GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Tuesday 7 April 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 FOURTEEN)

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

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

THE CORONER: Good morning. Does anybody want to say anything before we start? If not, then can we have the jury in please, if we may? We had the excitement of the fire alarm this morning.

MR JENKINS: Both lifts seem to have police crime scene tape across them. I do not know why. One speculates as to why that might be.

THE CORONER: It is nothing to do with me. As long as we are all in safely.

(In the presence of the jury)

THE CORONER: Good morning. You coped with the excitement this morning, did you?

DR WILCOCK, re-called

THE CORONER: You are still under oath, Dr Wilcock. I would be grateful if we could go on to Elsie Devine, please.

A Sir, Mrs Devine was a frail 88-year old woman with significant medical problems; namely, chronic renal failure. She was admitted with an episode of confusion to the Queen Alexandra Hospital and was diagnosed with having multi infarct dementia. This was on the basis of a history examination and appropriate investigation, including a CT scan of the head, which was suggestive of this diagnosis. An infection may also have contributed to her episode of confusion in that her white cell count was raised in the bloodstream. She was given an antibiotic. The white cell count continued to increase. She was switched to another antibiotic and that did seem to coincide with some improvement in her mental state. She was transferred to Gosport War Memorial Hospital for rehabilitation.

Over the duration of this admission, her mental state did appear to deteriorate, in that she was given thyridazine, which is an anti-psychotic medication, to be added to her drug regiment. She was also re-referred back to the psycho-geriatricians, which would be in keeping with the deterioration in her mental function.

At the same time it was also noted that her renal function had also deteriorated. On the day that she was reviewed by the pyscho-geriatricians, a Fentanyl patch – Fentanyl is a strong opiary which can be given as an analgesic patch – was commenced, and the reasons for this are clearly documented. The next day she clearly became very agitated in that she had to be what is called "specialed" by two nurses. This would suggest her level of agitation was such that she was either a danger to herself or to others. She required an intervascular dose of chlorpromazine to settle her, and that is quite a sedative anti-psychotic. A syringe driver was started an hour later containing diamorphine, midazolam, and she died two days later.

The issues for you in this case hinged on whether she was someone who was most likely to be naturally entering the terminal stage of her chronic renal disease. In my experience I look after people with cancer who may develop renal failure, and my experience of them entering their terminal phase is one of a gradual decline with increasing drowsiness and so on. So that was a concern: was she naturally entering the terminal phase?

The other concern for me was whether, when it was noted that her renal failure was deteriorating, her creatinine level in her bloodstream was going up, whether there was something simple, appropriate and reasonable to have been attended to that may have stabilised or improved that situation. In providing my report to the police I also phrased those questions really and as a result of that an expert report was also obtained from a Dr Dudley. Has that been submitted?

B THE CORONER: Yes, we have got that.

A Having read Dr Dudley's report, my take-home message from that was, that whilst, yes, most people who are dying from renal failure may deteriorate gradually, nevertheless it is recognised that people entering the terminal stage from renal failure can present with an acute confusional state or an acute agitated state.

C The other issue he covered was whether anything simple or straightforward may have stabilised or improved her deteriorating renal function. Although he mentions a number of things could be considered, in the overall scheme of things he felt that this was unlikely materially alter to any great degree what happened.

So although I feel there are issues around how the drugs were used, I am reassured by Dr Dudley's report that the nature of her death was in keeping with her entering the terminal stage naturally from her renal disease, and that there was nothing simple or reasonable that

D could have been done that would have materially altered that to any great extent.

THE CORONER: So your management would not necessarily have been the same, but the outcome you do not resist.

A Yes. I think the documentation justification for the use of the transdermal fentanyl patch is lacking. If that is lacking, then the rationale for using the dose of diamorphine of the dose that was used is lacking, so there are issues around the prescription of strong opials

E being used, in my opinion, in this case, but I think it would be difficult to separate out with any certainty the impact that that would have had on her situation.

THE CORONER: So on the basis of Dr Dudley's report, you are settled in your conviction that she was in a terminal state.

A Yes. The key issue for me, looking through the notes, was to try and determine whether, in all probability, she had definitely entered the terminal stage.

F

THE CORONER: Thank you. Mr Jenkins.

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

MR JENKINS: Thank you, just to spell out again, Dr Dudley's view, and I know the jury have heard me read this about five times already, but you have played it in so I am just going

G to remind us of what it is that Dr Dudley says. For those of us who have the report it is page 10, paragraph 8, under the heading, "Opinion". Dr Dudley answers this question,

> "Beyond all reasonable doubt was Mrs Devine dying due to her failing renal condition?"

He gives his answer,

H

"In my opinion, beyond all reasonable doubt Mrs Devine was dying from a combination of amyloidosis" –

we have heard that that is to do with the kidneys --

"progressive renal failure and dementia. It is probable that the acute deterioration in her condition noted on 15 November was precipitated by an unidentified infection".

B

You defer to Dr Dudley's opinion in that regard because he has greater experience of seeing renal deaths than you do.
A Yes.

Q He goes on to say, when he is asked about the acute confusional state,

C "Would the acute confusional state that Mrs Devine developed be in keeping with dying from renal failure?"

You will recall that Mrs Devine was admitted to hospital on 9 October by a letter from her GP saying that she had been confused for a couple of days. She was seen at the Queen Alexandra Hospital by Dr Taylor, a female psychiatrist, noted to have been confused for a number of days and the confusion remained for some period of time, so the question
D Dr Dudley answers,

"Would the acute confusional state that Mrs Devine developed be in keeping with dying from renal failure?" –

his answer,

E "Mrs Devine appears to have had a chronic confusional state – dementia – which had acutely worsened resulting in her admission to the Queen Alexandra Hospital. During this admission and after her transport to Gosport War Memorial Hospital, her confusional state fluctuated. This chronic confusional state, with episodes of exacerbation, was likely to be due to a number of factors, including progressive renal failure on a background of multi-infarct dementia" –

F "multi-infarct" meaning a number of --
A Mini strokes.

Q Yes, mini strokes. He deals with another question,

"Would the acute confusional state be untypical of someone dying of renal failure?"

G He answers that in this way,

"Death from renal failure is usually characterised by increasing drowsiness, leading to coma".

I break off. That was your experience too, was it not?
A Yes.

H

Q He goes on,

"However, in a proportion of patients renal failure is characterised by an acute confusional state and such an observation would not be untypical in a patient with terminal renal failure, particularly when a previous chronic confusional state exists".

Again, "chronic" means long term; "acute" means sudden.
A Yes.

Q He was asked to comment on the use of strong opioids to calm, keep comfortable and enable nursing care in someone dying of renal failure, which was not an obvious plan, and Dr Dudley makes this comment,

"Strong opioids are commonly used in the terminal care of patients dying of renal failure who are agitated and restless to ensure comfort and calm, to enable nursing care and to maintain dignity".

Again, on your reading of the notes there was quite a lot of agitation and restlessness with this lady.
A I would not agree with that.

Q You would not?
A No.

Q But that is his reading.
A That is his view, but that would not be my view. Again it comes down to morphine being a useful drug, but it should be used for specific indications. Like any treatment, you should have a treatment goal that you are trying to improve. As I mentioned yesterday, 15 out of 100 people dying in a specialist post-care unit, did not require opioids when they were dying. I think that in the hospital survey only two-thirds of people -- one third of these had cancer, two-thirds of them did not have cancer -- but only two-thirds of those received opioids in the last 24 hours of life. So I think it is very important to sort of separate out the fact that if people are dying, they should not have opioids as a general panacea. If people are dying they may have symptoms which would be best managed with the use of strong opioids, like pain, breathlessness and so on. I do not feel that I am alone in this view because, alternatively, in the Wessex Guidelines, I think they are called, or Palliative Care Guidelines, please find me a section which says, "Is your patient dying? If yes, give them opiates". What you will find in those guidelines is that if there is a specific problem like pain, opioids can be used. If there is a specific problem like breathlessness opioids can be used. Under delirium or confusion, from recollection the only mention of opioids is that they can be a contributing factor to it.

THE CORONER: Professor Black was quite clear that he would use it for distress and agitation, and that I think what he said was that it was his drug of choice. But that is not a view that you share?
A No.

MR JENKINS: What about when a patient is agitated.
A No, and again, if it is used, it may be based on historical – "this is what we do when people are dying", as opposed to – if you can find any contemporary literature that actually

says it would be a good thing to do, then I would be interested in reading that. But I think if you looked at any guidelines that are published it would be quite specific as to the indications for strong opiates.

Q Again, can I just come back to the report? For those of us who have this report it is page 18, paragraph 6.15 and 6.16.
A Can you repeat the number please?

Q Yes, it is page 18, paragraphs 6.15 and 6.16. He is dealing with 19 November, which is the day after the fentanyl patch had been used. He says,

> "It is my opinion, certainly by 19 November, that this lady was terminally ill and it was a reasonable decision to come to this conclusion".

I break off. Do you agree that Mrs Devine was in a terminal state?
A Yes.

Q He goes on,

> "Equally, not all clinicians would come to exactly the same conclusion, and some might have referred her back to the District General Hospital, when a creatinine of 360 was noted on 16 November. However, on balance, I believe that many clinicians would have come to the same conclusion after a month in hospital",

namely; that she was dying.
A Yes.

Q "Having made the decision that the lady was terminally ill, the next decision was whether or not to offer palliative care".

Again, I break off. Palliative care is to treat pain, restlessness, symptoms.
A Appropriate relief.

Q Absolutely, I understand.

> "Mrs Devine was reported as extremely restless, aggressive and in some distress".

You do not agree with that?
A I agree with that.

Q I will read it again,

> "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".

Do you agree with that?
A Yes.

THE CORONER: I think the disagreement is how you would medicate that. That is the position, is it not?

A Yes.

Q That is where the difference lies.
A Yes.

Q You would have medicated, but medicated differently.
A Yes.

MR JENKINS: Can I just deal with something you raised yesterday? The Liverpool Care Pathway. It was brought in towards the end of the 1990s.
A Yes.

Q There have been a number of initiatives since then which has led to a widespread adoption of the Liverpool Care Pathway.
A It is part of a national – it is certainly a nationally promoted initiative.

Q The government has been supporting it since 2005.
A Yes. As I say, it is a nationally supported initiative.

Q I understand, but the dates might be relevant.
A Without checking I do not know.

Q Right, but over the last four years or so the government has followed it up.
A If you know the date, then that is right.

Q The emphasis in the Liverpool Care Pathway is that with sufficient resources, effort and concentration on dealing with people who are dying, patients can, not be ignored or pushed to one side, but they can be treated with dignity and can be allowed to complete their lives in a manner that is acceptable.
A Acceptable to whom?

Q Acceptable to them and their relatives, and particularly also the staff.
A I am not quite sure what you are getting at.

Q I have looked this up overnight, OK?
A Right.

Q A lot of the emphasis is on time for the carers. They need time to deal with the dying and the relatives of the dying.
A The Liverpool Care Pathway, in a nutshell, is just a way of, in many respects, acting as an aide memoir to good practice. It is essentially ensuring that good care is documented and in being documented, reminding the staff to provide holistic care to the patients and also to the relatives. So in a way it is a reminder; it is an aide memoir; this is what you should be doing as part of good practice; this is one way of just acting as a bit of a prompt. In addition to that, there is a series of guidelines, and there will be a series of guidelines about the management of pain, the management of pain in patients who are what we call, "opioid naïve" -- they have not previously received strong opioids -- and there are guidelines on how you manage pain when people are already on opioids. Where the symptoms which are common in the dying are agitation and so guidelines round the management of agitation are

there, and within those guidelines there is no mention of the use of strong opioids for the relief of agitation.

Now in my report I did not mention the Liverpool Care Pathway as a nationally supported initiative because at the time of this, I did not feel it was going to be widely known, or certainly widely available in all settings.

B Q I agree.
A But you brought it up so I can talk about it.

Q I am just responding to what you raised yesterday.
A Those patients that we surveyed at the hospital, were actually patients who were on the Liverpool Care Pathway. I think I mentioned there that it was the oral morphine equivalent dose, which I think was 30 mgs, for those dying on the Pathway, which made their C medium dose of diamorphine in a pump 10 mgs. The upper limit in that survey of oral morphine equivalent was 90 mgs, which would make a diamorphine 24-hour dose in the syringe driver 30 mgs. So again that just adds a bit of flesh to the bones of the case.

Q What I wanted to talk about was the ethos underlying the Liverpool Care Pathway. The jury have heard about the circumstances and the resources that were allocated to the Gosport War Memorial Hospital. They know that when Dr Barton resigned, a full-time D doctor was employed. I just want to look at how things may have changed since the late 1990s, not only in terms of resources – we have heard the evidence about that – but also in terms of the ethos; what emphasis is now placed on the care of the dying by government and what changes there may have been. Part of the Liverpool Care Pathway, as I understand it, is that health professionals need to be given time, which perhaps they might otherwise not have had: time to deal with patients and relatives. Can I read you a sentence from the document put out by the Liverpool Care Pathway? This is a bit of a mouthful and they are not my E words, but let me read it to you:

> "We continue to believe that the Liverpool Care Pathway is a means to empower health professionals by winning time in the climate of 'busyness', to enable best practice in the last hours/days of life".

I hope you can understand it at first reading. I could not, but I will read it again, F

> "We continue to believe that the Liverpool Care Pathway is a means to empower health professionals by winning time in the climate of 'busyness' to enable best practice in the last hours/days of life".

The stress there is on giving time to the healthcare professionals to concentrate on the quality of life of patients who are dying. Would you agree?
G A It is clearly open to interpretation. My understanding of what they were trying to do was to actually free up the time that might be taken to, let us say, "Should this patient still be receiving this particular treatment? Is it clear that they are now dying?" If it is clear that they are now dying, then things should be discontinued that are of no overall benefit to them, and that may include intravenous fluids; that may include taking their temperature or their pulse every four hours or their blood pressure every four hours. There may interventions that are no longer beneficial to the patient that can be put to one side that would free up time to allow H caring staff to focus on the fact that this person was dying, ensuring that they are comfortable

and maintaining good communication with the relatives and so on. But none of that is rocket science. None of that is not what should not in a way already be being done; but this is an aide memoir as a way of trying to reinforce that. "What is happening with this patient? Are they now actively dying?" In which case, "What are the appropriate treatments?"

Q But the Liverpool Care Pathway also gives advice to management as to how the resources should be structured and that the emphasis should be on giving resources to hospitals, wards, hospices, where people may be terminally ill so that patients who are dying can be dealt with in an efficient way where the staff and medical practitioners have time to deal with them. Do you not agree with that? Let me read the last sentence on this page,

> "The Liverpool Care Pathway is valued because of the positive impact on the patient, carer and staff, and it can therefore bring about a change in the culture of an organisation".

That is part of what this is intended to do, is it not?
A I am lost in how it applies.

THE CORONER: It is referred to as the management of death. That is how coroners look at it, and how do you manage death? If you are going to put different words on it, that is not going to help us a great deal. That is what we are talking about, is it not?
A I am not sure how it is relevant. That is what I am not clear about here. I am not sure how the Liverpool Care Pathway now, in its state today, is relevant to what happened in this situation.

MR JENKINS: Thank you.

THE CORONER: Ms Ballard?

Cross-examined by MS BALLARD

MS BALLARD: Just to come back to a comment you made, or that the coroner made to you, that you would have medicated but have medicated differently. That appears to be a fairly common theme that runs through a number of these individual deaths. That just represents a different approach, does it not, to the medication of diamorphine.
A Again it is trying to understand what the specific problem is and what you are trying to achieve.

Q Yes, but your approach is, "I would not have used diamorphine in those circumstances".
A I may not have, unless there was a good reason to use it.

Q But that is your approach, is it not, and there is a difference of opinion as to how diamorphine is used in these circumstances, is there not?
A There clearly is, but again, I am not alone in my opinion. Nowhere in the Wessex Guidelines does it say use diamorphine or morphine for agitated restless patients. Nowhere in the Liverpool Care Pathway under their guidelines for agitation does it say use fentanyl diamorphine or morphine for agitated patients.

Q But it is an opinion that has been expressed in person by Professor Black and in writing by Dr Dudley, and in writing by Dr Petches.
A Yes.

