that Mrs Devine, at that time, was physically able to walk, at least short distances, unaided by either staff or walking aids, but, 'Needs supervision with washing and dressing and help with bathing', probably means that at this time, due to Mrs Devine's confusion, she needed guidance and direction, but that she was physically capable of both dressing and washing. However, when Mrs Devine was taking a bath, she needed help to do so.

'Continent'. This is a further reference to Mrs Devine's passing of urine, and is aware of the fact. There had been no change in Mrs Devine's status since I last saw her, namely she was still aware of any need to pass urine, she was able to control that need and was not wetting herself. Had Mrs Devine suffered from any incontinence of the bowel then this would be separately noted.

'Quite confused and disorientated.' This would probably mean at that time Mrs Devine may not have been aware that she was in hospital, or the time of day, day of the week, et cetera".

THE CORONER: That you wouldn't take just from your --
A That may have been from my own observations, but certainly from talking to the nursing staff. As I said, this information would have been obtained from verbal reports obtained from the nursing staff on Dryad Ward. The note is supported by the following example; undressing during the day. That is someone who is quite confused. This part of -- I think that is self-explanatory in the notes, as an example of Mrs Devine's confusion at that time.

> "As previously stated, this information would have been provided in the form of a verbal report from the nursing staff and from the notes.
>
> 'Is unlikely to get much social support at home'. This sentence is a reference to earlier and current reports that Mrs Devine's home circumstances provided by the nursing staff, namely that prior to admission to hospital Mrs Devine was living with her daughter and son-in-law, however, her son-in-law himself was undergoing a bone marrow transplant in London. Mrs Devine's daughter was staying with her husband in London, and there was no-one at home to provide care, support or supervision to Mrs Devine at that time".

Then I have written:

> "'Therefore, try home visit to see if functions better in the home'. This is a suggestion made by me in order to assess Mrs Devine's level of confusion. Elsie Devine appeared to be suffering from dementia. A person suffering from dementia often functions worse in unfamiliar surroundings. For example, being within a hospital, changing hospital, or changing wards within a hospital.
>
> It appeared to me that Mrs Devine's condition with regard to her confusion had worsened since my visit of 25th of October. As is often the case, the person suffering from this condition can improve if returned to more familiar circumstances, more familiar environment. The suggestion was, therefore, to try a supervised part of the day at home with an occupational therapist to see how Mrs Devine functioned in her, what we call, 'Activities of daily living'. In other words, ability to wash, dress, move around the house, et cetera. At the same time, an assessment could be made of what support would be required for her to return home, or whether Mrs Devine would require a position in a residential or nursing home, and, in addition, what support she would need under these circumstances. This home visit would be dependent upon Mrs Devine's physical condition which appeared from my visit on 1st November, 1999 to be stable.
>
> The main focus of my note on 1st November, 1999 appears to be Mrs Devine's confusion. Had there been any concern over her physical condition at that time, then I would have made a note of it. I note from the prescription sheets that on 1st November 1999 Dr. Barton prescribed to Elsie Devine the drug Amiloride".

Do you want me to add, slightly, to the statement, if it would be helpful to the jury?

THE CORONER: Yes, it would be.
A Amiloride is a diuretic. In other words, it makes people pass urine, if they have fluid retention. It is possible that the prescription of Amiloride was discussed between Dr Barton and myself during my ward rounds. However, I haven't made any mention of it in my note of 1st November, and do not have any personal recollection of such a discussion of it.

THE CORONER: But it would seem to be sensible that if you are doing a ward round with Dr Barton --

A It probably is as a result of that. Yes. I said here:

> "The drug Amiloride is used to treat fluid retention in heart failure. It is entirely compatible with the other drugs prescribed to Mrs Elsie Devine at that time".
>
> I provided a further statement regarding drugs prescribed to Elsie Devine. In my further statement I have detailed the dosage and two possible reasons for its prescription. I note from the prescription sheet that Mrs Devine was first administered Amiloride on 2nd November, 1999 and continued to be given the drug until 18th November, 1999. The dosage remained the same throughout that period.

The next note on the same document is dated 15th November 1999. This note has been written by me, and should be read as follows:

> '15 November 1999: Very aggressive at times. Very restless. Has needed Thioridazine'".

I will talk about that in a moment. On treatment for a urinary tract infection:

> "'Mid-stream specimen of urine sent because blood and protein in urine'. That means a sample has been sent to the laboratory for testing.
>
> 'On examination, pulse rate 100 per minute. Regular temperature 36.4°C. Jugular venous pulse not seen'".

My statement goes on to talk about later on about what some of these things mean.

THE CORONER: Yes.

> "'Hepatic jugular reflux negative. Oedema gross'".

"Oedema", means swelling:

> "' ... gross, of the legs, extending to the thighs. Heart sounds, nil added ...'"

which means normal heart sounds:

> "'Chest clear. bowels regular'".

The rectal examination, 13th November:

> "'Rectum empty but good bowel action since'".

Then I have put an asterisk, because this was probably reported to me later on that day:

> "'Mid-stream specimen of urine, no growth'".

In other words, in the sample that was sent to the laboratory there was actually no infection:

> "Ask Dr. Lusznat to see'".

Dr. Lusznat is a consultant in old age psychiatry, and he specialises in the treatment of elderly people with confusion and dementia:

> "My interpretation of this note is as follows: that I saw Mrs Devine on Monday, 15 November as part of my weekly visit to Dryad Ward round. It was two weeks since my last visit to Dryad Ward round as I had been on leave. No note has been made on Mrs Devine's clinical notes since my note dated 1st November, 1999. It was reported to me that as a result of face-to-face contact, verbal reports from the nursing staff and possibly Dr Barton, that Mrs Devine had been, 'Very aggressive at times'. This could mean either verbally or physically aggressive or both towards either staff or other patients or both.

'Very restless'. This probably meant that Mrs Devine was continuing moving about whilst sitting or lying. In addition, she may have been pacing around the ward. Both of the above symptoms can be brought on by deterioration of a person's physical state, and deterioration of physical state can cause anxiety and further confusion which can, in turn, cause a person to become more aggressive and restless.

The above comments on the notes have been bracketed by the words, '(Has needed Thioridazine)'".