Q So it is an opinion which you could say is specific to the specialism in which those individuals operate. Yes?
A It is clearly their view, as I have already said. This may be based on historical practice, but trying to find any document, guidelines or anything that would say, "If you have an agitated patient use morphine", which is contemporary to this period, I have not been able to find that. In my practice, again it is: treat the underlying cause. What are the problems? And rational prescribing follows a rational assessment of what the problem is.

Q But you would accept, would you not, that in a patient with dementia who may not be able to express pain in other forms, other than through anxiety, if you take time to try and find a cause for that, that patient would remain to be in pain while you are taking time to find that cause.
A I agree completely that it can be incredibly difficult to assess pain in someone with dementia. I completely accept that, but by the same token, if pain was considered to be a problem there would be a stepwise, rational progressive approach to it, and that is not what is documented.

THE CORONER: I do not think that is right. I think there is, is there not, because the fentanyl patch is the start.
A The fentanyl patch --

Q It may not be something with which you agree.
A The fentanyl patch is 25 micrograms per – the problem with the fentanyl patch is, because it is not called "morphine", people seem more relaxed. So if I was to say, "I am going to start you on morphine", they go, "Oh morphine, that is a bit worrying". If I say, "I am going to put you on this pain patch called fentanyl", they go, "Right, fair enough", because it has not got the same stigma that morphine has. From a doctor's perspective it is 25 micrograms per hour. Gosh, that seems like a really small dose, but actually fentanyl is a very potent, strong analgesic and so as a 25 microgram per hour patch, the literature you would get from a company would say that that could cover a dose range of up to 135 mg of morphine a day. There may be other company literature that says 90 mg a day. From our own work on the floor subsequently, we would say it is about 60 mg a day, but that has been arrived at more recently. Nevertheless fentanyl transdermal patches were licensed only for severe cancer pain, and if they were to be used as a first line strong opioid it would be in patients who had received normal doses of a weak, step two opioid. So to go from nothing to a fentanyl patch in this instance requires justification. That is all I am saying, and that is my issue about how the drugs were used in this situation.

Now, I have already said that I believe, on the basis of Dr Dudley's report, that this lady was entering naturally the terminal phase of a chronic renal failure, and the nature of her deterioration was in keeping with that. She was agitated. I have also said in my report that I felt the use of chlorpromazine and midazolam was an appropriate approach for the agitation. The dosage I might have issues with but nevertheless if somebody is agitated, anti-psychotics and benzodiazepines are what you would find in the Wessex Guidelines; they are what you would find in the Liverpool Care Pathway. The diamorphine, again you might say, "Well, what if she was in pain?" And I would say, "Right, that might be difficult to assess".

Q So is your response to the matter that you were asked --
A So again in a lady with end stage renal failure who effectively has not been receiving opioids chronically, then a fentanyl patch in my opinion was way too high for a starting dose and a much smaller dose should have sufficed and should have been used.

Q I think Dr Barton's point when she dealt with that was that it was a question of how she was going to administer a drug that she wanted to give and that she was not appropriate for a driver; she was not appropriate for any change I think is how she put it, and the method of administration of choice was the patch as being the most suitable way of dealing with it. That is how she dealt with it.
A Again my comment there is, what about the Oramorph, the liquid morphine?

MR JENKINS: Can I just deal with that? Dr Taylor saw her on the AT, and she was not taking any medication.
A I do not know if she said that. She said tablets make her mouth sore, but Dr Taylor similarly said, "though deteriorated in a mental sense, her physical condition is unchanged".

Cross-examined by MR LIEPER

MR LIEPER: Can I ask please that three documents be handed to this witness? The first one is the table that I prepared. Could I ask also that this witness have the medical records? Do you have a copy, sir?

THE CORONER: Yes, I do.

MR LIEPER: I am grateful. Dr Wilcock, we will come back to the merits of Dr Dudley's report in due course, but you can confirm, can you not, that at paragraphs 8.2 and 8.4 he says that,

> "her clinical condition may have improved or stabilised for a few days"?

That is against the backdrop of his considering that further deterioration was likely.
A Yes.

Q But he does say that her condition could have been stabilised for a few days. Do you see that?
A Yes.

Q It is paragraph 8.2.

MR JENKINS: Can the whole sentence be read?

THE CORONER: You are looking at Dr Dudley's report?

MR LIEPER: Yes.

THE CORONER: Just for you to comment on, he says,

> "The diuretic therapies, I cannot read the drug chart clearly, however the patient's weight chart shows no marked change in weight to suggest significant further

depletion. My opinion is that simple measures, such as stopping diuretics, use of intravenous fluids and/or antibiotics was unlikely to have had any significant effect on the eventual outcome. Although her clinical condition may have improved or stabilised for a few days, further deterioration culminating in her death was inevitable".

MR LIEPER: Exactly so, sir, and paragraph 8.4, over the page.

THE CORONER: It reads,

"Mrs Devine's renal function declined progressively over the course of 1999 with a further acute deterioration in the final phase of her illness. As stated above, although simple measures such as stopping diuretics, use of intravenous fluids and more antibiotics may have improved or stabilised her clinical condition for a few days, further deterioration culminating in her death was inevitable. Treatment options such as dialysis would not have been appropriate given her age, frailty and general medical condition".

MR LIEPER: I am grateful for that, sir. It appears to be Mr Dudley's view – we will come back to the merits of that in due course in relation to death being inevitable, it appears to be his view -- that her condition could have been stabilised for a few days, is it not?
A As was read out, yes.

Q The table you have in front of you, which I prepared, records that which was administered to Elsie Devine from 18 to 21 November. You can see that she was given a fentanyl patch on 18 November at quarter past nine which remained in place until removed at 12.30 the following day. Correct?
A Yes.

Q She received a 50 mg chlorpromazine injection at 8.30 on 19 November. Correct?
A Yes.

Q And she received 40 mgs of diamorphine and 40 mgs of midazolam over 24 hours commencing at 9.25 on 19 November, again on 20 November and again on 21 November when she died. Correct? I do not think there is any dispute about the accuracy of that.
A OK. That says that in the table.

Q Because individuals react differently to opiate analgesia, it is important to comply with the stage approach for the administration of analgesia. That is a general principle and that is what you set out yesterday.
A Guidelines always need to be used with imagination. If someone has severe pain then you may go to strong opioids without necessarily going through each step of what is called the WH analgesia programme. But in a chronic pain state, more often than not there is a progressive increment in the strength of the analgesia that is required.

Q If you start with a dose in excess of the recommended dose you are running the risk of adverse consequences, are you not?
A Yes.

Q The greater amount by which you exceed the recommended dose, the greater the risk of adverse effects.
A Yes, there is generally a dose response.

Q Given that Elsie Devine was 88; described as frail; had a history of impaired kidney function and that she had never previously had an opiate analgesia, she was at particular risk of adverse side effects of excess liquid analgesia. Would you accept that?
A I think that again, if you were using a treatment, you would need to use it appropriately and there are certain factors, like a person's age, like any existing co-morbidity, like renal failure, hepatic failure, that you would take into account in what would be considered an appropriate starting dose.

Q The fact that there was previous renal impaired function would highlight the fact that there is a risk of her suffering adverse side effects in the event of her receiving too much.
A It depends on the opioid.

Q OK, with what we have here, diamorphine.
A Again, if you are wondering why we are all here, we are all here because it is a complex situation. Fentanyl is actually considered renally clean. Actually in the Liverpool Care Pathway, the dying pathway that has just been released for end stage renal disease, actually fentanyl is recommended as the strong opioid of choice. However, it is recommended subcutaneously and that is because it allows you to give a smaller dose than you are currently able to give with the patches. Actually, since this time, the 12 mg patch has become available, but even so, in the renal care of the dying pathway, the opioid they recommend would be subcutaneously administered; it allows you to give a smaller dose. So as it turns out, fentanyl being a renal clean one, would be one that is seen as a reasonable choice in people with end stage renal failure now, but I do not think that was seen as something that obvious at the time we are talking about.

Q But so far as diamorphine is concerned?
A Still, it is a matter of saying, if you are using an opioid, are you using an appropriate dose? And although fentanyl may be renally cleaner, to me that dose would have to be justified as necessary and in my view it was not. Diamorphine is essentially turned into morphine in the body and morphine is excreted by the kidneys, so on the other hand, diamorphine is probably the worst one to give people with renal failure. However, when I talked to the renal physicians in Nottingham -- because they have a palliative care interest group and I supported them in various initiatives -- when I tried to say to them, "Look, morphine is not a good drug to use in people with renal failure", they said that it was what everybody else uses in the renal units. What that boils down to is that they were used to using it correctly and safely, and what that would have meant was that they were using smaller doses. They were using it perhaps instead of every four hours, every six hours.

So what I am saying is it is not easy. It is not clear enough to just say you can use that opiate; you cannot use that one. There may be guidelines to inform us, but what people do practise sometimes differs from the guidelines. In respect of the use of the opioids, my main issues are: a 25 micrograms per hour patch of fentanyl is a significant dose of a strong opioid whether or not it is renally excreted, and in terms of the GMC saying that you should prefer your treatments and avoid giving treatments that are excessive to patients, that to me means there should have been clear documentation for indicating why it is required. Again, the justification for the dose of diamorphine I do not believe is clearly documented in the records,

and as such that dose of diamorphine in someone dying of renal impairment, with no justification, I can only leave you with the opinion that it is excessive in my view.

Q Dr Wilcock, I have a number of questions I want to go through with you and there is a fair amount of ground to cover. If you could, if and in so far as you are able to, confine your answers to the specific propositions that I put to you, I would be grateful. You have made reference to the patient information guidelines that would have accompanied the fentanyl patch.
A Yes.

Q One sees this is a document, the guidelines, with which the clinical assistant was familiar and you will see that on page 1 of that document it makes clear that fentanyl can be fatal. You see the first bullet point there.
A I am sorry, are you saying that Dr Barton was familiar with this?

Q She was familiar with these guidelines, yes. That is what you have said in giving your evidence.
A Yes.

Q Will you confirm that it says that it is life-threatening, pure analgesics can cause serious side effects, including trouble breathing which can be fatal, especially if used in the wrong way. Yes?
A Yes.

Q It also confirms – this is the last bullet point on page 1 – that it is only for use for the opioid tolerant.
A Yes. Have we got a date for this information?

Q No. Do you see the definition of "opioid tolerant" at the bottom there?
A Yes. I think the relevant thing here is that, in 1999 the only licence indication was for cancer pain. It subsequently got a licence for chronic pain, but at the time it was used here it was licensed for use for cancer pain.

Q That was the next point I was going to come on to, but it makes it clear, does it not, that Duragesic Fentanyl should only be used for those who are opioid tolerant.
A Yes.

Q There is a clear definition of what opioid tolerant is.
A Yes. Again it is relevant because I think when the licence was extended to chronic pain, this perhaps was more clearly spelt out. What I have is a card provided by the company with the relative doses. I think I have got it in my report actually, because I did dig out the relevant contemporary data on fentanyl. This is from my report

> "Fentanyl is a strong opioid analgesic similar to morphine. In 1999 fentanyl transdermal patches were only licensed for the relief of chronic intractable pain due to cancer. The company produced prescribing advice and anticipates that if used as a first line strong opioid it would be in patients who had failed to get adequate relief from regular weak opioids".

From recollection they do not actually specify the dose. I was involved with the trials of fentanyl and the entry criteria were that patients had to be on at least 240 mg of codeine a day.

Q Which equates to what in morphine?
A About 20 mg of oral morphine.

B Q So back in 1998/99 it would only have been appropriate to commence somebody on fentanyl had they had pre-existing morphine.
A My view is that it is perfectly legal for doctors to use products outside their licence indications. The licence indications do only regulate drug companies. However, given that it is a strong opioid; given that that starter patch contains a significant amount of opioid; given that the prescribing advice provided by the company suggests that this should be for patients who have already been on weak opioids, I think it would be particularly relevant that the C doctor prescribing would ensure that it is being used in an appropriate and safe manner, and that would include documenting or demonstrating perhaps that other more usual approaches had failed or were not appropriate.

Q The British National Formulary, which was in place in 1998/1999, makes it clear that fentanyl may produce severe respiratory depression. Are you happy with that?
A As any opioid.

D Q Thank you. As Professor Black confirmed, it indicated that it was appropriate for chronic intractable pain due to cancer.
A Yes.

Q There is no evidence, no contemporaneous evidence that Elsie Devine was in chronic intractable pain in the notes.
E A There is no documentation that supports that.

Q We have heard from a Nurse Turnbull, that the nursing staff were under an obligation to include significant matters which would include any identification of pain.
A Yes.

Q We have been told that there were difficulties in Dr Barton's note keeping because of F pressures of time, but we have not been told of any difficulties with nurses keeping records of patients' pain.
A Yes.

Q No one has suggested that nurses were doing other than what they should have done in relation to the relief of pain in relation to Mrs Devine. Elsie Devine was seen by a psychiatrist on 18 November.
G A Yes.

Q We know from Dr Barton that she was seen at around 9 o'clock that morning, 9 o'clock on 18 November.
A Yes.

Q The fentanyl patch was applied at 9.15.
H A Yes.

Q We have a record from Dr Taylor – page 405 in the medical records. There is a reference to circumstances in which she was transferred for review. There is a reference to her being aggressive, wandering, removing other people's clothes, refusing medication. Then he goes on to detail his findings on review – do you see that –

"Reviewed on ward. Happy. No complaints. Waiting for her daughter. Not obviously paranoid. Says tablets make her mouth sore"

A Yes.

Q You would expect, would you not, that if somebody was in chronic pain, that is something that would have been recorded there?
A More than likely.

Q Yes. She was seen by both Sandra Briggs, her daughter-in-law, and by Hilary Devine on 18 November. So far as you are concerned there is no evidence of there being chronic pain which would justify the fentanyl patch on 18 November.
A In my opinion there is insufficient justification for the use of that amount of a strong opioid without any obvious attempts to try intermittent Oramorph or intermittent codeine or something along those lines.

Q What you have said in your report is,

"I am justifying 'excessive' and this patch is likely to deliver a high dose of strong opioids and too much for an elderly frail and opioid naïve patient".

A Yes.

Q And you think that if and insofar as analgesic drugs should have been commenced at all, that they should have been given in a proportionate way.
A Yes.

Q You state at page 15 of your report that the fentanyl patch far exceeded that advised in the frail elderly.
A Yes.

Q Your evidence is that, if and in so far as you are going to start, in no circumstances should it be more than 30 mg of morphine.
A Again, looking at the doses that are either quoted in the British National Formulary or the Wessex protocol, these are what would be considered the usual doses. In addition to that you would take into account the patient's age, frailty and again renal or liver function. It would be prudent to start with a smaller dose.

Q That is what you would expect to happen.
A Yes.

THE CORONER: Are you going on to the diamorphine now?

MR LEIPER: I am just finishing with the fentanyl patch, sir. The problem that Dr Barton said she had with the fentanyl patch that she used, was that that was the weakest available at that time; there was nothing less than that and if she was going to choose a patch it had to be that one. I think that is what she was saying. That is what she was saying.
A Again it is use.

Q You are saying you would not have used the patch.
A No. I am aware that people used to cover half of the patch. The delivery rate of the drug is proportional to the surface area of the patch, and as patches deliver more they actually get bigger. So in some circumstances, like in paediatrics, what they would attempt to do is halve the rate of drug delivery by covering up half the patch. That is not recommended by the company. It was never robustly tested whether that actually worked or not, but nevertheless it was a practice that some people adopted. You could not cut these patches because they contained the drug in a liquid form. Subsequently, because of feedback, they produced a 12 microgram patch.

Q You have said in your report that the fentanyl patch is equivalent to 135 mg of morphine.
A That is what the – my appreciation, again I was trying to think of what information doctors would have to hand, and from recollection of seeing the drug representatives from Jansen, these were the sorts of things they would be handing out to doctors and that information is straight from Lithco.

Q So the information available to the clinical assistant as at 1999 would be that they are dependent on what you say is 135 mg of morphine.
A Again, all you can say is that they have put four hourly. This is dose conversion and what it meant to say is that if you are on these doses of morphine, this would be an appropriate starting dose of fentanyl. So what they are saying is, if you are on 20 mg four-hourly or less, you would use the 135 a day unless you choose the 25.

Q Given that 30 mg of morphine is the recommended starting dose, is the recommended safe level --
A In my opinion, if you take into account frailty and renal impairment, that would be a reasonable dose, yes.

Q The effect of the application of the fentanyl patch was to give conceivably up to four times the recommended dose.
A Yes.

Q A fentanyl patch is a slow release patch. It takes up to 24 hours to become fully effective.
A There is a very wide range, but yes.

Q But it can be.
A And it can take even longer to reach what is called steady stage; that is, steady levels in the bloodstream.

Q But it can become fully effective in 24 hours.
A In reaching an effective level that relieves the pain there is a wide dose range in terms of levelling off so you can fully assess the impact of that dose.

Q It can, but it can be fully effective within 24 hours.
A Yes, that is within that range.

MR LEIPER: If Elsie Devine was in urgent need of medication on the morning of 18 November, it would not make sense to give a slow release patch which is unlikely to have effect over the course of the next 24 hours, would it?

THE CORONER: He said he could not understand the reasoning behind the use of the fentanyl patch.
A I do not know the full reasoning.

MR LEIPER: There does not seem to be any logic to it, does there?
A There was nothing in the notes. There is no justifiable indication for use of the patch documented in the medical records.

Q If there had been a symptom which needed relieving immediately, there are a number of other things that could have been done.
A Yes.

Q We know that Elsie Devine had all her medication at six o'clock on the morning of 18 November, from the medical records. Can you just confirm, that is page 276 if you want to refresh your memory? I think you have the right page there. What we have got is the drug chart. I put mine together and one can see that at six o'clock on the morning of 18 November.
A Yes.

Q She told the psychiatrist that the tablets made her mouth sore. But that would not be a reason for not giving oral morphine.
A I would say it is a reason to look in her mouth. She may have an infection called candida which could be very readily treated.

Q But that would not be a reason for not giving her oral morphine, would it?
A Not particularly. Oramorph can sting, so if you had a sore mouth, it might make your mouth sting. But if you have an elderly patient telling you they have got a sore mouth, you look in their mouth.

Q The doses of opioid which are excessive to a patient's need, I think you confirm, can be associated with episodes of delirium.
A Yes.

Q And episodes of confusion?
A Yes.

Q And risks of aggravated confusion.
A Agitation, yes.

Q Where an elderly person is confused and experiencing delirium, that can manifest in agitated and aggressive behaviour.
A Correct.

Q Elsie Devine had a previous history of confused and aggressive behaviour going back to October 1999.
A Yes.

Q There are two records, one dated October 1999 and the other a letter dated 15 October 1999 which suggests that she was confused plus plus, aggressive, wandering, in the notes.
A Yes.

Q On the morning of 19 November, there appears to have been an episode of extreme behaviour. We have been told that on 19 November Mrs Devine had been throwing staff into a book case. This was Staff Nurse Debbie Barker. During the night she had been found to pull patients out of bed, hitting out at anybody who interfered. The jury heard from a witness to that incident on the morning of 19 November, Lynn Barrett, in the first week of this inquest, in response to questions from Elsie Devine's granddaughter, and Lynn Barrett certainly confirmed that the behaviour was certainly out of the range of Elsie Devine's usual behaviour. It is a matter which is also commented on in Dr Barton's notes, that there had been a marked deterioration overnight and nurses also confirm marked deterioration in the last 24 hours.
A Yes.

Q So what happened on 19 November appears to be out of the norm so far as Mrs Devine's pre-existing episodes of confusion and agitated behaviour are concerned.
A The fact that she needed to be "specialed" by two nurses would suggest that.

Q That episode of marked deterioration in her behaviour coincides with the time at which the fentanyl patch might have been expected to become fully effective, does it not? The fentanyl patch had been applied 24 hours previously.
A Yes, again it reaches analgesic levels and then a steady stage within 24 to 72 hours.

Q So the answer is yes.
A Yes.

Q That marked deterioration coincided with the time when one might have expected the fentanyl patch to come fully into effect. Yes?
A Yes.

Q You have expressed the view, at page 19 of your report, that the deterioration in her mental stage on the morning of 19 November was likely to have been caused by the fentanyl transderm patch the day before. That is what you said.
A My view was, again it is a question of asking why: why have things changed?

Q Can I just say that that is what you put in your report?
A Yes, but I will have to qualify it. It comes back to something that I have said at the beginning. I have already stated that my main issues were whether this lady was likely to be naturally entering her terminal phase or not.

Q We will come on to that. We will come on to Dr Dudley's analysis.
A In my report I gave two views, as it were, on the basis of whether it was likely that she had entered her terminal phase naturally, or whether she was unlikely to be entering her

terminal phase naturally. So I think in Dr Dudley's report it is obviously moving more towards the former.

Q We will come on to Dr Dudley's report and the reasons which informed that report in due course. I just want you to confirm that what you said when you did your report was that the deterioration in her mental state on the morning of 19 November was likely to have been caused by the fentanyl transdermal patch the day before. Correct?

B A I think somewhere I say that if somebody deteriorated to that extent you would look for a probable cause, and amongst those causes one would consider whether a change in the medication, such as the opioid, may have had anything to do with it.

Q Exactly so. At the bottom of the page you go on to say,

> "A rapid worsening of Mrs Devine's mental state would be more suggestive that an
C underlying aggravating factor, for example, an infection or a cerebral vascular event or a drug. The latter is particularly relevant given the newly prescribed fentanyl transdermal patch given the night before".

Correct?

A Yes.

D Q If I may just put Dr Dudley's report aside – we will come to the reasons for his conclusions in due course – it would be quite possible that what happened on 19 November was attributable to the consequences, the application of the fentanyl patch.

A On my reading of the notes, it was my conclusion that that could be a relevant factor.

Q Yes. I think you have heard about Professor Black's views, and he has said that her mental deterioration may have been due to the use of fentanyl on top of everything else.

E A Yes.

Q You have confirmed and given evidence in relation to Mr Cunningham that every time you assess a patient and consider giving medication, that you have to consider what has happened in the past in relation to the effects of their previous medication.

A In terms of what their existing analgesic requirements have been.

F Q Yes. And the effect on them of a previous analgesia.

A Yes.

Q Following her marked deterioration on 19 November, within the hour Elsie Devine was given 50 mg of chlorpromazine – that was at 8.30 in the morning – and at 9.25 she received 40 mg of diamorphine and 40 mg of midazolam over 24 hours. It does not appear as though consideration was given to the effects on her of the fentanyl patch at that stage.

G A She had not had a period of not having the fentanyl patch and not having any of the others, so you cannot answer -- I do not think you can answer that.

Q Given the dangers associated with an opioid device and the potential for her mental state to have deteriorated in a temporary or reversible way, a more measured approach would have been called for, would it not? That would have been your expectation.

H A If it could be considered without reasonable doubt that she had not entered her terminal phase, then yes.

Q When you reviewed the medical records there was that doubt in your mind originally.
A I had that doubt and I expressed that doubt.

Q When she was given the chlorpromazine, she was given a dose of 50 mg which, from what you say, was double that recommended for an elderly frail patient by the BNF.
A Yes, by the BNF.

Q You say a much smaller dose would have been preferable.
A Yes.

Q It appears as though she was given double the recommended dose on the morning of 19 November. Correct?
A With regard to the advice given by the BNF, yes.

Q Yes. It is your view that she was given too much chlorpromazine.
A Well, --

Q I mean, you said in your report that it was excessive.
A On the basis of the guidance in the British National Formulary given her age and frailty, she should have had a smaller dose than that.

Q She should have had a smaller dose.
A Yes.

Q That is your view as to what should have happened.
A Again, I have less of an issue about the medical treatment of an agitated state when it is severe to the extent that she needs "specialing" by two nurses, which suggests she was a danger to herself or to others, but again you manage those situations in a measured approach. Although anti-psychotics would be seen as the treatment, again you would apply them in a measured way. The best that I could say is that from the British National Formulary, the dose that would be considered reasonable in somebody of her age, her frailty would be less than what she was given.

Q I am just asking for your view as an expert who is well experienced in dealing with this medication. Was she or was she not given too much chlorpromazine at 8.30 on the morning of 19 November.
A I do not use chlorpromazine. I use levomepromazine, and levomapromazine is a closely related drug to chlorpromazine.

Q But that is not what she was given. She was given chlorpromazine.
A Yes.

Q The question is, would that have been too much chlorpromazine for her in that situation?
A When I did general medicine and I was giving chlorpromazine to healthy young men running round car parks with me rapidly running behind them, 50 mg may well have been appropriate. But in an elderly, frail patient, based particularly on the BNF guidance, it would recommend a smaller dose than 50 mg.

Q So that is a yes.
A Yes.

Q If you could perhaps provide slightly shorter answers as long as they accurately represent your competent considerations at the time, it would be appreciated. So far as the midazolam was concerned, she was given 40 mg of that.
A Yes.

Q I think that you are critical of that because there had been no opportunity given to assess the long-term effect of chlorpromazine. Yes or no?
A It is contextual. My concern when through the notes it was not clear that she had definitely entered her terminal phase, I would have been concerned that she had a larger than anticipated dose of chlorpromazine. The effects of that dose had not worn off before a syringe driver was commenced with what would be considered a larger than normal starting dose of a midazolam.

Q What you said in your report was that,

"If the use of midazolam was deemed necessary, it would, in my view, have been more appropriate to give smaller doses – 2.5 to 5 mg – by intermittent subcutaneous injection as required. The starting dose of midazolam of 10 mg over 24 hours would have been more reasonable".

A Yes.

Q So she was given four times as much midazolam as you consider appropriate in the circumstances.
A From my reading of the notes, yes.

Q So far as the diamorphine is concerned, you have said that,

"In the absence of pain, shortness of breath or cough, in my view there is no justification for the use of diamorphine".

Correct?
A Yes.

Q And that is your view.
A There was no documented reason that justified it.

Q And the absence of pain, shortness of breath or cough, there was no justification for its use. That is what you said.
A In as much as we have discussed how diamorphine is used, yes.

Q Yes. Had there been any justification for it, it would have been appropriate to start at 10 mg of diamorphine.
A Yes.

Q So had there been any justification, it appears that she was given four times as much as the recommended dose of diamorphine.
A Yes.

Q There was an overlap between the administration of the fentanyl patch and the diamorphine, for a period between 9.25 and 12.30 on 19 November.
A Yes.

MR LEIPER: You have said that the fentanyl patch was up to four times the recommended dose. You have said that the diamorphine given was four times the recommended dose. In those circumstances would it be fair to say that Elsie Devine received eight times the recognised safe amount of opiate analgesia --

THE CORONER: It is not as simple as that is it? We have had the discussion that the fentanyl patch is a slow release patch. You do not get a dosage when you apply the patch. It is transdermal and it is slow release. Is that right?
A The way that it works is you apply it. It starts to release the drug right away, but the depo needs to form in the subcutaneous tissues under the skin. Once that has developed it then starts to get into the system and that is why there is a delay from the time that it is applied to the time of it working.

Q You do not get 25 mg when you apply the patch.
A No. It will build up over certainly 24 hours.

Q So the question, would she have had eight times the recommended dose –

MR LEIPER: Twenty-four hours after its application.
A Again, the fentanyl patch is a bit like a syringe driver. It is delivering a certain amount of opioid over a period of time, so it will be delivering 25 micrograms per hour of fentanyl as a steady dose.

Q So over 24 hours the likelihood is that it is administering what it is there to administer, and you have confirmed that it would be administering four times the recommended dose, over the period of 24 hours, approximately.
A Again, there is a range. Some people would consider it equivalent to 60 or 90 mg of morphine over 24 hours, but the product literature said up to 135.

Q OK. You have confirmed the four times the recommended dose. You have also confirmed the four times the recommended dose of subcutaneous diamorphine.
A In my opinion.

Q So would it be fair to say that as from half past nine onwards, on the morning of the 19 November, Elsie Devine was receiving eight times the recommended dose of diamorphine?
A I see it as four times. If you have 10 mg over 24 hours which is what I consider a reasonable dose and she was given 40 mg over 24 hours that is four times.

Q That is the diamorphine, but she has also had the fentanyl patch on for a period as well, has she not?
A But that has been removed.

Q No, it was not removed until after midday on 19 November.

A I do not see that as a major issue because, in the same way, as soon as you take off the patch the levels will start to fall and they can take 12 to 17 hours to fall into half the dose that they were. At the same time, as you set up a syringe driver, it will not work right away. It will take a few hours to build up. On that dose of fentanyl – let us take it this way – it is not that she was sedated; it is not that her respiratory rate dropped. By contrast, she was agitated, she was confused. She required two nurses to settle her. So the dose of fentanyl that she received in my opinion was not sufficient to sedate or respiratory depress her at all. But because I feel it was excessive to what her likely needs would be, it certainly risked making her confused state worse.

Q So far as the diamorphine is concerned, that was, if and insofar as it was justified to use it at all, it was being used at four times the recommended amount. Yes?
A In terms of what I could consider reasonable, having read the notes, yes.

Q Thank you.

THE CORONER: Are you moving forward because the tape machine is just about to become static. Shall we take five minutes, please?

(The hearing adjourned for a short time)

THE CORONER: Mr Leiper?

MR LEIPER: Sir, I am grateful. Dr Wilcock, I will take you through your opinion as shortly as I can. When you originally did your report you did not consider that Elsie Devine's death was typical of patients dying with chronic renal failure.
A In my experience.

Q It was your experience that one would expect a more gradual onset associated with increasing weakness and drowsiness.
A Yes.

Q A gradual physical decline over days or weeks would be more typical. That was your view.
A Yes.

Q When you reviewed the notes you would have noted that she was physically stable in the period up until 19 November.
A The comment in the note from Dr Taylor was, I think, "appeared well", or words to that effect.

Q You are absolutely right. That was on 18 November when she was reviewed at nine o'clock in the morning. Dr Taylor confirms that her physical condition was stable.
A However, her renal function was clearly deteriorating.

Q We will come on to that. That, as I understand it, is with reference to the blood test.
A Yes.

Q Absent evidence of the blood test, there is no evidence of a decline in her physical condition.

A But the blood test of itself is very significant.

THE CORONER: I think what Mr Leiper is saying is, the results not being there, you would not be aware of the significance of that.
A In terms of what is documented, no.

MR LEIPER: It is the blood test which leads you now to believe, having read Dr Dudley's report, that she was likely to have been terminally ill with chronic renal failure. Correct?
A My concerns were the nature of her decline and also whether anything reasonable could have been done about her deteriorating renal function.

Q Dr Dudley places significant reliance on that blood result which came through in November and you do as well, presumably.
A Yes.

Q The blood result in three had the creatinine in her blood at 360.
A Yes.

Q It was that which, so far as you were concerned, may have indicated a significant compromising renal function.
A Yes, that was a significant change from the previous level.

Q You are aware of the fact that her creatinine levels had fluctuated during the course of the last year. Were you aware of that?
A Yes.

Q I can take you to the pathology results if need be, but in September 1999 her creatinine level was 203. In October 1999, 18 October, her creatinine level was 201, and on 9 November her creatinine level was 200. Yes?
A Yes.

Q And between that there was some fluctuation.
A Yes.

Q You will be aware that the antibiotic trimethiprin can cause an important irreversible increase in creatinine concentration levels.
A I did not know that.

MR LEIPER: All right. I have handed up to you the manufacturer's leaflet of information for Aloprim, which is the product name for trimethiprin. If you go to page 3.

THE CORONER: Can I stop you just a moment. On my desk in my retiring room there is a leaflet that is still in its packet. I wonder if I could possibly have it please? Do go on Mr Leiper.

MR LEIPER: Thank you, sir. Page 3, under the heading "precautions do you see, "Use with caution in the following circumstances", second bullet point, "Impaired renal function". It says, "trimethiprin may cause a significant reversible increase in serum creatinine".
A Yes.

Q So it appears from the people who produce the product, that you should be aware that it can cause a significant increase in creatinine levels.
A Yes.

Q The rise in creatinine level between 9 and 16 November, the rise from 200 to 360 coincided exactly with a five-day course of trimethiprin. That is page 276 in the medical records. Again, I do not think there is any dispute about this. It begins at page 277. Do you see this?
A Yes.

Q You see trimethiprin, it is administered between 11 and 15 November. Yes?
A Yes.

Q Which are the exact days when trimethiprin was being administered. Yes?
A Yes.

Q The month previously there had been an almost identical pattern of creatinine level rising in conjunction with trimethiprin. Were you aware of that?
A That would have been my question, because she obviously had trimethiprin at the Queen Alexandra.