Thioridazine is a major tranquiliser:

"The fact that this drug has been administered to Mrs Devine would have been obtained from my face-to-face contact with the nursing staff, Dr Barton if present, and from my examination of the drug prescription chart. I would not necessarily expect administration of this drug to have been entered on the clinical notes, although it would be good practice to do so.

"In my opinion, this is the correct drug to be given for the reported behaviour displayed by Mrs Devine. The dosage given at that time in my opinion was low".

On treatment for urinary tract infection:

"Mid-stream specimen sent because of blood and protein in the urine. This information had also been gleaned from verbal reports made to me by staff, and also from Mrs Devine's medical notes, but since I had last seen Mrs Devine on 1st November, a mid-stream sample of urine had been taken from Mrs Devine and that had been subjected to a dipstick test which had shown the presence of blood and protein".

"Dipstick", is a little stick you put in a sample of urine, and it changes colour according to the contents of the urine. It is a simple test carried out by nursing staff which involves the use of a reactive strip, and indicates the presence of blood and protein within the urine. Having identified the presence of blood and protein, staff have then sent Mrs Devine's mid-stream sample of urine to a laboratory for further examination, and that was done at a laboratory:

"The nursing staff could have carried out this test and submission of the sample on their own initiative, or on the instruction of the Clinical Assistant, Dr Barton. It appears that there was concern regarding Mrs Devine having developed a urinary tract infection, and that steps had been taken to treat this. It would have been best practice that a note had been made of this on Mrs Devine's clinical record".

Sorry, I will read that again:

"It would have been best practice that a note would have been made of this on Mrs Devine's clinical record, regarding the start of any new treatment".

Beside the treatment of the notes I have entered an asterisk. This indicates to me that at the time of making the entry I questioned the staff as the results of the urine sample had been sent to St Mary's Hospital for examination."

Later on, the note made by me, which says:

"MSU mid-stream specimen no growth'. This indicates that while still engaged in my examination under making any note of the examination of Mrs Devine, the results of the mid-stream sample of urine obtained by the urine -- the results had been obtained and it showed no growth which indicated to me there was no infection in Mrs Devine's urine.

'On examination pulse rate 100 beats per minute and regular. Temperature, 36.4'.

On examination, there is a note by me that I carried out a physical examination of Mrs Devine. Pulse rate of 100 per minute and regular would be regarded as the upper limit of normal, with normal pulse rate being 60-100 per minute. Pulse rate of 100 per minute on regular would not cause any undue concern. Temperature of 36.4°C would be regarded as normal, the normal temperature range being 35-37:

'Jugular venous pulse not seen. Hepatic jugular reflux negative'.

This means that when examining the jugular veins in Mrs Devine's neck, they were not distended, sticking out, and that there was no pulsation seen in the veins.

THE CORONER: That would be an indicator?
A It can be an indication of fluid overload and heart failure. When I applied pressure over Mrs Devine's liver, that is this area here, if you have got heart failure, fluid can (Inaudible) in the liver as well as the legs, and when I press over here it increases the amount of blood that returns to the heart and the neck veins stand out, so what that means is that there was no evidence of heart failure:

"Oedema gross, extending to thighs".

That means an examination of Mrs Devine, I found that the legs were very badly swollen up to the thighs, because of fluid retention. This can be caused by either heart failure or renal failure, and can be a symptom of other conditions:

"The above examination was carried out in order to eliminate heart failure as the cause of Mrs Devine's very bad oedema. Nil added".

This indicates that – "Heart sounds miladi". This indicates that I had listened to Mrs Devine's heart sounds and found them to be normal:

"No murmurs or abnormal beats. Chest clear".

This indicates that I had listened to her chest and found her breathing to be normal. Both of these examinations gave no indication of any significant heart or chest problem:

"Bowels regular, rectal examination 13th November showed the rectum to be empty, but since that time Mrs Devine's bowels had moved".

This had been reported to me verbally by the nursing staff as a result of enquiries made by me regarding Mrs Devine's bowel movements and formed part of my investigation into Mrs Devine's increased aggression and confused state.

The nursing staff would be expected to carry out a rectal examination of a patient if a period of time had elapsed without a patient having a significant bowel movement. It was reported to me by the nursing staff that such an examination had indeed occurred on 13th November and Mrs Devine's bowel was empty.

THE CORONER: Had been carried out?
A Yes. This was an indication that Mrs Devine was very unlikely at that time to be suffering from constipation. Further note that a good bowel action since as a result of further reports by the nursing staff since the examination, it had been noted that Mrs Devine had passed solid waste. This provided a further indication that she was not suffering from being constipated and (inaudible) constipation can be a cause of confusion, aggression and anxiety in an elderly patient.

The final note by me on Mrs Devine's clinical notes after the midstream urine result was asking ask Dr. Lucznat to see. This was an instruction that Mrs Devine be referred to Dr. R M Lusznat. I believe that this doctor's initials, R M, stand for Rosemary, however, I am not sure of this. She is, however, known as, "Rosie". Dr. Lusznat is a consultant in old age psychiatry. Due to Mrs Devine's increasingly confused, aggressive and restless condition and having found no apparent physical cause for her decline, I have written that instruction that asked Dr. Lusznat to see. This instruction would be for Dr. Barton or for the doctor covering her responsibilities to carry out.

The next note on the same document is dated 16th November, 1999, and the note begins, "Dear Rosy", and entered the words, "Can you help. Many thanks". This note is then signed. I recognize the writing and the signature of this note to be that of Dr. Jane Barton. This indicates to me that the notes of my examination of Mrs Elsie Devine on Monday, 15th November, made during my weekly ward round on Dryad Ward had been read by Dr Jane Barton and a referral has been made to Dr. Lusznat as instructed.

I have been shown another document bearing an exhibit reference number. This is the next page of the clinical notes of Elsie Devine. The first note on this document appears to be dated 18th November, 1999, and is headed, "Elderly mental health". This note appears to have been signed off by a locum staff psychiatrist. This indicates to me that Mrs Devine was seen by someone from Dr Lusznat's team on 18 November 1999 following my instruction of 15 November 1999.

My next ward round on Dryad Ward would have been on Monday, 22 November 1999. My examination of exhibit number 7, I note that Mrs Elsie Devine had died at some time during the evening of Sunday, 21 November, 1999. It appears from the clinical notes that I had no further dealings in the care of Mrs Elsie Devine after Monday, 15 November 1999.

I have been asked to comment on the lack of notes made in the clinical notes between the following dates -- do you want me to read these?

THE CORONER: No. I think we can take those as read.
A As previously stated, if there is no marked change in a patient's condition of treatment and management, then I would not expect an entry to be made on the patient's medical notes.

B

Between 21 October and 25 October, there appears to be no marked change in the condition, treatment and management of Elsie Devine. Therefore, I would not necessarily expect any note to be made.

Between 25 October 1999 and 1 November 1999, other than Mrs Devine appeared to be slightly more confused, but again, there appears to be no marked change in Mrs Devine's
C condition and management. The drug Amiloride was prescribed on that day and first administered on 2 November, the following day. I am unable to recall if I discussed the prescription of this with Dr Barton. It would have been best practice for an entry to have been made on Mrs Devine's clinical notes of this prescription.

Between 1 November and 15 November 1999 for a period of 14 days, no entry has been made in the clinical notes. During this period I took a period of leave which included my
D weekly ward round which would have been on Monday, 8th November. I am unable to say if this responsibility was covered by another consultant in my absence. However, as previously stated, had the Clinical Assistant required any consultant input regarding a patient's treatment and management then I would have expected the Clinical Assistant to have contacted the Elderly Medicine Officer at Queen Alexandra Hospital and that an entry be made on the patient's clinical notes.

E From my review of the clinical notes and prescription sheets of Elsie Devine for the period 1st November to 15 November it appears that Mrs Devine's condition and treatment had undergone a marked change. On 11November Mrs Devine had begun a course of the antibiotic Trimethoprim for five days to treat a urinary tract infection. In the early hours of the morning of 11th November, at 01.15 hours, Mrs Devine was administered one 10 milligram Temazepam tablet. On 11th November, 1999, later that day, Dr Barton prescribed, on an as required basis, the drug Thioridazine, a drug which is used in the treatment of
F agitation, restlessness and confusion, which has a sedating and tranquilising effect. Thioridazine was first administered at 8.30 in the morning of 11th November.

Whilst in my opinion the prescription of both Trimethoprim and Thioridazine in the case of Mrs Devine and the above drug administration was fully appropriate at that time, I would have expected a note to have been made on Mrs Devine's clinical notes regarding this. It would have been best practice to do this, as, clearly, on 11 November 1999 there had been a
G marked change in Mrs Devine's condition.

Treatment of the urinary tract infection and administration of the drug Thioridazine are both mentioned in my ward round of 15th November 1999.

THE CORONER: Can I just take you back to 11th November? There is a significant hole in the record keeping.
H A Yes.

THE CORONER: And you have referred to that earlier. I just wonder by how much it would be appropriate to rely on nursing notes to keep you up to speed with clinical patterns.
A Well, in any position when I was doing ward work I would be reliant on both medical notes and information from nursing staff. I think information from nursing staff (Inaudible) is actually critically important to being able to get a sort of holistic picture of someone's condition. I would never normally rely on just the medical record.

B

THE CORONER: Dr Barton told us that she was under considerable pressure and that is why, quite often, notes were not --
A Yes.

THE CORONER: Clinical notes, but that she would rely on the nursing staff to be able to record what was happening and what had gone on?
C A Yes.

THE CORONER: Would the nursing notes contain the clinical picture?
A The nursing notes would often contain a clinical picture. For example:

"Patient seen by Dr Barton, MSU, mid-stream sample of urine sent".

D So, it would often be information in the nursing notes about what actions Dr. Barton had taken.

THE CORONER: Okay. Thank you. Next ward round, Dryad Ward, Gosport War Memorial Hospital.

A It would have been during the afternoon of Monday, 22 November. Elsie Devine died
E during the afternoon of Sunday, 21st November. Having seen Mrs Devine on three occasions I am almost certain that I would have enquired as to her whereabouts on my subsequent visit to Dryad Ward. This is mainly because the turnover of patients in Dryad Ward was relatively low, and therefore I can usually remember from the previous week which patients had been there. In addition, when last seen by me, Mrs Devine had been very agitated and I had made a full note in the clinical notes which instructed her to be seen by Dr. Lusznat. I would normally make an enquiry of Dr Barton and/or the nursing staff
F as to what had happened to any patient I noticed was no longer on the ward. There would not normally be any point for me to take further action after the death of a patient unless there was suspicious or unexplained circumstances, or that the death required discussion with a coroner. I do not recall there being any such discussion of any concern regarding the death of Elsie Devine at that time. I have been asked what contact I have had with Mrs Devine's family since Mrs Devine's death on 21st November, 1999 --

G THE CORONER: I am not sure I find that terribly helpful, or that the jury will.
A Okay.

THE CORONER: Thank you. We can go on to your next statement at this point.
A Right. Shall I start from the top of page --

THE CORONER: Yes, if you would. That is to explain --
H A -- the content of the documents issued in the prescription sheets, and provide an

explanation of each drug detailed on them, also to give an account from these documents of what the dose rate of each drug was as shown on the prescription sheet. Finally, to comment on the use of each drug being prescribed.

I first wish to state that I am not the author of any of the notes written in this these documents. My name appears at the top of page 277 next to the word, "Consultant". From my examination of these documents, together with my examination of the clinical notes as referred to in my earlier statement, I am able to say that any of the earlier drugs listed in the prescription sheets as prescribed by me were prescribed on my advice or instruction. There is, however, one possible exception to this, that being the drug Amiloride, which we have already mentioned. This drug was prescribed on 1st November. It is possible that Dr Barton consulted me regarding the prescription of this drug in Mrs Devine's case, or that Dr Barton prescribed it on my instruction. These documents would have been available to me and would almost certainly have been examined by me on each occasion that I conducted a ward round of Dryad Ward during the period that Mrs Devine was on the ward, namely 21st October, 1st November, and finally on 15th November.

I feel that these documents are best explained by detailing each drug in turn by date order. On 21st October, 1999, Dr. Barton prescribed a regular dose of Thyroxine 100 micrograms daily. This drug is used for the treatment of hypothyroidism, this is an underactive thyroid gland which, if severe and untreated, could cause confusion. In my experience I would say that this was a very common treatment for a person suffering from this complaint. The dosage is monitored by carrying out blood tests. Mrs Devine would have taken this drug in tablet form. There are no major side effects of this drug. I note from the prescription sheet that Mrs Devine took this drug from the 22nd October until 17th November. I can only assume that Mrs Devine's condition after this time had been such that she was no longer able to take the drug orally or was refusing to take drugs orally.