Q Yes, she did. She had it between 9 and 13 October and the effect on her creatinine levels appears at page 247 of the bundle. My page 247 looks like that.
A Mine says 2247.

Q Do you see there, there is a rise in the creatinine level to a figure of 288?
A Yes.

Q That coincides exactly with the period over which she had trimethiprin – you can see that from page 272. It was between 9 October and 13 October. Yes?
A Yes.

Q It did not mean that she was terminally ill at that stage, did it?
A No.

Q What those responsible for her did was simply take her off trimethiprin and put her on the antibiotic sebatcol(?). It is on page 162 if you want confirmation of that.
A I do not think that was in response to the creatinine going up though.

Q Right.
A I think it was in response to the fact that she had not improved and her white cell count was continuing to increase. That was my reading of this.

MR LEIPER: So be it. When she came off the trimethiprin on13 October, her creatinine level again reduced, and the next reading is 18 October when there was a blood test and her creatinine was back down to 201. You see that at page 359 if you want to confirm that.

THE CORONER: I suspect you are just about to ask Dr Wilcock something he cannot answer actually. He was not aware of the effect trimethiprin could have.

MR LEIPER: No, but he can do the best he can with the material we have got before us, sir. So trimethiprin having finished, the creatinine level goes back down to how it was prior to the trimethiprin having been given.
A Yes.

Q In the light of the role that trimethiprin appeared to play in raising Elsie Devine's creatinine levels, would you accept that it would not be safe to arrive at a conclusion that Elsie Devine was terminally ill as a result of the raised creatinine level obtained in the week before she died, simply by reference to the blood test result itself?
A I have a general thought about that that if trimethiprin leads to a rise in creatinine, as I think you have demonstrated, the nature of the rise when she first was given it was 224 to 288. I am not sure why the nature of any other trimethiprin associated rise would be any greater than that. That is just a thought. In terms of a renal physician knowing that trimethiprin puts up creatinine, I would have thought Dr Dudley would have been aware of that and taken that into account in his report. But I guess the question needs to be asked of a renal physician.

Q The difficulty is that Dr Dudley was provided, slightly unusually, with the clinical assistant's statement, and at page 6 of that statement the clinical assistant said that trimethiprin had not been given.
A I do not know.

Q I am telling you that that is the position.
A I will take your word for it.

Q At the very least, those responsible for Mrs Devine's care should have been cautious about placing too much weight on this increased creatinine level when it appears that there was a link between trimethiprin and the increased creatinine. Do you accept that?
A Again, I think you would have to ask a renal physician.

Q But as a matter of the general practice experience you have had in the past, it would be appropriate to be cautious about it, would it not?
A I think the concerns I expressed in my report are there for all to see. I had a concern -- was she likely to be entering the terminal phase or not naturally? -- and in my view that has been guided by Dr Dudley. I think any difference to that, based on what you have asked me, you would have to ask Dr Dudley about.

Q Fine. But you recognise that there appears to be a link between the trimethiprin and the creatinine levels.
A Yes. There appears to be a link but it is not a consistent link, in the sense that the degree of the rise is clearly greater second time round.

Q But any analysis done of the significance of the creatinine result which came through in the middle of November, made in ignorance of the fact that she was given trimethiprin, may well be flawed.
A I do not know. You would have to ask someone else.

Q So far as the other matter is concerned, it is clear that Dr Dudley places significant weight in relation to the raised creatinine level.
A Yes.

Q The other matter that he places significant weight on is the agitated behaviour being exhibited by Elsie Devine.
A Yes.

Q We know that Elsie Devine had had a confusional state -- the notes mention it -- in October 1999. Yes?
A Yes.

Q And we know that there had been an extreme manifestation of that confusional state on the morning of the 19th.
A Yes.

Q It is what happened on 19 November which appears to be relied on as being evidence of acute confusional state.
A Yes.

Q When Dr Dudley wrote his report, he expressed the view, perhaps surprisingly in the light of the view that you have expressed, that the administration of the Fentanyl patch and other opiates was appropriate in the circumstances. Correct? The last page of his report. The last sentence of the first paragraph, "Summary of conclusions",

> "She was treated appropriately in the terminal phase of her illness with stronger opioids to ensure comfort and calm, and to ensure nursing care and to maintain dignity".

Correct?
A It does not specify whether he is separating out the Fentanyl patch and the diamorphine. He certainly seems happy with the diamorphine because he then goes on to say that is appropriate.

Q Yes, and you have confirmed that it is at least possible that what happened on the morning of 19 November was as a result of the Fentanyl patch. You confirmed that as a possibility.
A Yes. There was a doubt, again it has to be contextual and the context is whether she was likely to be naturally entering the terminal phase of her life or not.

Q Just answer the question. You have confirmed that it was at least possible that that episode on the morning of 19 November is a consequence of the Fentanyl patch.
A It is a possibility, yes.

Q You stated yesterday that where a patient has been treated with thyridizine, and that is then subsequently stopped, it can result in an increase in agitated and confused behaviour. Do you remember saying that?
A If someone was on it regularly as a night sedative and then it was stopped.

THE CORONER: I think how you put it yesterday was that if she had been on it and that had been satisfactory, why not continue it.
A Yes.

THE CORONER: That was the question that was put, I think.
A Yes.

MR LEIPER: You see on the drug chart that Elsie Devine had been on thyridazine between 11 November and 17 November. Page 278. She was prescribed 10 mg three times per day if required. We have been told that that was the lowest dose that could be prescribed. She had 10 mg on 11th, 10 on the 12th, 20 on the 13th, 20 on the 15th and then 10 on the16th, 10 on the 17th, and then it is discontinued on 17th. Do you see that?
A Not that it is discontinued, but she had no further doses, so it is not crossed off.

Q If we go to page 194 we see that it was not given because not required. Page 194, nursing care plan dated 17 November, the entry dated 17 November,

"Slept well. Out to toilet twice. Thyridazine not required".
A Yes.

Q So it is conceivable, is it not, that the agitated behaviour, which happened following the discontinuance of that thyridazine, was a consequence of that drug having been stopped? It is possible, is it not?
A By its nature that drug was there to be used if required, and clearly on some days she has required it and on other days she has not required it.

Q She has had it over a period of five or six days.
A I would not say that was a purposeful attempt to discontinue that medication.

Q No, but it is a fact that it was discontinued.
A She may not have taken any. I think it is a small but important point.

Q She stopped taking it for whatever reason.
A It was there if she required it. As you just demonstrated, there were periods when she did not require it. I can imagine, and having been in that experience, if people are agitated to the extent that they need two nurses to special them, they are not going to swallow anything.

Q That is on 19 November.
A Sure, but what I am saying is that it was there. Thyridazine is there to be used if required.

Q Exactly, if required. The fact that it was not used, if she was agitated, agitation was the reason for the Fentanyl patch having been administered. But if she was agitated and required medication, then a way of dealing with it would be to use the thyridazine.
A Again, in my view there is insufficient reason to justify the use of the fentanyl patch. I have not heard for what reason it has been used.

THE CORONER: It was used because it was the desired avenue by which it could be given. It may not be a reason that you agree with and it may not be one that stacks up but that is what Dr Barton told them, that she wanted to produce morphine and was not going to be able to do it any other way and that is why she used the patch. That is her reasoning.
A I am sorry, what I meant was, I do not know what the indications were, what the specific reasons were for using it.

MR LEIPER: Given the absence of reliance that can be placed on the raised creatinine level blood results, in the light of its connection with trimethiprin, and given the possibility that the agitated behaviour which occurred on the morning of the 19th was attributable to the Fentanyl patch, there would appear to be no good reason to conclude that this was an episode of irreversible renal failure.

A Again it is an important point, but I think on both counts I would be guided by a renal physician in terms of their opinion of whether the mode of her deterioration, the likelihood of the ability to stabilise the situation existed.

MR LEIPER: But on the whole, your personal view – because you give expert evidence – doing the best you can, what has been relied on --

THE CORONER: Using your own expertise.

MR LEIPER: What Dr Dudley has relied on is the agitation on the morning of 19 November, and he has also relied on the raised creatinine level blood result which came through.

A Yes.

Q In the light of what you said, there must be substantial doubt as to whether or not these two are reliable indicators of terminal illness attributable to renal function.

A You will have to ask a renal physician. I am sorry, but it is such an important point and as I have understood what was the likely cause of her demise, I think how you phrase those two questions, it has to be answered by a renal physician. Whether it would materially alter what he would do.

Q If we can – I mean, can you confirm this? That it is indeed surprising, in the light of what you have said about the level of diamorphine that was administered, given that it was four times the recommended dose, it is a matter of some surprise, is it not, that Dr Dudley has said that what happened was appropriate?

A Again, I think I have laid out quite clearly --

Q It is a view that you disagree with.

A My view is that opioids are used but they are used for specific indications and they should be used in doses appropriate to a patient's needs.

Q Just before we go on from Dr Dudley's report, he received a statement from the clinical assistant, but he also received a summary from the police which recorded a past medical history of myeloma.

A Yes.

Q That is incorrect, is it not?

A Yes.

Q So Dr Dudley's report was based on incomplete information in relation to trimethiprin; incomplete information in relation to whether or not there was a pre-existing myeloma.

A No, I think in fact it was quite clear that she had not got a myeloma. They went on to perform a bone marrow biopsy and it revealed no evidence of myeloma, so I think a careful reading of the notes means it is fairly readily apparent that this lady did not have myeloma.

Q Then he goes on, if you look at page 19, at the bottom of page 8 and the top of page 9, you see he is talking about multiple myeloma and at the conclusion of the top of page 9, that paragraph,

> "Between these two extremes is the condition of smouldering multiple myeloma which has some but not all the features of multiple myeloma and probably represents an early stage of this condition".

A My reading of the report was that he did not consider her to have multiple myeloma.

Q You can see him referring there to the condition and it is completely irrelevant.
A Yes.

Q So it is a report that appears to be based on incomplete information.
A I do not believe on that point that is correct.

Q Thank you.
A It says,

> "In my opinion, beyond all reasonable doubt, Mrs Devine was dying from a culmination of amyloidosis which can arise from the paraprotein anaemia, aggressive renal failure and dementia".

Q If I can bring things back then to the suggestion made that Elsie Devine may have been dying from dementia, that is not a view that you share, is it?
A It is the degree as to whether it becomes a part two. In terms of it being the primary cause of her death, no. It may be a condition that contributed to it.

Q You have seen the review done by the psychiatrist, conducted on 18 November, where he has placed her on the waiting list for the Mulberry Ward.
A Yes.

Q With the changes in medication recommended.
A Yes.

Q And he recorded her on 18 November being happy, no complaints, waiting for her daughter.
A Yes.

Q So if she was dying from dementia as of the night of 18 November, one might have expected the care assistant responsible for her mental health to draw attention to that.
A I am not clear what point you are making.

Q There is no evidence of her dying from dementia on 18 November.
A No, but I do not think --

THE CORONER: Let me just check and see what she actually says.
A I think in terms of the primary condition, I do not think that has been mentioned.

MR LEIPER: Then we can put it aside.

THE CORONER: If it was going to come in, it would come in as a two in any event, and that is not the principal cause of death.
A Correct.

MR LEIPER: At the time, Elsie Devine was under a renal physician.
A Yes.

THE CORONER: Dr Stephens.

MR LEIPER: Exactly so, sir, exactly so. And Dr Stephens was monitoring her renal function on an intermittent basis between six weeks and every two months. She would last have been seen in September 1999. If there were obvious concerns in relation to her having a deteriorating kidney function in November 1999, you would expect, would you not, for her to have been referred back to the consultant who was responsible for that aspect of her care?
A If I was looking after her, then I would feel that that would be a reasonable thing to have done.

Q That is what you would expect to have happened.
A Different people do different things, but if I was looking after her, I would obviously defer to the renal physician. Again the question, and I have mentioned it before, is that one of the issues I had was: could anything simple or appropriate have been done that may have stabilised her situation? If, within your own knowledge base, you cannot answer that question then again, from the GMC point of view, you are duty bound to seek a specialist's help.

THE CORONER: Duty bound to seek specialist help.
A Yes. Whether something could be done is a different matter.

MR LEIPER: You confirm that Elsie Devine was frail, with a history of kidney problems, never having previously had opioid analgesia. As such she was clearly at high risk of the adverse consequences of excess analgesia, was she not?
A You maybe need to be more cautious about the use of analgesics.

Q That was a reason why you needed to be more cautious, because she was at greater risk of those consequences.
A Because her body would be dealing with the drugs differently, which means you should show more caution in terms of dosage.

Q You confirmed yesterday that the mechanism of death associated with excess analgesia is that it can result in loss of consciousness, dehydration, lack of fluid and respiratory depression.
A Yes.

Q We have been told by Professor Black that one of the classic indicators of respiratory depression associated with excess opiates are where a patient may stop breathing for long periods and then take a deep breath. OK? That is Professor Black's view.
A I do not feel that is a particularly specific sign, I have to say.

Q But it can be an indicator of it.

A My understanding is that what tends to happen is that the depth of the breathing tends to become more shallow and as the depression continues, then the respiratory rate itself goes down. The pattern of breathing can be influenced by a number of things.

Q But it can be influenced by opiates inducing respiratory depression.
A All I can say is that in my experience the most consistent sign is that the breathing becomes more shallow and slows. In terms of the pattern of breathing, I am not certain or I am not aware of any particular pattern of breathing otherwise as a reliable indicator of excess opiates.

MR LEIPER: But if a patient's breathing appears to be laboured, that might be an indication.

THE CORONER: What Dr Wilcock is describing as a shallow pattern of breathing is not laboured.
A Again, if you depress the respiratory drive to that extent, the whole point is --

THE CORONER: It leads to laboured breathing.
A Yes.

THE CORONER: Until it stops.
A Yes.

MR LEIPER: On 19 November at three o'clock in the afternoon Elsie Devine's daughter arrived at the Gosport War Memorial Hospital, and she has told the jury already that she went into her mother's room, took her hand and shouted, "Mum, mum", "thinking that I would wake her up". She went on to say that she was completely comatose. She was again completely unresponsive on 20 November. That is evidence consistent with excess analgesia, is it not?

THE CORONER: Let us be sensible about it. It could be on the menu. Any kind of drug overdose might be on the menu. She could be dying. It could be symptomatic of the renal failure. It is the way it is put to you as being what is the likely cause.
A It is consistent.

MR LEIPER: I am trying to be as fair as I can.

THE CORONER: Is it consistent with it?
A If you are overly sedated to a point where you are unresponsive, then drugs may be playing a part in that. But similarly, if you are in the terminal phase of your illness a slide into unconsciousness would be a natural normal part of that process.

MR LEIPER: If you were. You also confirm that death can be a result of dehydration and lack of food, and we know that at no time following her becoming unresponsive on 19 and 20 November, was Mrs Devine given a drip. The absence of a drip may have resulted in dehydration and lack of food.
A Again, we have to step back. We have to step back to the point at which, was the decline in this woman's condition a terminal event, or was there an acute medical reason that would potentially reverse what was happening. This is why I am saying anything I have got

to say is contextualised by those two propositions and I am guided by the fact that she is most likely to have entered her terminal stage by Dr Dudley.

Q Putting that aside, putting Dr Dudley's report aside just for the moment, the absence of hydration and the absence of food, following on from her unresponsiveness may have contributed to her death.
A If it was considered that she was in her terminal phase, it would be unlikely that she would be put on a drip. It would be seen as a treatment that would not add in any way to her comfort.

Q If she was not in a terminal phase.
A You would step back two steps from here. If she was not in her terminal phase, it is what needed to be done on the day she got agitated, not when she is obviously dying. It is asking that question, was anything else appropriate? Could anything else have been done before she got to this stage?

Q In the light of the loss of consciousness, in the light of the dehydration and lack of food, which would have followed from that lack of consciousness, and in the light of Professor Black's view at any rate, that she showed the classic signs of respiratory depression from the withdrawing of opiate analgesia --
A I am sorry, what specific point are you making?

Q Do you accept that it is at least possible that she died --
A Are you saying there is a specific point that suggests that she had respiratory depression?

Q The evidence of Code A was to the effect that when she visited on 20 November,

> "Mum continued to squeeze my hand sometimes as we chatted. We were told that this was just a reflex. She appeared to stop breathing for long periods but then suddenly take a very deep breath".