On 21st October, 1999 Dr Barton also prescribed a regular dose of Frusemide 40 milligram tablets, one daily. This drug is used in the treatment of fluid retention in heart failure and other conditions. The dosage prescribed is the most usual starting dose of this drug. This drug was administered from 22nd October until 17th November, 1999. The use of these two drugs together is quite compatible.

On 21st October, 1999, Dr Barton also prescribed on an as required basis the drug Tamazapam, 10 milligram tablets, one at night. This is a sleeping tablet and one 10 milligram tablet is the normal starting dose for this drug. The drug was administered on one occasion only to Mrs Elsie Devine, at 01.15 on 11th November. Given the history and admission to Dryad Ward of confusion and the fact that changes of environment (Inaudible) can increase confusion, particularly at night, I do not feel that it was unreasonable to prescribe this drug on an as required basis on admission to Gosport War Memorial Hospital.

It must be borne in mind that nursing staff are not permitted to administer drugs without first being prescribed by a doctor. Gosport War Memorial Hospital operates with its own Clinical Assistant, Dr. Jane Barton, and therefore there was no resident medical cover in the form of a doctor on site 24 hours a day. It was therefore in my opinion good practice to prescribe on an as required basis a sleeping pill for this patient. This would allow nursing staff to administer the drug if required without consulting a doctor.

On 21st October, 1999, on admission to Gosport War Memorial Hospital I note that Dr Barton has also prescribed, in the as required section, the drug Oramorph at a strength of 10mg and 5mls in a dose of 2.5 to 5mls four hourly, as required. This drug is an oral morphine drug in solution and the dose prescribed is 5-10mg. This is the usual recommended starting dose for this drug. This drug is usually used for the treatment of pain.

Could I add to my statement?

B

THE CORONER: Yes, certainly.
A Usually in the treatment of pain, but it is also, and also and continues to be widely used in the treatment of distress in elderly patients, patients who are distressed and agitated, who are unwell and who one thinks are terminally ill or may become terminally ill in the next few days.

C

THE CORONER: Right. Thank you.
A Given that there is no resident doctor at -- sorry, I have missed a sentence.

This drug, according to the prescription sheet, was never administered to Elsie Devine. Given that there is no resident doctor at Gosport War Memorial Hospital, I feel that it would be entirely reasonable to prescribe, on an as required basis, a simple analgesic, that is a simple pain killer, which the nursing staff could then administer if required. In the absence of

D

any documented pain being reported in the case of Mrs Devine, I feel that the prescription was inappropriate at this stage.

THE CORONER: That is subject to that --
A That is subject to, yes. What I am saying is that there didn't appear to be any justification in the notes for its prescription. I couldn't say whether it was appropriate in what caused the (Inaudible) there. This is because analgesics, pain killers, can be divided into three levels of

E

groups, under which Oramorph falls into the strongest level group.

On 1st November I note that Dr Barton has prescribed the Amiloride, 5 milligram tablets, one daily. This drug is used to treat fluid retention in heart failure. This is the usual recommended starting dose of the drug and is at the lower end of the starting range. It was administered from 2nd November to 18th November. Use of this drug is entirely compatible with Frusemide and Thyroxine. This drug was possibly discussed with me prior to

F

prescription, as stated earlier. There are two reasons that possibly led to the prescription of this drug. The first being that Mrs Devine's fluid retention was increasing, namely her legs were swelling more, the second being that Ferusamide can have the effect of lowering potassium levels of the blood which can cause complications of the heart, whereas Amiloride can have the effect of raising potassium levels in the blood. Therefore, it can be extremely useful to use these drugs in combination. However, Amiloride can, in some cases, cause a worsening of renal function and requires monitoring if given. This is achieved by blood tests.

G

On 11th November, 1999 I note that Dr Barton prescribed Trimethaprim, 200 milligram tablets, one daily, for a period of five days. Trimethaprim is an antibiotic which is commonly used for the treatment of urinary tract infections. This, in my opinion, is entirely correct, so is the length of treatment. The drug is compatible with other prescriptions taken daily by Mrs Devine at this time.

H

I note that Mrs Devine completed the course of treatment involving this drug on 15 November 1999. Caution should be taken when administering this drug to patients suffering from impaired renal function. However, failing to treat a urinary tract infection can also have adverse consequences in kidney function and therefore there is a need to monitor kidney function.

On 11th November 1999 Dr. Barton prescribed on an as required basis Thioridazine, 10 mg tablets one, three times daily. Thioridazine is used to treat restlessness, agitation and confusion. It has tranquilising and sedative effects. The drug prescribed in Mrs Devine's case was at the very bottom end of the dosage range. The drug was administered on 10 occasions between 11th November and 17th

November -- do you want me to detail them?

THE CORONER: No, I do not think so.
A No more than two tablets were given in any one day, the prescribed limit being three tablets. The drug is compatible with the other prescribed drugs that Mrs Devine was taking on a daily basis.

On 15th November, 1999 I carried out a ward round on Dryad Ward at Gosport War Memorial Hospital. On Mrs Devine's clinical notes of that day I noted the use of this drug to treat Mrs Devine's aggression and restlessness. I have also referred to its use in my earlier statement and mentioned that I felt it was important that when a new drug was prescribed, the reasons for it were recorded in the medical notes. This does not appear to have been done in this case. I would consider that the dose prescribed of Thioridazine, however, was fully appropriate at that time, in the treatment of Mrs Devine's aggression and restlessness.

THE CORONER: Thank you. You also had some involvement with Gregory.
A Yes.

THE CORONER: Is your statement the same as mine? 24th October?
A 2005.

THE CORONER: And I think you can probably go to page 5, "Asked to detail my involvement with the patient Sheila Gregory".
A Yes. I have been asked to detail my involvement with the patient --

THE CORONER: Can you stop for a second? I am getting signals that we are just about to -- okay.

(Short adjournment)

THE CORONER: Right. We can go to Gregory, please. Detail your involvement with the patient, Sheila Gregory.
A Yes. Date of birth, Code A I do not remember this patient, or the subsequent treatment that was administered. I have been shown the medical records relating to the patient Sheila Gregory. I can confirm that I have written the following entries:

> "13 September 1999, leaning to the left whilst standing. Poor appetite, confused but witty. Poor inhaler technique -- try nebuliser. Then a week later, 20 November,

managing nebuliser, very poor appetite, mobilising two steps with help of two persons. Check routine bloods".

On the 27th of September:

"Appetite slightly improved? Mood improving, continue Fluoxetine. Generally less well, but no obvious physical signs. Catheterised. Occasional fecal incontinence".

4th October 1999:

"Much better motivated. Needs help of one person, occasionally two, for most activities. Occasional agitation needing Thioridazine, the tranquilizer. Still occasional fecal incontinence, still needs encouragement to eat and drink".

On the 11th of November:

"Still very dependent, delightfully usually confused. Needs nursing home placement. 18th October, incontinent of unformed feces" --

THE CORONER: Is, "Unformed", not, "Uniform"?
A Yes.

THE CORONER: I thought; I wonder where you get those! Sorry. Do go on.
A "Unformed feces, withhold Lactulose pro tem and refer for nursing home care".

A week later again, 25 October:

"Can walk with a frame with persuasion ++".

In other words, needed a lot of persuasion to walk:

"Needs one to two to transfer dress, et cetera. Catheterised, only occasional fecal incontinence".

On 1st November:

"Episode of vomiting today. Seems well now. Still soft, mushy stools, decrease magnesium hydroxide up to 10mls BDA".

15th November:

"Less well. Chest infection. Frailer. Occasional bouts of nausea. On examination apyrexial, pulse rate 80 over 40 and irregular, heart sounds loud, VS (Inaudible)..."

That just means that there is a murmur present at the heart:

"Zero oedema", means that there is no fluid in the legs, "Continue present treatment except Thioridazine to PRN as required".

I presume it has been (inaudible) regularly prior to that. On page 70 of the medical records I have written the following entry:

> "Further decline. Comfortable. Opening eyes to speech. Short verbal response. Pulse equals uncontrolled AF..."

Which is atrial fibrilation, which is an abnormal, rapid rhythm of the heart:

> "... respiratory rate 24 per minute. Chest clear at present. Stop Frusemide, continue diamorphine".

THE CORONER: I think we can go to the following page now to clarify the entries you have written in the medical notes, unless anybody has any observations. Bottom of the next page.
A Which page is that, sorry, sir?

THE CORONER: Page 8.
A To clarify the notes that I have written in the medical notes, commencing at page 67, when I have written, "Leaning to the left while standing", firstly I have normally reviewed the previous entries in the medical notes. I note that on 6th November 1999, that Dr. Ravendrain had recorded that the patient had a left-sided facial droop. He has also recorded the results of a neurological examination which appear to be otherwise normal. In view of this I may have been looking for other neurological signs and have subsequently recorded that in my notes.

At this stage I would probably have been considering that the patient might have had a very mild stroke, leaning to the left and left facial droop:

> "Poor appetite".

This is self-explanatory:

> "Confused but witty".

This probably means that Mrs Gregory was not fully orientated in time and place, but was providing amusing answers to my questions:

> "Poor inhaler technique -- try nebuliser".

This almost certainly reflects the fact that the nursing staff had told me that Mrs Gregory found it difficult to coordinate the use of an inhaler, and I suggested the use of a nebuliser which does not require manual dexterity.

On the 29th of September I have written, "Managing nebuliser". This refers to the fact that the nursing staff had reported that using the nebuliser was successful:

> "Very poor appetite".

That had been reported to me by the nursing staff. I would have noted from the prescription sheets that the patient had been prescribed on the 7th of September, 1999 Fluoxetine 20mg

once daily with the first dose being given from 8th September. Fluoxetine is an antidepressant. This drug is manufactured by a number of pharmaceutical companies, one of which markets it under the drug name, "Prozac:

"Variable confusion".

This would have been reported to me by the nursing staff, but it may also have been my own observation:

"Mobilising 1-2 steps with help from two persons".

This may have been reported to me by the nursing staff, but it was usual in my practice to assess patients walking for myself:

"Check routine bloods".

I have asked for this to have been done because of the history of poor appetite and variable confusion. This was an order to exclude a physical cause for these symptoms. It is likely that these tests would have been done the following day, and the results would have been available at the ward in the next two to three days. I would not see them until the following week. Dr. Barton would see the results of the blood tests whenever they arrived in the ward, whether they were normal or abnormal. She would take whatever action was necessary.

27 September:

"Appetite slightly improved? Mood improving, continue Fluoxetine".

This would have been reported by the nursing staff, and my question mark about whether the patient's mood was improving could have reflected both the views of the nursing staff and my own observations. As antidepressants can take some weeks to be effective, as Mrs Gregory had been on antidepressant for just under three weeks, I felt it important to continue the prescription of Fluoxetine:

"Generally less well. No obvious physical signs".

This could have reflected both the observations of the nursing staff and my own observations. So, it is likely that it also reflected the fact that the physical examination failed to reveal any abnormalities. It is also likely that these observations included measurement of temperature, pulse, blood pressure and respiratory rate:

"Catheterised", indicating the presence of a drainage tube in the bladder, "Occasional fecal incontinence", means occasional loss of bowel control, and would also certainly be reported to me by the nursing staff.

4 October 1999:

"Much better motivated", reflects that poor motivation can be a symptom of depression and this statement implies that improved motivation could have been due to the prescription of Fluoxetine, the antidepressant:

"Needs the help of one person, occasionally two for most activities".

That is self-explanatory:

"In the action of daily living, washing, dressing and toileting, would require the help of one, occasionally two persons. Occasional agitation needing Thioridazine".

B

This agitation would have been reported to me by the nursing staff. I have also observed the prescription sheet that Mrs Gregory has been prescribed Thioridazine, which is a tranquilizer. The dose was 10mg to be administered on an as required basis. This is the lowest dose normally prescribed and is appropriate:

"First administered on 1 October. Still fecally incontinent".

C

That would have been reported to me by the nursing staff. It is not an uncommon problem in elderly patients who are confused:

"Still needs encouragement to eat and drink".