A Again the breathing pattern can very commonly change when people are dying and it could be stimulated by various different things. What may be being described there is what is called chain stokes breathing, and chain stokes breathing can occur in about 25 per cent of normal people. They looked at this in healthy elderly people on geriatric wards, but nevertheless in the dying phase, changes in the pattern of breathing are not uncommon. So people often take big breaths, the breaths settle down and then there is a gap, and then there is a big breath and the breaths sort of build up again and die down again. This is why I am saying the breathing pattern is not a specific indicator of definite respiratory depression.

THE CORONER: Does it satisfy you beyond all reasonable doubt that it happened?
A That what happened?

THE CORONER: That she had respiratory depression secondary to the excess analgesia?
A I would not say that a pattern of breathing like that, which is commonly seen in dying people and of opioids, could be seen as a specific indicator of respiratory depression.

Q Right. Nevertheless it is consistent with it. That is what you have said.

A Yes.

MR LEIPER: Sir, can I deal with a matter in Dr Dudley's report. You were asked about Dr Dudley and the suggestion was made that because Dr Barton's account had been affected by the notes she had been shown by the police, she had not appreciated that trimethiprin had been given. Her understanding from the notes that she had got was that trimethiprin had not been given to Mrs Devine, and this is when she was at the Gosport War Memorial. It was put to you that, because of that, Dr Dudley may have been misinformed as to the history.
A I am sorry, I must be getting tired. Dr Barton prescribed the trimethiprin.

Q Trimethiprin was certainly prescribed for Mrs Devine for a suspected urinary tract infection.
A Yes. Dr Barton had access to the notes.

Q Dr Barton was given access to medical records so that she could recall the history. The records she had were in some disarray and she did not see the part of the notes which indicated that trimethiprin had been given.
A Right.

Q I just want to ask, it has been suggested to you that Dr Dudley may have been misinformed as to the history, and therefore that he may not have appreciated that trimethiprin had been given.
A I do not know. I have heard.

THE CORONER: He knew that there had been an antibiotic, but there is a world of difference between sebatcol and trimethiprin, and there is no indication that he was aware that trimethiprin had been given. There is no clear indication in this report to say whether trimethiprin was the antibiotic that was used.

MR LEIPER: Can I just ask you just to confirm then, Dr Wilcock, to go to page 7 of Dr Dudley's report, five lines up from the bottom? He is dealing there with 15 November. Dr Reed saw the patient. He indicates, Dr Dudley, that the patient was receiving treatment for a suspected urinary tract infection.
A Yes.

Q The only antibiotic that was prescribed was trimethiprin, I think.
A Yes.

Q If he has looked at the prescription records, then he will have known that it was trimethiprin that was being prescribed. Dr Reed is noting that the patient is receiving treatment for a suspected infection. The only one that was prescribed was trimethiprin, so Dr Dudley cannot have been misled or misinformed.
A No.

THE CORONER: Ladies and gentlemen, we come now to the cause of death. Please go on.
A Again, on the basis of reading through Dr Dudley's report, 1(a) would be chronic renal failure; 1(b) would be analoid basis; and 1(c) would be IGA, high protein and whether or not dementia is put as a two.

THE CORONER: Thank you. Then we move on.

A Mr Wilson was a 74-year old man who was admitted to hospital after falling over and fracturing the greater tuberosity of his left humerus. This is a bone at the top of the left shoulder. He had a multiple series of medical problems. Alcohol related sclerosis, which was leading to liver failure and encephalopathy. Encephalopathy is a situation that arises when the liver is no longer able to get rid of the toxins in the bloodstream because that is severely damaged, and these toxins in the bloodstream have an adverse effect on mental
B function. It is also noted that he had heart failure and again alcohol in excess is a direct toxin to the heart. It can interfere with the heart working. He also had kidney failure, although during the course of his admission this seemed to settle down.

There is a very precarious link between your liver and your kidney and if your liver is complaining, that can have an adverse effect on your kidney function as well, so the best way to consider his situation is that it was a bit of a tightrope that this guy was walking between
C liver failure and kidney failure.

Other problems include early dementia which again can be related to alcohol, depression and a high level of dependency. During his time at the Queen Alexandra Hospital he became mentally more alert and there may have been a number of reasons for that. As I said, his kidney function returned to normal. One of the reasons for that is that they stopped his water tablets which, if they are working too well, if you like, they would dehydrate him, they would
D dry him out and that in turn would have a negative effect on the kidneys. He also appeared to be in urinary retention at one point, which again would affect the kidney function.

However, having stopped the diuretics, having given him some fluids, over the next few days he became more and more swollen again, more oedematous. This was considered to be due to heart failure but it was also most likely due to his serious liver failure. I thought the two may well have co-existed together. When you fall over and fracture a bone, you can imagine
E the amount of trauma you cause and the damage and swelling to the soft tissues would indicate that the pain you get is likely to be worse at the time you did it, and over a period of time the soft tissue swelling settles down. In general you would expect the pain to get better.

If a bone is broken, and particularly part of a bone where muscles are inserted, it is not unusual that pain remained on movement and it could be that certain movements would have been particularly more painful than others. Nevertheless the general tendency was that his
F analgesia, although variable, generally reduced over the time he was admitted to the Queen Alexandra Hospital.

The most I could see that he had was made up of morphine injections and codeine, which were equivalent to about 20 mg of morphine in one day, and that was close to the time of his original fracture. By the time he was transferred, he was taking usually regular paracetamol and at most one extra codeine of 30 mg a day, which would be equivalent to about 3 mg of
G oral morphine, but as I have said, it would not be surprising that pain was persisting.

He was admitted to Dryad Ward and again a lack of clinical note-keeping, thorough documented medical assessment of this patient does make the care given difficult to unpick. On admission it was regular paracetamol, which was paracetamol at that time, was discontinued, which, if he was still having pain was interesting. He was only having codeine PRN in the other hospital, but this was not listed on the drug list when he was transferred.
H Nevertheless he was not prescribed that PRN, instead he was prescribed morphine 5 to 10 mg

PRN. Although this is a range and it may be seen as a range that people would write, he never received the 5 mg dose. So the 10 mg of which he received two represented similar sorts of levels that he had had at around the time of his original fracture.

The next day he was commenced on 10 mg of morphine every four hours and 20 mg at night, and in that period he would have received 50 mg of morphine, so again you can get a sense of what he received on Dryad compared to what he required around the time of the original fracture. However, in my opinion the impact of that dose is impossible to judge because in the early hours of the 16th he deteriorated very rapidly. It looks as though his breathing became noisy; it looks as though there were a lot of secretions; he was seen by a doctor. He was given water tablet treatment, which would make me think that he had developed fluid on the lungs. Whether this was an accumulation of his liver failure plus the heart failure or both together I think it would be difficult to say. It was considered that it may have occurred as a result of a heart attack. It was commented that this was a silent heart attack which meant it occurred without pain, which can occasionally happen.

Either way, he went into a rapid decline. The progression over the next few days was really this excess fluid, this pulmonary oedema, fluid on his lungs. He was treated with a syringe driver. The dose of diamorphine was increased from 20 mg to 60 mg and he died.

In my opinion the nature of his rapid deterioration could actually be in keeping with his severe liver failure and heart failure, and I think it is difficult to state with any certainty that the doses of morphine or diamorphine that he received could have contributed more than negligibly.

THE CORONER: Thank you. I could not quite write down the last part.
A Again, there are comments in the notes referring to copious amounts of secretions requiring suction, and I think if you have copious amounts of secretions, that sounds like the pulmonary oedema and as such, that is one of the reasons I would suppose cardiac failure. 1(b) I considered alcoholic cardiomyopathy and then 2 would be alcoholic sclerosis of the liver. But I think it could be difficult to separate out whether it was all of them, part or a combination.

Again the nature of his death, with the copious secretions, makes you think of pulmonary oedema.

THE CORONER: As being the terminal event?
A Yes.

THE CORONER: The underlying feature.
A Yes.

THE CORONER: It really is just what is the most sensible view to take? It may be Mr Sadd has a view and Mr Sadd is the chap in the green tie, and he represents Mr Wilson. He may have a view but he will take you to that as and when. So number one would be cardiomyopathy.
A Yes, and 2 would be alcoholic sclerosis of the liver.

THE CORONER: Right, Mr Jenkins?

Cross-examined by MR JENKINS

MR JENKINS: Dr Wilcock, Mr Wilson was transferred to Dryad Ward on 14 October 1998 and clerked in by Dr Barton. He was prescribed and given some Oramorph for pain in his arm. The nursing note that we have for 15 October, page 265 says that the wife was seen by Sister Hamblin who explained that Robert's condition was poor. There was then a decline overnight. The nursing note says, the doctor's note, on 16th,

> "Decline overnight with shortness of breath. On examination weak pulse, irresponsive to spoken orders. Oedema plus plus in arms and legs".

That is a lot of fluid in the tissues.

A Yes.

Q "Query [question mark] silent MI",

The heart attack that you suggested.

> "Query deterioration overnight".

Dr Malmen(?) increases the Fluzamide, which is a drug which reduces the fluid in the system.

A Yes.

Q We know that it is later, after Dr Malmen has seen the patient, that the syringe drug was started and the entry in the nursing records at that time – page 265 – say,

> "Syringe drug commenced, 20 mg diamorphine. Explain to family reasons for driver. Wife informed of patient's continue deterioration",

and on the next day, the 17th, mention that the pharyngeal secretions increased, as the oral "pharyngeal secretions increasing overnight".

That is *this* part of the system.

A Yes. It is the upper part of the airway.

Q "The pharyngeal secretions increasing overnight. Diamorphine 20 mg. Wife and step-daughter stayed last night. PM: slow deterioration, already in poor condition. Required suction very regularly",

And so forth. There continued to be a deterioration until he died just before midnight I think on 18 October.

A Yes.

Q Your view on that, and in particular on the rapid change in condition in the early hours of 16 October is that those are in keeping with worsening heart failure, with or without a sudden event such as a heart attack.

A Yes.

Q You can say that that, combined with his liver failure, could easily have precipitated his terminal infarct.
A Yes.

Q You said at page 41 of your report, six lines down,

"In my opinion, given Mr Wilson's combination of severe liver failure and heart failure, this rapid deterioration was most likely to be a terminal event, and as such it was appropriate to focus his care on comfort measures".

You mean the deterioration in the early hours of 16 October.
A Yes.

Q The one noted by Dr Malmen.
A Yes.

Q You say,

"From the description it is likely that Mr Wilson had developed an acute worsening of this pulmonary oedema",

that is fluid in the lungs.
A Yes. Which was demonstrated at the other hospital. When he was given fluids he developed crackles in his lungs which was considered to be fluid on the lungs. That is one of the reasons they then had to stop the IV fluids, because he had a propensity to develop this complication.

Q I think he gained a lot of weight whilst in hospital.
A The weight gain is the peripheral oedema, so the oedema of his legs, plus the fluid in his abdomen, and there are comments about his arms being adapted.

Q From the description you say that it was likely that Mr Wilson developed an acute worsening of this pulmonary oedema. We can leave that there. You stick with, I think, the view that it is the liver failure and the heart failure leading to the rapid deterioration and that that is the most likely cause for the decline.
A In terms of his decline, yes.

MR JENKINS: Thank you very much.

THE CORONER: Ms Ballard?

MS BALLARD: No questions, sir.

THE CORONER: Mr Sadd?

Cross-examined by MR SADD

MR SADD: Dr Wilcock, inevitably we will have to go over ground that you have already covered, and I apologise for that in advance, and to let you know where I am going to go, I am going to be asking you, in the light of everything that you say to me as we go through

the medical records, to revisit your conclusions and I suspect you can imagine that that is an inevitable path that I am likely to take.

As the Coroner has told you, I represent the Wilson family, and as you probably know from the inquest, this is an investigation into how somebody died, and through me there are questions that they want to pose, and that they seek your expert advice on. It is with that introduction if I may, that we are going to go through Mr Wilson's medical records, so you need to have those to hand. I would also like you to have to hand Professor Baker's report, please, and Professor Black's report. Finally, you will also need Dr Barton's last statement in relation to Mr Wilson. So just to make sure that they are all in reach --

THE CORONER: What I suggest is that we make a start and anything that is missing we can get over the luncheon adjournment. Does that make sense?

MR SADD: Of course.

THE CORONER: Anything you can get on with now will be helpful up until lunch time.

MR SADD: If we can start then, Dr Wilcock, with Mr Wilson's admission to Queen Alexandra Hospital and the approach adopted to his care at that stage, and in particular the approach adopted to the drug regime that was thought appropriate to mitigating the pain. What you will need to turn up, please, is page 106 of the records, and keep your finger in page 169 as well. Page 169 is marked at the top of the page. Do you have that?

A Yes.

Q Looking first at his admission on 169, we can see, as you have already described to the jury, that on 24th – I think the fall occurred on 23rd, but certainly he was transferred from the Accident & Emergency Ward where he stayed overnight, and was brought into the orthopaedic ward and on 24th was given diamorphine 5 mg and from prescription chart on page 106 we can see that that is actually transcribed as 23rd. Is that right? Do you see that there?

"23/09 15.40 5 mg".

Although they have used the phrase, "diamorphine", they refer to diamorphine but there is no reference to it.

A I have got it that the 10 mg of morphine was given as Cyclomorph. It must have been a different page. There is obviously another sheet where a further 10 mg was written up, but I do not believe it was given, because the time of administration was not stated. So I think at that time he received morphine 10 mg IV as cyclomorph.

Q Thank you, and we can see, looking at the drug chart, page 106, on 24th, the dose at 06.15 as 06.5, 2.5 on each occasion.

A Yes.

Q If we look at page 107, it appears, does it, between 24th and 3 October, no morphine is prescribed. Is that fair?

A What I have summarised in my report is that between 23 and 24 September the pain seems severe. He received three doses of morphine, 5, 2.5 and 2.5 IV subcut, five dosages of codeine and one dose of paracetamol, and I think that summarises it.

Q That is fair enough, Dr Wilcock, but my question which can get lost in the attempt to look at notes is that after 24th, Mr Wilson received no morphine until 3 October. Is that right?
A Yes.

Q And between 24th and 3 October, it looks as if he was prescribed paracetamol.
A On 25th he commenced Co-dydramol which is a combination of dihydrocodeine and paracetamol. He received that for the first five days, when it was swapped to paracetamol alone.

Q I am sorry, it was swapped on 30 September. Is that right?
A Yes.

Q Thank you. Do you have a view, from looking at his various medical records during his time at the Queen Alexandra, as to the appropriateness of the dosages of morphine in the context of his condition? Did you consider it a reasonable approach or was he under-dosed?
A It was that clearly, as I said, it seemed to be that his pain was quite variable, and there seemed to be periods where it did not seem to be bad and there seemed to be periods when it was much worse. The pain in general always seemed to be on movement, and the pain at rest did generally seem to settle, which is what I would anticipate with a fracture. I guess it is to what extent he maybe moved again that would determine to what extent the pain was troublesome, and maybe that explains why it seemed to fluctuate to that degree. Again, because of his liver failure, you would be cautious about the use of opioides and if you could, if you like, get away with using a weaker one, that is what you would do. Nevertheless you have a duty to relieve suffering and if someone is in severe pain because of a fracture, then using small doses of stronger opioids seems reasonable. In this context the 2.5 mg he was given seems a more reasonable dose than the 10 mg that he had originally. I have a problem concerning the IV. I would probably have given him a smaller dose than that, but the 2.5 mg, again it seems sometimes he would refuse the codeine or refuse the paracetamol and then end up having the morphine line.

THE CORONER: I think the question was put to you both, was it too much or too little? You have gone for the 2.5 as solving the problem.

MR SADD: My question was put in this way, Dr Wilcock, and again it does get lost in the water, and I am sorry. My question was this. Would you consider it to be too little or would you consider it to be reasonable? My understanding of your answer, so that the jury are clear, is that you consider it to have been a reasonable regime that reacted to different times and different pain levels.
A Yes.

Q Could we look, please, then at the nursing notes and going first please to page 35? Looking at page 35, before we look at the entries there, we know of course that on 8 October Mr Wilson had had a psychiatric assessment and there had been what is called a mini-mental test or mini-mental appraisal.
A Yes.

Q And Dr Lusznot had concluded that there was a finding of dementia. I think that is right.
A Yes.

Q She put him on an antidepressant.
A Yes.