This would have been reported to me by the nursing staff.

D

On the 11th of October:

"Patient still very dependent".

That, again, would have been reported to me by the nursing staff:

E

"Delightfully (usually) confused".

This statement would have been made as a result of my own observations as well as from the nursing staff:

"Needs nursing home placement".

F

This statement reflects my views that further attempts to rehabilitate to Mrs Gregory to a level where she would be able to manage again at home were not going to be successful, and that because of a level of dependency she would need care in a nursing home rather than a residential home.

At this stage I felt that Mrs Gregory should be considered for a nursing home for continuing care.

G

18th October:

"Incontinent, unformed feces withhold Lactulose".

That should read, "Pro tem", not, "Protein", and this would have been reported to me by the nursing staff, means that Mrs Gregory was losing control of bowels, and that her bowel

H

movements were of a soft, porridge-like consistency. This can be caused by Lactulose, and hence my instruction to withhold it for the time being.

The prescription of the administration of Lactulose would have been appropriate until the stage if bowel motions had been formed until this time:

"Refer for nursing home care".

Mrs Gregory was on Dryad Ward for rehabilitation. It reflects the fact that I no longer felt that rehabilitation to her home address would be successful, and that the move should now take place to transfer Mrs Gregory to a nursing home. This would normally be done by discussing with the family, and by making a referral to the Social Services. Nursing staff would normally make a referral to Social Services for assessment and placement in a nursing home:

"25.10.99. Can walk with frame with persuasion plus plus".

This means that Mrs Gregory was able to walk within a walking frame, but she was extremely reluctant to do so:

"Needs 1-2 to transfer, dress, et cetera", would have been reported to me by the nursing staff:

"A referral for nursing home care will continue to be appropriate. Catheterised..."
That is self-explanatory:

"Occasional fecal incontinence", is self-explanatory, and would have been reported to me by the nursing staff:

"1st November. Episode of vomiting today. Seems well now".

This would have been reported to me by the nursing staff:

"Still mushy stools, reduce magnesium hydroxide".

This would have been reported to me by the nursing staff. Because of this, I had taken the decision to reduce magnesium hydroxide, which is a laxative. It had initially been prescribed at 20ml BD, which means 20mls twice daily, and it was reduced because her motions were too soft.

From examining the prescription sheet it does not appear that Mrs Gregory ever received any magnesium hydroxide. This is probably because it was normal practice to allow nursing staff to use their discretion in respect of the administration of laxatives and antidiarrheal drugs according to the patients' bowels are reacting. At page 136, it records that Loperamide has been prescribed. That is a drug which is used to control loose stools and diarrhea. It was written up on 18 October, first administered on 29 October at 11.50 hours. It was also administered on 1 November at 07.15 hours.

15 November:

"Less well. Chest infection. Frailer. Occasional bouts of nausea".

This would have been reported to me by the nursing staff and it would also have been as a result of my own observations which were, on examination, apyrexial, in other words, normal temperature:

"Pulse rate 84 per minute regular", which is normal, "Heart sounds, loud, systolic murmur, radiating to the axilla ..."

To the neck, which is an indication of a leaky heart valve:

"No oedema", means there is no swelling of the legs, chest was clear:

"Normal pulse rate".

I have listed the patient's heart. To clarify this entry, a murmur is a sign which is due to turbulent flow of blood through the heart and the term, "Systolic", refers to time, it is the time of the timing in relation to each cycle of contraction of the heart muscle. In Mrs Gregory's case, I thought it possible that the cause of this condition was either narrowing of the aortic valve or a leaking of the mitral valve or a combination of both. This matter had previously been noted, and she had had it since at least 1995.

"No oedema", means there is no swelling of her legs. "Chest was clear". That means on listening to the chest (Inaudible) no abnormality. "These findings are total", meaning that Mrs Gregory did not have any new problem with her heart, lungs, and there was no evidence of heart failure or chest infection.

"Legs", with a double tick, means there is no swelling in the legs or evidence of thrombosis:

"Continue present treatment except change Thioridazine to as required".

This means that I felt there was no need to change any of Mrs Gregory's treatment, other than reducing the regular dose of tranquilizer to receiving it only on an as required basis. Mrs Gregory was prescribed Thioridazine 10mg twice daily on a regular basis commencing the 7th of October:

"Further decline".

This statement is likely to have been made in relation to a report from nursing staff and from Dr. Barton's notes on 18th November. I have noted that Dr. Barton has recorded further deterioration of general condition:

"Start oral opiates in small dose. Please make comfortable. I will speak to granddaughter. I am happy for nursing staff to confirm death? Further CVA ..."

Cerebrovascular accident or stroke, that means. This suggests to me that on 18th November Dr. Barton felt that Mrs Gregory was terminally ill, and that she might have sustained a further stroke, and that the overriding priority was to keep Mrs Gregory comfortable. Where I have shown further decline, this probably means that Mrs Gregory deteriorated more since being seen by Dr. Barton on the 18th.

"Comfortable". This means that Mrs Gregory appeared to me to be peaceful, and not in any pain or distress.

"Opening eyes to speech, short verbal response". This would reflect my attempt to assess Mrs Gregory's conscious level.

B "Pulse, un controlled atrial fibrilation". This means a rapid, irregular rhythm of the heart. It would appear from her records that Mrs Gregory has intermittently had this problem in the past. This can cause patients to become unwell, but it can also develop when patients become unwell from another cause.

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

"Stop Fruseide". Frusemide is a diuretic which is a drug used in the treatment of heart failure when fluid starts to accumulate in the body. However, as I have recorded that Mrs Gregory was only opening her eyes to speech, it is highly likely that at this time Mrs Gregory would have ceased to eat and drink, continuing Ferusamide would have meant D that she was at increased risk of dehydration, hence my decision to stop it.

"Continue diamorphine". I have written this instruction because Mrs Gregory appears to be very comfortable on the present dose of diamorphine without being over-sedated.

Although overall I cannot remember Mrs Gregory I feel it is likely at this stage that I felt that she was dying.

E

I have been asked to comment on why there was a break in the medical records commencing from page 67 of seven-day intervals. The reason is that there is a break of seven days, is that consultant medical ward rounds are conducted on a weekly basis and the previous entry on the 6th of September, which was conducted by Dr. Ravendrain who was at that time the Senior Registrar and usually accompanied me on my ward rounds.

F The fact that the entry for the 6th of September is written by Dr. Ravendrain was probably due to the fact that I was on holiday. Ward rounds would normally consist of Dr. Ravendrain and myself, together with the senior nurse in charge that day, and on alternate weeks Dr. Barton.

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

THE CORONER: Thank you. I think we go to page 22, the final paragraph. Any observations on that? Sorry, the penultimate paragraph, "It is my usual practice to review every patient's drug chart on a ward round".

H A Yes:

"It was my usual practice to review every patient's chart on a ward round. However, because this section is on the reverse and is infrequently used I do not remember noticing prescription of these drugs. I didn't have a conversation with Dr Barton about this particular prescription. I do remember having one conversation with Dr. Barton about a variable dose prescription of diamorphine in relation to one particular patient whom I cannot identify, nor when this took place. I believe Sister Hamblin was present as I believe this was prescribed for a patient who was in pain, and its prescription was, I felt, appropriate.

"I was concerned about the range of dosage. I got the impression that Dr Barton was not happy about being challenged about her practice. Dr Barton told me the reason she did this. Firstly, because she was a full-time GP and chair of Gosport Primary Care Group. She was not always immediately available, and therefore was concerned that if a patient should develop severe pain or distress nursing staff would be able to administer appropriate medication to the patient in a timely way as there could be a delay of some hours before she could attend to the patient. Dr Barton also told me that she was assisting in covering the wards when she was not available, e.g., on holiday, by the other partners in her general practice. She told me that some of her partners were reluctant to attend when called by nursing staff, and that again the prescription of these drugs allowed the nursing staff to relieve pain and suffering without delay.

As far as I can recollect, Sister Gill Hamblin was present when I had this discussion with Dr Barton. Gill Hamblin confirmed that some of Dr Barton's partners from the practice were reluctant to attend.

I also remember hearing informally from other members of staff that some of Dr Barton's patients were reluctant to attend the hospital. I do not remember specific names being mentioned.

I have been working in Gosport War Memorial Hospital, Dryad Ward, for a few months. Previously I had worked at Moorgreen Hospital in Southampton where we had a full-time Clinical Assistant present, Monday to Friday, 9 am to 5 pm, and therefore it was easy to respond to changes in a patient's condition. I haven't worked before in a hospital with a day-to-day hospital was provided by a full-time GP working as a part-time Clinical Assistant".

Could I just expand on that, because it is not strictly true. Thinking back, when I was first working as a consultant in Southampton, we had -- Moorgreen Hospital was a rehabilitation hospital with four or five elderly care wards, and, initially, the day-to-day cover there was provided by a GP Clinical Assistant like Dr Barton, but as workload in that environment developed, the task became too much for him and he was eventually replaced by a full-time Clinical Assistant.

THE CORONER: Right.

A "Although I was unhappy with this -- I was unhappy with this, I accepted Dr Barton's explanation, having been made aware of the difficulties she was experiencing. I trusted Dr. Barton because she was an experienced GP. She was highly regarded locally and she was trusted and respected by the nursing staff. She always responded

to their needs for help and support. Also, I believe Dr. Barton had been working at the Gosport War Memorial hospital for eleven years before 1999, and I had been working there at that time for six months.

I know that all of my colleagues who had worked there before me with Dr Barton in Gosport War Memorial Hospital had great respect for her. There had been no complaints with patients, relatives or nursing staff that I am aware of in the eleven years that she had been working there. In view of this I would not expect the offer the same level of supervision to Dr Barton as I would to a trainee doctor. I also trusted the nursing staff in using their discretion appropriately in relation to the use of opiates and I do not recollect anything other than the minimum dose initially being administered to patients.

THE CORONER: Thank you. I think that is all I want from that. Right.

The clinical notes that we have got, as far as they relate to Spurgeon, I think you have got two entries on that. Have you got a copy of the clinical notes? Do you want to make a start on my copy? 23rd March, 1999.
A Thank you.

THE CORONER: I think there are a couple of entries there.
A Thank you.

THE CORONER: Page 11. The reference letter from you. I do not know if that is what you wanted to refer to, or if we are looking at the entry on page 84.
A Yes. Would you like me to speak to this?

THE CORONER: Yes.
A One of our major roles in elderly medicine is rehabilitation, and after-care of patients when they have been on acute medical or surgical wards, and we are frequently asked to see patients on these wards to offer an opinion as to their future care and management, which may involve transferring them to our care. So, the background to this is that I have been asked to see Mrs Enid Spurgeon who is an in-patient on Haslar Ward, and I saw her there on the 24th of March, 1999. Shall I read out the letter?

THE CORONER: Yes, by all means.
A So, I have written to Surgeon Commander Scott who referred the patient:

"Dear Sergeant Commander Scott, thank you for referring Mrs Spurgeon who I visited in Ward E6 at Haslar on the 24th of March. Mrs Spurgeon had been admitted five days previously after tripping over her dog and fracturing her right hip. Before her fall, Mrs Spurgeon had been very active and had been in good health. When I saw her she was fully orientated and able to give a good account of herself. Her main problem was the pain in her right hip and swelling of her right thigh. Even a limited range of person movement to the right hip was still very painful. I was concerned about this, and I would like to be reassured that all is well from an orthopedic point of view. If you are happy that all is well I should be happy for Mrs Spurgeon to be transferred to the War Memorial Hospital for further assessment and hopefully remobilization".

THE CORONER: Thank you. Then I think we go to page (inaudible) 3 March 1999.
A Yes. That is the letter which was dictated in response to that entry in the notes. Shall I go through it?

THE CORONER: Well, I think it just confirms that you had done an examination.
A Yes.

B THE CORONER: Right. Further entry in the next section, which I have got at VJC45.
A Yes. I will read out that and then perhaps make a comment on it.

THE CORONER: Please, if you would.
A "Still in a lot of pain and very apprehensive. MST..."

MST is oral morphine tablets:

C

> "...increased to 20mg twice daily yesterday, Flupenthixol..."

Flupenthixol is what is called a, "Major tranquilizer", but it has got anxiolytic -- anxiety-relieving -- effects.