Q We also know that by the 10 October, so two days later, and on that note at page 35, the catheter had been removed. Do you have that? It is about two-thirds down page 35.
A Yes.

Q We have reference there to "Robert reports a good night's sleep".
A Yes.

Q That report of the good night's sleep does not appear to have been dependent on the administration of morphine, does it? We can check that by reference back to pages 106 and 107. Perhaps the page most helpful to you will be page 107 where we can see the administration of codeine phosphate on the 8th and on the 9th, but not on the 10th or 11th.
A Yes.

Q So this is in line with your assessment of what the records tell us, that it is as and when required.
A Yes.

Q And reacting to his complaints of pain.
A Yes.

MR SADD: Going back, I am afraid, to page 35 – I say "I am afraid" because it is frustrating to go backwards and forwards through the notes, though I am sure you are used to it – page 35, we look at the entry for the 10th,

> "7.30 pm, sat in chair; fluids taken; fair, asked to stay up for the night",

and we can see that he was able to pass urine on 11th. "Communicating well".

THE CORONER: "Asked to stay up for the night", what does that mean? Does it have any meaning? It is just that you said, "Asked to stay up for the night"; it actually says "Asked to stay up for night staff". Does that mean he was asked to stay up or did he ask to stay up?

MR SADD: I am sorry, sir, I misread it. It does appear as if that request was coming from him, that he wants to stay up and the night staff ought to be aware of it. On 11th October he communicated well, co-dydramol is 5, though no extra analgesia required overnight.

> "Assisted into bed. Aware. Sat in chair for about one hour then returned to bed. Bottle was used with minimal assistance".

I know you can read this, but the jury do not have this in front of them. On 11 October, "No problems with communications".

> "Robert is a bit clearer with his speech. A bit tired, pain remains quite bad in his left arm. Insists he is given (?) Robert managed to shave himself. Transferring him. Much better today".

Then reference to his transferring,

> "much better this afternoon; eating and drinking well".

Overnight on 11th to 12th, drinking well. Supporting physician,

> "appears comfortable with regular analgesia. Restless night, sat out in the chair for long periods; incontinent of urine".

On 12 October,

> "good breakfast taken. Remains in a lot of pain when being cared for. Hygiene needs met, save for night staff – refused to be weighed. Overnight no complaints of nausea".

Why would that be relevant?
A Because originally when he came in he was nauseated and vomiting, which was probably related to alcoholic gastritis.

Q "Arm and feet remain swollen and very uncomfortable. Restless overnight. Some time spent in the chair".

If we look, please, at page 107, at the prescription chart, we can see that on 12 October at 2100 hours he is given 30 mg of codeine phosphate.
A Yes.

Q In the context of those complaints as recorded at page 36, do you consider that to have been a reasonable response, given all his underlying serious problems?
A Yes. I mean the pain is clearly variable, but it can be severe. He is being given codeine but he is only using it once a day, no more than once a day. I think if it was two or more times a day, you would say, "Does this chap need a regular dosage?".

Q It appears from the note on page 36, 13th,

> "weight gone up to 114.4 kg. Refused to change clothes. Left unsupported on pillow. Wash given. Bio fleece applied to right foot, leg still elevated. In a good mood this am".

A Just to interrupt, I think the weight going up to 114 is a significant comment. I think I am right in saying that at this point it represents that his weight had gone up by 10 kg, which is equivalent to 10 litres of fluid.

Q It is all to do with fluid retention, is it not?
A I think in the notes there is a comment about the heart failure, but you cannot separate this out from the liver failure. It is going to be one of those things, so a combination with the liver failure.

Q It is exactly the point there, Dr Wilcock, that the fact of the swollen legs, the fact of the weight increase, that goes hand in hand, as it were, with the damage done to his liver, is that right, or a consequence of liver failure?

A Yes.

Q Looking at the bottom of the page, please, the last line down,

"Discharge to Dryad Ward tomorrow. Has remained on his bed all pm. No complaints of any pain. Passing urine independently using the bottle".

B There is a question mark on 10th. Then overnight,

"Robert had a peaceful night. Slept well. No complaints of pain".

We know by reference to page 107, the prescription chart, that overnight on 13th and 14th, before he is transferred to Dryad, he is prescribed codeine phosphate again at two in the morning. Do you have that?

C A Yes.

Q Again it is simply a matter of record, prior to transfer to Dryad, the last prescription of morphine was on 5 October.

A Yes.

Q Then 2.5 mg.

D A Yes.

Q Would it be fair to assume from those entries – I know one can only go by the entries, Dr Wilcock, so I understand the difficulty you might have – but can we assume that the codeine phosphate appears to have been a reasonable pain reliever, given the entry for instance on the 13th and 14th that Robert has had a peaceful night?

A I would say it is the combination of the regular paracetamol and the codeine taken as

E required that seemed to be a satisfactory analgesic regimen for him.

Q At the point of transfer to Dryad on the morning of the 14th, can you see any reason in the medical records to change that regime? Just at the point of transfer.

A Before he actually left, no.

F THE CORONER: Can I just stop you there for two minutes? (*Pause*)

MR SADD: Dr Wilcock, please can I ask you to turn to page 40 of your report dated 21 May 2006? The first main paragraph of that report deals with your view of the approach to analgesia and two-thirds of the way down, the sentence starts, "Given this infrequent use". Do you have that?

A Yes.

G Q "Given this infrequent use of additional analgesia in my opinion the quoted list of Mr Wilson's analgesia was reasonable".

You go on to say, and we are going to come on to the transfer letter in a moment,

"Although the transfer letter noted, 'still has a lot of pain in his arm and difficulty moving', overall his analgesic requirements have reduced over the course of his admission [at the Queen Alexandra Hospital]".

H

You do not say at the Queen Alexandra, but by reference to the time spent at the Queen Alexandra.
A Yes.

Q Would you accept from our brief review of the entries in the medical records, that certainly Mr Wilson's mental state appears to have been sunnier than it was on the 8th? So by the time of his transfer there are references to his talking, to eating. One can see on the 9th, for instance,

> "Robert had visitors all afternoon. Chatty and appears well".

Generally there appears to be an improvement in demeanour.
A Yes.

Q It may be all relative but nonetheless there appears to be an improvement.
A Yes, during his admission he did improve in regard to his level of alertness.

Q Thank you. That is just what I was going to come on to. That is at page 28 of your report, is it not, than you have just referred to. I will read out the whole paragraph so the jury can have it,

> "During his admission Mr Wilson did improve with regard to his level of alertness. He was more talkative and eating and drinking more. There may be several reasons for this improvement: absence from alcohol; discontinuation of sedative drugs; correction in dehydration and better nutritional intake".

You make an important qualification,

> "Nevertheless it was considered likely that he had an alcohol related early dementia and he remained dependent on others for care".

We know too that by the time of his transfer to Dryad, the renal problems had been dealt with.
A They had improved, yes.

Q They had improved. So can we look then, please, at page 77 of the medical records? This is the transfer letter and we can see at the top there, the reason for admission to hospital, "Fracture of humerus". There is a reference to his medical history. It is difficult to read. "18 months ago alcohol problems". Reference to his domestic circumstances. The reason for the transfer there is given as continuing nursing care needs. His Bartle score is given as 7. The summary, perhaps we can take it in turns. Can you read out the summary, please, Dr Wilcock?
A "Mr Wilson fractured his left humerus, still has a lot of pain in his arm and difficulty in moving. He requires specialist nursing care due to his low creatinine. He is on a high protein diet. He legs are very oedematous and he is at high risk of breaking down. Secondary to cardiac failure and low protein. He is also at high risk of self-neglect. He needs 24-hour nursing care until his arm is healed".

Q Then there is a reference to the medication that he is on. From our reading of that record, and from everything else that we have read prior to his transfer, what have you understood to be the reason for his transfer to Dryad?
A The state of the continuing nursing care needed.

Q Can I take you to page 179, and this is the clinical records for Mr Wilson's time at Dryad? We have at the top there an entry for 14 October 1998.

"Transfer to Dryad Ward. Continuing care".

Is that right?
A Yes.

Q Were you aware that Dr Barton had nursing staff that had been with her for a long period of time at that date of transfer? Were you aware of that?
A I do not think I have been provided with anything specific that says that.

Q Were you aware that she had a senior sister and a clinical manager at the time known as Gillian Hamlyn?
A The name is familiar, yes.

Q From the entries in the records and the nursing records we know that she was involved in Mr Wilson's care certainly on 17 October. I wonder whether Dr Wilcock could be given a copy, please, of Gillian Hamlyn's statement. (*Document handed*) This is her statement dated 11 June 2005. I am just going to read to you a passage from that statement, please, Dr Wilcock, and invite you to comment by reference to a question that I am going to pose to you. At page 3 of that statement, at the bottom of that page, she refers to something called a spell summary, and the penultimate paragraph reads,

"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. Over the page she sets out the diagnosis and she comments,

"This shows the treatment that was administered to the patient, in this case the commencement of the syringe driver which was on 16 October 1998. This diagnosis has been obtained by me as a result of reading the medical records which accompany the patient. Prior to a patient being transferred to my ward, elderly services of the QA Hospital would ring the ward and let us know of forthcoming admissions. 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 available bed and any other equipment that was needed. On referring to the notes of this patient, Robert Wilson, I noted that he had multi-organ failure. The prognosis that I made was that he was being admitted for terminal care at Dryad Ward".

Dr Wilcock, having read the records, from your clinical perspective do you have any comment to make on the care of Mr Wilson in the light of that assumption, once he was on Dryad?
A I mean, when reading through the notes, what I try and ascertain is whether somebody's medical condition was stable or whether there were any clinical history, via his clinical examination, or any blood tests results that indicated that the condition was not stable, because I think what subsequently happened has to be taken in light of that assessment. Although this gentleman's condition improved in terms of his mental state, from my reading of the notes, the fact that his weight was increasing 10 litres, this gentleman's physical condition would not be considered stable to me.

Q Was he in terminal care on 14 October 1998?
A Again, you have the report of Dr Marshall. He was a gastroenterologist who specialises in liver disease.

THE CORONER: That is not in our bundle, but you have seen that.
A Am I able to read from it?

THE CORONER: By all means. The copy in my room has gone.

MR SADD: I am facing some difficulty, sir.

THE CORONER: Can I suggest you look at it over the luncheon adjournment? That seems to be a sensible thing for us all to do.

MR SADD: I will need to assess it in the course of an hour, sir.

THE CORONER: I think the witness can point you to the section he wants to refer to.

MR SADD: My difficulty is that I have not been able to take Professor Brown to it, but there it is.
A Shall we leave it?

THE CORONER: By all means. Dr Wilcock has a copy and it may be we can photocopy it.

MR SADD: May I ask the question again and once we have got the answer – no disrespect at all, Dr Wilcock – but in the absence of that report, for present purposes -- and we will break you will be glad to know after this because we are coming up to one o'clock and I am sure that is what the Coroner will want to do -- was the note that you have heard me read out. Was the approach that she assumed was to be adopted to Mr Wilson on transferring on 14th one that on the evidence the clinical staff were entitled to adopt? Was he in terminal care?
A The word "terminal" is very loaded. In terms of, would you anticipate that this man is likely to die in the next few days at the time of his transfer, I would have estimated no. If you say, "Is his prognosis limited?" the answer is yes. So his medical condition was deteriorating because of the increasing oedema so his prognosis was poor, but prognostication is a guess at the best of times. Were there any indications at the time of his transfer that he was likely to die suddenly, on my reading of the notes, no. In terms of what subsequently happened it was clearly a very rapid and sudden deterioration in his condition.

THE CORONER: When you say he was likely to die suddenly, by that do you mean suddenly or do you mean soon?
A Soon.

THE CORONER: Very well, we will come back at 2.30 p.m.

(Luncheon adjournment)

(In the absence of the jury and the witness)

THE CORONER: Mr Sadd?

MR SADD: Sir, I have done something rather presumptuous. Because I am going to address you on the extent to which the parties can be entitled to use Mr Marshall's report, to avoid Dr Wilcock being in any way compromised, I have asked that he stand down. Of course that is your prerogative rather than mine. I hope you do not mind. Might I mention that, not having seen this report and now having read it, the reason for my original reluctance was that I thought it might be another 48 page report. In fact it is a much shorter report and therefore much easier to read and much more accessible. I simply ask for your direction as to the extent to which, on behalf of the Wilson family, I may be entitled to refer to the report and inevitably to the various conclusions. I am thinking in particular of the conclusions that we get to at around about page 15 of the report. I say "round about", I mean specifically at page 15 of the report. It is really in the context of what will be in your mind, and has been in your mind throughout this inquest – you have made it very clear, sir, that you have not made up your mind about this but of course we have to address you in due course – as to the potential verdicts that can be left to the jury.

It may come as no surprise to you that nonetheless it will be my intention to try and persuade you that so far as Mr Wilson's case is concerned, a verdict of unlawful killing could properly be left to the jury. Of course you might consider that this is such a borderline case in those circumstances that the discretion as to whether or not to leave it to the jury is one that lies ultimately with you.

This report, as you know, the bottom of page 15 –

THE CORONER: The impact of regular morphine was likely to hasten his decline?

MR SADD: And it goes on to say,

"Its sedative effects would worsen the hepatic (?) which he undoubtedly had".

THE CORONER: You see he says, "which he undoubtedly had" and I am not sure that that is right. Sorry, I am interrupting you midsentence. Can I tell you that I think we were at number 26 of the expert's reports in this case. I have chosen two of them and I was severely criticised by one or two people for doing that, but I had to take a view on how to limit this inquest and how to limit the ambit of it, if it was only going to last for six weeks. We could have got it to last six months, but that would not have helped the jury and would not have helped anyone else. That is why this is not included. If you want to refer to it, it is certainly right that the witness has seen it, and I think if you want to refer to it you may wish to do so through his eyes. The alternative is that you read this to the jury and I really do not want to

do that because I am not terribly happy about it going in. I do not think it is appropriate, but this witness has certainly seen it and if you want to elicit it from him, I think you can do that. That is part of the conditioning for his reasoning, the way that he reaches his conclusions. The evidence of that is when he said this morning that he had seen the report of Dr Marshall.

MR SADD: Yes.

B THE CORONER: That was the point at which we said no.

MR SADD: Sir, it will come as no surprise to you and to my colleagues that the course of the questioning that I am about to embark on with Dr Wilcock includes an assessment of the risk as at 14 October as to the administration of morphine in those doses, given what we know about Mr Wilson's existing liver disease. That is something that, with his expertise, as you will have seen at the beginning of this report, Dr Marshall deals with in some detail, to
C the point where you have at the bottom of page 16 and perhaps in the context of Mr Wilson's case, an unhappy Freudian slip, in the last line. You have the

> "administration of high doses of morphine while an in-patient on Drylands however must be considered reckless. Warnings about morphine usage in the context of liver disease are readily available in standard prescribing publications such as those given
D by the BNF. No attempt appears to have been made to justify the use of opiates in this case. There also does not appear to be any attention paid to appropriate dose reduction or monitoring in Mr Wilson's case".

I am going to take Dr Wilcock to the issues that were raised in there, as set against Mr Wilson's liver disease. The difficulty that I have, and perhaps that you will have ultimately, is that I will be making submissions still on the issue of a verdict of gross negligence by manslaughter. You can or cannot reject those, but here you have a stage four,
E if you want, opinion. What I mean by stage four is that, as you know, sir, there are four stages you need to go through; duty of care, breach, causation as a consequence of that breach, and whether that amounts to negligence. That is a jury issue.

THE CORONER: Gross negligence, you mean.

MR SADD: Sorry, gross negligence.
F

THE CORONER: I am not with you and I think I would want you to deal with Dr Wilcock directly, and I think if you elicit from him his understanding of the matter, I would accept that, in the light of the report. What say your colleagues?

MR SADD: Sorry, can I finish? Sir, if you are not with me, then at the half-way house might I invite you to consider the reference to warnings about morphine usage in the context
G of liver disease that were readily available and if I were to quote him that.

THE CORONER: I think that is in the BNF, is it not?

MR SADD: Because we know already that is Dr Wilcock's view, I want to put to him and ask him to comment on the penultimate line of page 15. I will leave out the reference to reckless.
H

THE CORONER: Do you mean in the penultimate line,

> "The impact of regular morphine administration is likely to have hastened his decline"?

MR SADD: Yes, sir, and I am going to be taking Mr Wilcock not only to this report, but also to Professor Black's report and Professor Baker's report.