I think the significance of this is that normally we would use drugs called,
D "Benzodiazepines", things like Diazepam, Valium, for people who are mildly agitated, but if agitation becomes so pronounced that it becomes almost unreasonable in its -- it seems to -- if the level of anxiety is beyond which one would normally would anticipate, it would become necessary to combine it with a tranquilizer. So, Flupenthixol has both anxiolytic, so anxiety-relieving, and tranquilising properties. So I must have felt that Mrs Spurgeon was really pretty agitated at that time as well as being in pain.

E Then I have written:

> "For x-ray of hip movement still quite painful. Also about 2 inches of shortening of the right leg."

Now, I think it is important that I describe what I felt was the possible diagnosis of
F problems were at that stage. Four possible problems. The first is that Mrs Spurgeon's hip could have been dislocated. Usually hip location starts -- it happens suddenly, and people immediately become -- immediately develop significant pain, and that had not been the case, I understand, in Mrs Spurgeon's case prior to this. She had been in a lot of pain, as far as I could see, from the day I saw her in Haslar. So, that seems an unlikely diagnosis, but, nonetheless, possible.

The next reason for her being in pain or discomfort is a superficial wound infection, which
G really just means where the skin has been cut on the side of her thigh, and that usually responds to sort of simple antibiotics which (Inaudible) were prescribed.

The third possibility is that we have a deep infection of the hip, and what I mean by that is infection in and around the bone, and if I remember correctly, there was a screw that had been inserted in Mrs Spurgeon's case, so there was a piece of foreign metalwork, and unfortunately infection can tend to gather and focus in that area.

H

I will talk about the treatment, or the potential treatment of that in a moment, but the fourth possibility is that because Mrs Spurgeon was very elderly, she had previous fractures, she has got very thin bones, it is possible that this hard metallic screw could have caused the head of the femur to disintegrate, and that is very painful, as is deep infection.

Now, the only way of dealing with both of these scenarios is to take someone back to theatre, remove the metalwork and the remains of the hip, and if you imagine that if someone's femur is like this, the neck of the femur, and a ball sitting there like that, that is your hip joint. What we have to do is chop off from here, and let the shaft -- the top of the shaft of the femur move up into the socket of the hip. I do not think it takes much imagination to think just how awful that is.

THE CORONER: A very graphic description yesterday afternoon from (Inaudible).
A It is a disaster, and I can quote from the British Orthopedic Association who have recently produced a guide to dealing with fractured neck of femurs and the complications associated with them, and patients who develop this complication, in other words, deep infection, the mortality rate is up to 50 per cent and few of them ever walk again.

Now, Mrs Spurgeon was 92. We see fractured neck of femur in patients from their sort of mid to late seventies upwards, so being 92 it is likely that her mortality was likely to be greater than 50%, having sustained this complication. I asked for an x-ray to be done to see if we could establish what the cause of this might be, was it dislocation, was there any evidence of infection, had the head of the femur crumbled? So that was my thinking on that day.

THE CORONER: Right. That, really, is the end of --
A Well, I saw her once more.

THE CORONER: Oh. I have not got a note of that. Where are we?

MS. BALLARD: It is on the same page, sir.
A It is on the same page.

THE CORONER: Right. Okay.
A I saw Mrs Spurgeon five days later and I have written, "Now very drowsy", and I have written in brackets, "(since diamorphine infusion established) to reduce", that is the dose of diamorphine, "... to 40mg per 24 hours. "However, if pain reoccurs, increase to 60mg", and I record that, "Patient able to move hip without pain, but patient not rousable".

My view would be that at this stage that Mrs Spurgeon was dying, and that the overriding priority should be that she should be kept comfortable.

THE CORONER: Right. Okay. Thank you. I have got that at page 48.
A Now, could I say, sir, that this particular note refers to my examination of her while she was in – while Mr Packman was in Queen Alexandra Hospital.

THE CORONER: Yes.
A I have written, "Cellulitis..." Cellulitis is an infection of the skin and soft tissues:

"... Cellulitis of left leg settling. Switch to oral Flucloxacillin". That statement probably refers to the fact that she had been on intravenous Flucloxacillin, or intravenous antibiotics prior to that:

"Oedema of left more than right foot. Continue Frusemide".

That is to do with the swelling. I have written:

"Arthritis of knees left greater than right, plus plus plus".

That means that Mr. Packman had extremely severe arthritis of his knees.

My next line is:

"Arthritis of hips -- mild, left greater than right".

The next bit is:

"CNS intact".

That means examination of the neurological system didn't reveal any abnormality. I have also written:

"Apyrec".

So, in other words, the temperature had come down:

"Blood pressure satisfactory. Continue Felodipine".

Felodipine is a drug which is used to treat high blood pressure, but I have written:

"Reduce the dose to 2.5mg daily because of oedema".

One of the side effects of Felodipine is that it can cause swelling of the legs. If your legs are swollen you are more likely to get a blister and get an infection, et cetera. So, it is important to do.

THE CORONER: The next entry is the 1st of September on page 46.
A I beg your pardon? Which page, sorry?

THE CORONER: Page 56. 1st of September, 1999.
A 55.

THE CORONER: Oh. Right. Sorry.
A So, 1st September 1999, and this was when I saw Mr. Packman on Dryad Ward in the War Memorial Hospital:

"Rather drowsy but comfortable. Passing melena stools."

Melena stools are stools which are black and tarry in consistency, and indicate the

presence of older blood, in other words that someone is having a gastrointestinal haemorrhage. I have written:

"Abdomen huge, but quite soft"

Which means that I felt that he was unlikely to have something like peritonitis, or a ruptured bowel:

"Pressure sores over buttocks and across the posterior aspect on both thighs. Remains confused. TLC".

That is tender loving care:

"Stop Frusemide and Doxazosin. Wife aware of poor prognosis".

At that stage I felt that Mr. Packman was terminally ill. He was drowsy, so therefore probably unable to take in adequate quantities of food and fluid, and so I suggested that his Ferusamide should be stopped, because if that were to be continued he would be likely to become dehydrated and possibly more uncomfortable, so I think it was an important step in palliation.

THE CORONER: Right. I think that does it, does not it? Right. What do you want to do? Tomorrow morning, or do you want to make a start this afternoon? Enough for one day? You have actually had to work a full day today! 10 o'clock tomorrow.

(The hearing was adjourned to the following day)