THE CORONER: I think that is right. What I do not want to do is admit this report as it is, but I think you can elicit the information from Dr Wilcock. I do not have any problem with that at all.

MR SADD: By reference to my quoting, and being very careful with the quote from this report? Are you happy with that?

THE CORONER: You can say that that is the report that he received. I may have to mop up after the event, as it were, depending on how you put it would help, and he understands that. Would that make sense?

MR SADD: Sir, we will see what happens. I understand your ruling and I understand that I have to be very cautious and I understand very clearly that I am not to make any reference whatsoever to the quality of the decision making conducted at the time.

THE CORONER: Thank you.

MR JENKINS: Sir, I agree with the route you are taking. There are vast numbers of documents in this case and to make it bearable for those involved –

THE CORONER: Or to make it understandable.

MR JENKINS: Yes, certainly, but the families, they do not want to be here for six months, and in the hearing here, the jury would not be able to cope with that, I suspect, and it might be a strain on some other individuals including the Coroner and the lawyers.

THE CORONER: It would not have been me, let me tell you that.

MR JENKINS: The approach you have taken throughout clearly is that it has been for you to select that material which is to be placed in front of the jury; it is for you to select which witnesses and which statements are to be in evidence before the jury. We know that there are independent reports. Mr Leiper has sought to refer to one. I have sought to refer to others and we have been stopped, and I do not suggest that that was anything other than an appropriate way to deal with it. We have been allowed to read out section of reports of people who are to be witnesses and put that to one witness and invite him to comment. We have not been allowed to put to witnesses sections of reports or statements of people who are not being witnesses, either read or called live, and consistent with that it would be absolutely right, in my submission now to not allow Mr Sadd to use this report, or even to quote sections from it. What he can do and what he is perfectly entitled to do is invite Mr Wilcock to reflect on certain propositions. But it would not be right to say, "This is from the report".

THE CORONER: No, that is not the way to handle it at all.

MR JENKINS: What he can say is, would you agree with this proposition?

THE CORONER: Yes, and you must bear in mind that Dr Wilcock has read the report and has said in court, "Have you seen the report?" So we are aware the report exists.

MR JENKINS: We also know Dr Wilcock's view as to the terminal sequence of events. It was not drug related. It was to do with Mr Wilson's underlying condition, but I am not going to address you on the facts.

THE CORONER: You can address me on the facts at this point. It is when you come to your submissions that you cannot address me on the facts.

MR SADD: Sir, there remains the delicate problem of what it was that Dr Wilcock is going to refer to in Dr Marshall's report because to make it plain, he wanted to refer to it, and he will have seen Dr Marshall's report, and at that point we stopped it. We do not know what he meant so we do not know what he is going to refer to, but certainly on my part, on behalf of the Wilson family, I would not want to stop him.

THE CORONER: I do not think it is right to stop him, because that is part of the background upon which he founds his conclusions, is it not? That is where he is coming from.

MR SADD: I agree with you, sir, but I am just worried by Mr Jenkins' submission.

THE CORONER: What I do not want is to put this report in. I think that would meet the condition of Mr Wilcock in the light of what he says to me. I do not see how else I can deal with that.

MR SADD: It is a difficult problem and there is no doubt about that and maybe we should see what Dr Wilcock says first. Certainly I would not want him to be prevented from making reference to Dr Marshall's report.

THE CORONER: It depends what he is going to say. I cannot condition a witness. I cannot break his arm and I have no intention of doing that. If he says that he formed an opinion because of something he read in a report from Dr Marshall, that is how he formed his opinion.

MR JENKINS: May I suggest that what you might consider it appropriate to do is to ask Dr Wilcock in before the jury come back and ask him what it is he wanted to refer to in Dr Marshall's report and take things from there.

THE CORONER: I think that is conditioning a witness in the middle of his evidence.

MR JENKINS: You will not have said anything to him. You will just have asked him what it was he wanted to refer to.

THE CORONER: What I would have said is, "What do you want to refer to"?

MR JENKINS: Yes.

THE CORONER: Ms Ballard, is there anything you want to add?

MS BALLARD: Sir, I do not think there would be any concern with asking the witness what he wanted to refer to, and then if there is going to be further comment upon that he is then asked to leave again. But asking him so that we can further progress how to deal with the matter may be a sensible way forward.

B THE CORONER: Mr Sadd's position in relation to dealing with the matter before the jury come back in would seem to be the way forward.

MR SADD: Sir, inevitably it is going to be a two-way process. If you are going to ask Dr Wilcock what does he want to refer to, and then we all look at each other and raise our eyebrows and worry about it, the consequence of that is going to be on Mr Jenkins' line, "Actually, Dr Wilcock, I would prefer it if you did not", and there is your concern that we C have a witness in the middle of his testimony being asked to give hearsay evidence. There is a great danger in seeking out from him at this stage what he is going to say.

THE CORONER: If he produces hearsay, what is there to stop me adducing hearsay? What actually would stop me from admitting that as evidence? I do not think I have any difficulty with that. I do not have to then recall him. The fact of the matter is that Mr Wilcock has read the report and it has conditioned his belief.

D

MR SADD: I agree with that, sir, that is why I am –

THE CORONER: I feel very uncomfortable calling him in and prodding him. I really do not want to do that.

MR JENKINS: Then you must not do it. If one looks at the way in which Dr Wilcock dealt E with Dr Dudley's report, for example, we have played in those parts of Dr Dudley's report, so the jury know about Dr Dudley's report. They know what Dr Dudley's view was on various matters and the jury know the questions you would have asked. They should not know that with Dr Marshall. They should not know what Dr Marshall's view was because he is not to be called as a witness. You had not indicated at the start of the hearing that he was going in as a witness.

F THE CORONER: I was not adducing him under oath.

MR JENKINS: There are reasons for thinking that he has not quite grappled with all the issues. He does not quite deal with the decline on 16th, which the others do. So it would not be appropriate for any part of his report to go in.

G THE CORONER: But he has affected Dr Wilcock's mind.

MR JENKINS: The point is, it is Dr Wilcock's evidence we are hearing; it is Dr Wilcock's views that we are hearing. If he was to say, "Well, I have read Dr Marshall's report and he has influenced me", we stop at that point, "What is your view?"

THE CORONER: Can you cope with that, Mr Sadd? It has got to be Dr Wilcock's evidence.

H

MR SADD: It sounds as though I will have to. I want to protect Dr Marshall in his absence, that he does deal with the 16th, but that is a peripheral issue, so there is nothing more I can say. You have my submissions and it appears that it is Dr Wilcock's evidence after all that we have to hear and the jury has to hear.

THE CORONER: Right, so if I caution him when he comes back and say that it is his evidence we want to hear, and whilst he may have read numerous documents it is his evidence that we want about what he found; it may have been as a result of information, whatever it might be, but it is what is his view in the light of that.

MR SADD: The thrust of that is that there should be no reference at all to Dr Marshall.

THE CORONER: He may well feel that he was conditioned by Dr Marshall's evidence, and certainly that is where he was coming from, was he not? In the light of that information he will no doubt tell you what you want to hear.

MR SADD: That will have helped him form his own views.

THE CORONER: Indeed. That is right. But how do we form a view then? It comes from the information that is about us, does it not? If your only information here is the evidence that you have heard, you would not be asking the questions you are asking, would you? It is that that enables you to make progress. Right, let us see how we go.

(In the presence of the witness)

THE CORONER: Dr Wilcock, I am sorry about this. The issue we are grappling with is that the evidence you are giving needs to be yours, and your opinion may have been formed as a result of other information, information from outside the inquest. But it is the way in which your view was formed that we want to deal with. I am anxious that we do not look at other reports – I think there are 26 expert reports over and above those that are being called – and I am not calling that and I am not referring to it but it may have formed your opinion and it is purely your opinion evidence that we are looking for. Does that make sense?
A Yes.

THE CORONER: Thank you. Then can we have the jury, please?

(In the presence of the jury)

THE CORONER: Any idea of time, Mr Sadd?

MR SADD: It will certainly be nearer three o'clock, sir.

THE CORONER: I am not trying to put a restraint on you. I am just trying to forward think.

MR SADD: Just before lunch, Dr Wilcock, I took you to Nurse Hamlyn's statement, and in a rather laboured way my follow-up question I will ask you again, and I hope in a better way. Whether your review of the notes on Dryad from 14th until Mr Wilson's death, whether you have formed the view that that reference to terminal care on his admission informed the approach to his care and medication once on the ward?

A I think you are going to have to ask me that again, in the sense that he was transferred to Dryad Ward for continuing care, and that is what is documented in the notes.

THE CORONER: That is the transfer letter. Your point was that Sister Hamlyn says it was for terminal care.
A The entry in the notes that I referred to was the one by Dr Barton.

B MR SADD: I understand that. Maybe I will come back to the question, but I asked it knowing, as we do, that on 14th there was prescribing of Oramorph and we know that on 15th Oromorph was given I think on four occasions. In the light of the prescription regime that was instigated on his admission on 14th, do you consider it to have been better suited to somebody who was in terminal care rather than continuing care?
A I do not particularly see a distinction. If people require opioids it should be for a clear and specified reason, and whatever their prognosis might be, it is a matter of saying, "Was C that appropriate?" I would not divide it up into this person fits a certain category and therefore you can give them opioids, or this person fits a certain category and therefore you cannot give them opioids. So my opinion is that it is a matter of saying, "Are opioids an appropriate treatment for this person given their specific reason for opioids?" That is how I would look at it.

Q Right, can we turn then to page 179, please, of the medical records? I am going to D read out the admission note – the jury have it – of 14 October 1998,

> "Transfer to Dryad Ward. Continuing care. History of presenting complaint, fracture of humerus left, 27 August 1998. Previous medical history alcohol problems, recurrent oedema, congested cardiac failure, needs help with all daily living, hoisting, continent, bar code 7, lives with wife".

E I think it says, "gentle mobilisation". Can you confirm with me, please, Dr Wilcock, that that is the extent of the entry on admission on 14 October?
A Yes.

Q Is there any reference to the pain assessment?
A No, there is not.

F Q Are there any entries relating to pulse, for instance?
A No.

Q Any checks of Mr Wilson's abdomen?
A No.

Q We know that on admission, if we go please to page 258 onwards, we have other the G prescribing charts for Mr Wilson on admission. Please could you go to page 262? At the top is there reference to Oramorph?
A Yes.

Q We see that two doses were given on 14th. In what quantity were those doses given and how were they given?
A Ten milligrams.

H

Q At what times?
A At quarter to three and quarter to eight at night.

Q Can you tell from the entry on the 14th on what basis those were prescribed?
A In terms of the written annotation from Dr Barton on 14th.

Q In light of what we have looked at this morning and Mr Wilson's condition on transfer and his medication history up to transfer, does the dosage or can the dosage be justified?
A On the basis of what we have done so far, the answer is no.

Q You referred this morning in answer to questions from Mr Leiper, you used the phrase, rational prescribing followed rational assessment. Do we have a rational assessment here?
A There is no documented pain assessment.

Q Does it follow – I am sorry if I am labouring the point – that the prescribing in light of your evidence appears to be rational or otherwise?
A I think the use of morphine could be argued that in terms of appropriate dose in my opinion would be 2.5 mg because that in effect would be in keeping with the dose of codeine that he had been receiving.

Q We also know, and the notes appear to recognise just by reference to the one or two words, "alcohol problems", that Mr Wilson had some serious underlying liver disease. Is that fair?
A Yes.

Q You have a view as to what was the cause of the apparent mental decline as observed by Dr Lusznat on 8 October. Was that associated in any way with his liver disease?
A I mean from recollection, having assessed him, I think her view was possibly alcohol related dementia, possibly vascular dementia, but I would have to look back for the exact wording.

Q You referred this morning, when opening your evidence about Mr Wilson, to the fact of his having encephalopathy.
A Yes.

Q Was that something that was as a consequence of his liver disease?
A Yes.

Q Was that present on his admission on 14th?
A In the sense that he was reported to be confused at times, then given his overall setting, that may well represent encephalopathy, yes.

Q Falling in and out of confusion is a symptom of hepatic encephalopathy, is that right?
A Yes.

Q In the light of that, are you aware of – as I am sure you are – of the BNF guidance on prescribing morphine to somebody in Mr Wilson's state on 14 October 1998?
A Yes.

Q What is that guidance? I mean, can you summarise it or would you like to see the reference to it?
A Are you going to have to read it out anyway?

Q No, I am happy to go with your account of it.
A When people have liver failure, again they can sit on a very fine balance and there is a range of problems that can precipitate or worsen encephalopathy. There is a number of drugs, particularly sedative drugs but in amongst those drugs would be opioids, so they require particular caution in their use on people with liver failure.

Q In Professor Black's report at paragraph 6.8 at page 17 – do you have that?
A Yes.

Q He refers there to an extract from Harrisons Principles of Internal Medicine, 16th Edition, New York, 2005. Is that a textbook that you are familiar with?
A Sorry, what paragraph are you on?

Q It is 6.8. I am going to take you to that quote in a minute, but the quote is taken from Harrison's Principles of Internal Medicine.
A Yes, I am familiar with that.

Q He says as follows,

> "The decision to give regular morphine at this stage, on 15 October" –

just pausing there. The dosage on 15 October was 10 mg every four hours, is that right?
A Yes, and 20 mg at night.

Q "is crucial to the future understanding of this case",

And then the quote follows,

> "The effects of hepatitis or sclerosis from the drug position range from impaired to increased drug clearance in an unpredictable fashion. The oral availability for first high class drugs such as morphine is double in patients with sclerosis as compared to those with normal liver function, therefore the size of oral doses should be reduced in this setting".

Can you translate that, please for the jury? It is the phrase, "The oral availability for first high class drugs such as morphine".
A Normally if you take morphine by mouth, a certain proportion of it will be metabolised and got rid of by the liver. If your liver is not functioning, in effect you receive a greater dose.

Q Is that a risk that would have been well known to a clinician in the light of Mr Wilson's presentation on 14 October?
A I would expect that most clinicians would know that certain drugs you have to deal with more carefully in the case of liver failure, yes.

Q Mr Wilson's case falls fairly and squarely within that group, does it?
A Yes.

Q What are the risks associated with medicating morphine at a normal dose as opposed to a lower dose for someone in Mr Wilson's condition?
A If the dose he received was excessive to his needs, then if you like you would expect to see the side effects occurring in a lower dose than normal. So sedation, because it particularly precipitates encephalopathy, confusion, maybe nausea, maybe vomiting. They would be the sort of typical things you would expect to see.

Q You are quite right, I am now going to quote from the BNF. The guidance said,

"It may precipitate coma in hepatic impairment".

Just for completeness sake, and to be completely fair, it goes on to say,

"May precipitate coma in hepatic impairment. Reduce dose or avoid but many such patients tolerate morphine well".

That is the guidance there. If you were going to introduce morphine, as was done here, what would you expect to do during the initial dosages? Would the clinicians be required to do anything having introduced morphine?
A On the basis that he was receiving codeine 30 mg, he was having a dose of that approximately once a day. We have already heard about his pain probably being intermittent, most likely related to movement. I would have thought continuing with the codeine 30 mg or using Oromorph in a dose of 2.5 mg is appropriate, because they are roughly equivalent. You would naturally want to know whether it was effective for his pain relief, but ensure that he was not becoming drowsy as a result of using it.

Q Sorry to interrupt you, in effect what you are saying is, if you are going to prescribe morphine in these doses, you should review the patient, the prescription having been given.
A In the sense that you would review any medication that you are giving for a particular problem. You want to know whether it is effective and you want to know if there are unacceptable side effects.

Q Does not this go a bit further, Dr Wilcock? Your view is that if morphine was going to be administered to Mr Wilson, given his liver problems, then the dosage should have been no more than 2.5 mg. Is that right?
A That would be my view, yes.

Q That would be 2.5 mg of Oromorph?
A Yes.

Q In fact we know that he was given 10 mg on Oromorph.
A Yes.

Q In my maths that is four times the dosage that you are suggesting. Is that right?
A Yes.

Q In those circumstances, do you consider that dosage to have been legitimate?

A The dose he received?

Q Of 10 mg of Oromorph, in the light of your view that 2.5 would have been appropriate?
A In the absence of a well documented pain history, in the absence of something that could clearly justify it, I do not feel that that was justifiable.

B Q Do you consider that a dosage four times what you consider to have been the appropriate one, carried with it risks?
A A dose that would be excessive to somebody's needs would carry the risk of side effects.

Q I am sorry, Dr Wilcock, that is not my question. I am thinking about Mr Wilson's case in particular and I understand why you might approach it in the general, but let us look C at Mr Wilson's case. We know that he has got the underlying liver disease. We know that there is probably hepatic encephalopathy on his admission on 14th. We know by reference to the BNF formula that one has to be careful, and here we have a dosage of four times what you would recommend. Did that dosage in those circumstances, given this individual's presentation, carry with it risk?
A Risk of what?

D Q Risk of coma, for instance?
A Risk, it being a dose that was excessive to his needs, as such, it may have risked sedation or hepatic encephalopathy.

Q It may be difficult, if not already difficult, but I just need an answer from you yes or no. Is that a yes that it did carry a risk with it of coma?
A I am not being awkward on purpose but the difficulty with this situation is that we do E not know, because something happened; something happened acutely in the early hours of the 16th I think so I am trying to give as honest an answer as I can.

Q I understand.
A I am perfectly happy to say that a dose that was excessive to his needs would put him at greater risk of side effects, undesirable side effects, and in someone with liver failure that may include hepatic encephalopathy. But can I answer the question the way you want me to F answer it, I think I cannot honestly answer that.

Q Would you in fairness say that you cannot exclude from your assessment of his records that what happens on the 16th, the night of 15th and 16th, you cannot exclude the effect of high doses of morphine?
A I cannot exclude – I am happier to answer it that way. I cannot exclude that the dose of morphine did not in some way contribute to his reduced consciousness.
G

Q If I ask you the same question in a different way – the classic barrister's approach – it may help you clarify your thoughts about this particular issue, and I am sorry to labour it. If you were presented with Mr Wilson on 14 October, how would you have assessed or measured the risk of hepatic coma with these doses of medication that were being prescribed?
A It is very difficult because obviously you could do things very differently, but I would not particularly have seen any reason to change his existing analgesics regiment. If for any H reason I did not want to give him codeine and I wanted to give him morphine, I would give

him 2.5 mg as required. Again, all I can say is that with any medication you assess whether you are achieving the desired result with it, at the same time as assessing any undesirable or serious side effects. It is an ongoing process. I do not differentiate between how specific it is. It is something that you do as part of the job.

Q The dosages of Oramorph on the 14th was a high dosage in the circumstances, was it not?
A In my opinion, yes.

Q And from your reading of the records, there is no pain assessment and no reference to pain justifying that amount.
A Yes.

Q I mentioned earlier the view formed by Nurse Hamlyn, for instance, that Mr Wilson was coming in for terminal care. The BNF formulary goes on to say under the reference of caution with morphine, under "palliative care",

> "In the control of pain in terminal illness, these cautions should not necessarily be attached to the use of opioid analgesics".

Would you accept from me that the jump from the Wessex Guidelines has been from stage one to stage three on 14 October that he was being given strong opioid analgesics?
A His only regular analgesic had been paracetamol, which is step one. Then he was written up to step two, codeine PRN. On the transfer he is written up for morphine, in the dose that I consider you would normally anticipate, so on the PRN side of that form he was having step two.

Q Would that dosage be more akin to palliative care?
A Again I do not distinguish this; a patient is not palliative and not palliative. The patient should be treated with an appropriate drug and appropriate dosage.

Q Dr Wilcock, sorry to interrupt you, there is a distinction to be drawn, is there not, between somebody who on the one hand is presenting with liver disease who has come in for continuing care, and on the other hand, somebody who is in the terminal stage of their life and in pain? Yes, or no? Is there a distinction to be drawn?
A Communication helps understanding. We have a gentleman who is known to have pain. That pain is arising from a fracture of his humerus. To a certain extent you are between a rock and a hard place in identifying an appropriate analgesic for this gentleman. If you think of step one options, basically paracetamol or non-steroid anti-inflammatory. You could argue similarly, in a different setting, that for somebody with liver impairment you have to be particularly careful about paracetamol and maybe the dosage of paracetamol should be reduced. I think this is important because I think his options for analgesia are relatively limited. I am not agreeing with the starting date that the morphine was given. But I do think we need to understand each other a bit better where we are coming from. So paracetamol, out of the two options, the paracetamol, or non-steroidal paracetamol is your option. It is not perfect, but given the benefits and risks, that was a reasonable choice. We could argue whether the dose should have been half of what it was and what have you.

If you were going to use an opioid, a step two opioid was your next logical step and trying to get away with the smallest dose of that was appropriate. They tried giving him co-dydramol

regularly. He appeared to get drowsy but he was also on another sedative, a benzodiazepine sedative as part of his alcohol withdrawal at the same time, and both drugs were stopped at the same time and his alertness improved. So we do not know whether it was the dihydrocodeine or whether it was the benzodiazepine. He is then not painful all the time, but his analgesic regimen appeared reasonable on the use of regular paracetamol and occasional codeine and in an overall sense his analgesic requirements went down in a way you would anticipate with someone who had had a fracture. At that point, when he went to Dryad Ward, I would have seen no reason to change his existing analgesic regimen. You could argue the toss over whether the 30 mg of codeine could be replaced by 2.5 mg of morphine. In effect it is like for like. Anything outside of that would be an increment in his analgesic regimen. I do not know if that helps.

Q That is very fair, and would you describe what happened to Mr Wilson as an exponential increment?
A Compared to what I would consider a reasonable dose, it is obviously a larger dose than that.

Q Would it be fair to say that it was an unsafe increment?
A In terms of justifying the dose, there is a lack of documented justification as to how that dose came about. What I mean by that is he was written up for a range of 5 mg to 10 mg, so let us say he had had two doses of 5 mg, and if that had not improved his pain, then you might say there is some justification here why this gentleman needed a larger dose. But he has had no experience at a lower dose.

Q Might I ask you the question again, is the increase an unsafe increase in the circumstances?
A Unsafe in what respect?

Q Given his underlying condition?
A All I can honestly answer is that that would not be the dose I would give. I think I have explained what I would consider to be a reasonable dose.

THE CORONER: Can we move on?

MR SADD: I will read out this statement. It is from Mr Wilson's statement, page 4?
A Sorry, whose statement?

MR SADD: Mr Wilson. I represent the family.

THE CORONER: It is Mr Wilson's son.

MR SADD: I am sorry, I should have explained. Mr Wilson is sitting at the back of the court. He says as follows,

> "I next saw dad on 15 October. He was laid in bed in an almost paralysed state. This was quite a shock considering how well he had been two days before whilst at QA. Dad was clearly distressed and confused. I do not recall him being on any lines".

And we have Nurse Hamlyn, the medical records at page 265, please. Do you have the entry, please, Dr Wilcock, of 15 October 1998?

A Yes.

Q It reads as follows,

"Commence Oramorph 10 mg 4-hourly to pain in left arm. Wife seen by Sister Hamblin who explained Robert's condition is poor. Please call day or night if any deterioration".

We can understand then from that that is before the event on the night of 16th.
A Yes.

Q Are you in a position to say, given the combination of what I read from Mr Wilson's statement tells us, and that entry there, whether or not that could have been a consequence of the effects of the Oramorph in the light of Mr Wilson's underlying liver condition?
A In the timing of Mr Wilson's son's statement, this was after the early hours of the 16th, or was this the 15th?

Q This was the 15th. This was before the event of the night of 15/16th.
A Would you mind reading that out again?

Q Of course.

"I next saw dad on the 15th. He was laid in bed in an almost paralysed state. This was quite a shock considering how well he had been two days before whilst at the QA. Dad was clearly distressed and confused. I do not recall him being on any lines".

In the light of what we do know about neurosis of Oramorph and in the light of what would seem to be a large increase over and above that that you would have prescribed, and what we do know about the underlying conditions that Mr Wilson was suffering from, are you able to help the jury about whether or not, albeit the very brief snatches of what was going on, that that could have been a consequence of the effects of the Oramorph?
A Yes, it could be.

Q We know that there is an incident over the night of 15th/16th, so that when Dr Knapman comes to review Mr Wilson, he considers that he has had a silent MI. In the light of the answer that you have just given me, could it also be the further stage of the coma as a consequence of the reaction to medication?
A This is a situation I have considered very carefully and at length. My opinion regarding this is that if the sole problem, as it were, was confusion, increasing drowsiness, reduced consciousness or loss of consciousness, in the absence of anything else then I think you could say, or you could ask the question, "Is this completely, totally and utterly related to these drugs?" So I thought that was a fair question to ask. What is giving me cause to feel unhappy or unable to say that with 100 per cent certainty is the bubbly chest, the noisy breathing, the fact that copious secretions were taken off the chest subsequently. Something in my opinion has happened at that point.

Q Could that also be a consequence of the effects of his going into hepatic coma, the secretions, the difficulty with breathing?
A I do not believe so, but I understand I could be – whenever I present my report back to the police I say, "Look, in terms of what would be considered as the normal mode of dying

from hepatic encephalopathy, talk to a gastroenterologist". I see people dying of liver failure when they have got their liver full of metastatic cancer, so I do see people dying of liver failure, but their mode of death is one of increasing drowsiness, reduced level of consciousness and slipping into a coma. I have not seen personally a situation where, slipping into hepatic coma they develop pulmonary oedema. That is not to say it does not happen, but it is not something that I have experienced.

B Q You refer at page 32 of your report, please, Dr Wilcock, about eight lines down,

"Diagnosis of myocardial infarction is one of several diagnoses available to the doctor on the morning of 16th".

Is that right?

A My view is that his heart failed. What precipitated that heart failure there may have C been more than one cause, yes.

Q You say,

"His reduced level of consciousness could have been due to hepatic encephalopathy precipitated by the morphine".

D A Yes.

Q "Or by a reduced level of low oxygen secondary to the pulmonary oedema".

A Yes. A low level of oxygen is another well recognised cause for triggering or precipitating hepatic encephalopathy.

E MR SADD: Is it fair to summarise your evidence as, we do not know, but what we cannot do is dismiss the effects of the morphine in causing or bringing about an hepatic coma?

THE CORONER: The trouble is with all these things it is almost an intellectual discussion, is it not, because Dr Wilcock has not seen Mr Wilson. All he can do is interpret the notes that he has seen, and I think that is what you are doing, is it not?

A Yes.

F

Q And to say is it more likely than not I do not think works, certainly not when we get to this stage. I mean you are not in a position to go one way or the other, are you?

A I have to say, if I felt on reading the notes I felt I could tell you something beyond reasonable doubt, that is what I would do, but I have to be honest and say that I cannot answer the questions in the way that you wish me to answer them.

G MR SADD: On the morning of the 16th, do you think that Mr Wilson's decline to death was inevitable?

A Yes.

Q At lunch time on the 14th do you think his decline to death was inevitable in the next few days?

A Not particularly predicted, no.

H

Q How then could the pre-prescription of diamorphine on the 14th, hyoscine on the 14th and the midazolam on the 14th be justified clinically?
A We probably covered this yesterday, but in my opinion the pre-emptive prescription of those drugs in those dose ranges by a syringe driver was not what I would consider normal practice.

Q It goes a bit further than that, does it not, Dr Wilcock, because those combinations – that is, the hyoscine, the midazolam and the diamorphine – appear to be a classic combination used to assuage those who are dying? To assuage the pain of those who are dying.
A They are drugs commonly used in the terminal phase, yes.

Q And we know that Mr Wilson is not in the terminal phase, I think is your answer, on the 14th.
A At the time of the transfer, no.

Q Can we come back then to a question I asked you earlier, having reviewed that part of it, because we know that that is what was prescribed on the 14th, is his approach to his care on the 14th one of treating someone who is dying?
A I do not feel I am best placed to answer why certain prescribing practices were followed, but I would say in other circumstances where obtaining medical input can be difficult, pre-emptive prescribing is used, but pre-emptive prescribing in terms of small doses of those drugs to be used subcutaneously as required, not in a large dose range in a syringe driver.

Q That was not the case here, was it? It was not in small doses.
A It was a wide dose range.

Q Equally, Dr Wilcock, those dosages and that mix of medication from the 16th through to the 17th and on to the 18th, would be a mix that would be adjusted by reference to the levels of pain the patient was feeling or appeared to be experiencing, as judged by the medical team.
A Again, in terms of the subsequent use of diamorphine, again I would say what were the indications for that? Now, I think at one point it was mentioned about him being breathless, so it may well be that the use of opioids for palliation of breathlessness would be seen as a reasonable thing to do. However, again, in terms of subsequent increases in dose, there are several comments in the notes where he was actually having these secretions aspirated from the back of his throat without apparently distressing him, yet on the same days the dose of the drug would be increased. So again within the notes I cannot see that the dose increments are necessarily justified, from reading the notes.

Q I summarise that by saying there was no rational temporal justification for an increase in those dosages on the 17th and 18th in the light of the medical records that you have seen.
A There is no documented rationale, no.

Q It goes a bit further than that, does it not, Dr Wilcock, because what the documents do tell us is that he is not distressed – page 278 of the medical records? You yourself just reflected that.
A Again, I think if you are putting a catheter down the back of somebody's throat that is an unpleasant stimulus that if people were going to react, they could react to that.

Q But on 16th it is written at page 278 – you do not need to find it but just so the jury know –

> "We also had noisy secretions phalangeal during the night but Robert has not been distressed. He appears comfortable".

On 17 October,

> "hyoscine increased to 600. His secretions increased. During the day diamorphine 40 mg. Hyoscine increased to 800 mg. Midazolam 20 mg added. Night, noisy secretions but not distressing Robert. Suction given as required. Appears comfortable, hot at times".

So it is a fact that the entries we do contra-indicate the increases.
A There is nothing to justify the increases.

Q Is the answer to my question yes?
A All I can say is that based on --

THE CORONER: I think the question is, is there anything to justify it and there is nothing that you can see.
A No.

THE CORONER: There is nothing in the notes that indicate that and, if anything, it is to the contrary. So we can take a yes if that is a help from me. Are you going on much longer, Mr Sadd, because the tape is about to stop? If so we will stop for a moment.

MR SADD: I have four questions but they all lead on to others.

THE CORONER: Very well. We will have a five minute break.

(The court adjourned for a short time)

(In the absence of the jury)

MR JENKINS: Sir, thank you for coming in. It is my request that the jury stay out of court for the moment. Having discussed matters with my learned friends, I am suggesting that after we have finished Dr Wilcock's evidence, the plan then was to go to Dr Barton. I know that we uncomfortably will not finish Dr Barton's evidence so far as Mr Wilson is concerned, but it occurred to us that we might want to do a little bit of reading today, to save your voice and because we know you have a lot of reading to do over the next couple of days, and Dr Wilcock will finish fairly soon so it might be a way of getting some of the reading done today.

THE CORONER: And it bespokes Mr Sadd coming back tomorrow.

MR JENKINS: Mr Sadd knows that he is coming back tomorrow anyway. He knows that is happening but it occurred to us that it might be some way to get some of the reading done. It breaks it up a bit for you and also for the jury. It is a suggestion we thought might be helpful.

THE CORONER: Thank you. Bring the jury in.

(In the presence of the jury)

THE CORONER: Welcome back, members of the jury.

MR SADD: Dr Wilcock, thank you for your patience and I know barristers always say three or four questions when they then ask about 14, so I hope I will restrict it to about three or four. I want you to have the opportunity to comment on your colleague's reports and specifically I want us to go first please to Professor Black's report, page 18 of that report, paragraph 6.11. It may well be, Dr Wilcock, that you have already dealt with this, but just to be clear and whether in the light of the exchanges that we have you have any cause to change your views, at 6.11 Professor Black comments as follows,

> "It is my view that the regular prescription doses of Oramorph was unnecessary and inappropriate on 15th October".

Then,

> "The patient was serious. Hepatic cellular dysfunction was the major cause of the deterioration particularly in mental state on the night of the 15th and 16th. It might be beyond reasonable doubt that these actions more than minimally contributed to Mr Wilson's death".

What is your view of that? Is that one you would dismiss out of hand or can you see why that view is reached?

A I can understand how that view is reached and if it was not for the pulmonary oedema, my conclusions would probably be along similar lines. But I have not heard, I do not believe I have heard Mr Wilson's son's evidence before reporting that his father was drowsy on the 15th. I do not believe I have seen that before and in that circumstance I would question whether the morphine dose was such that it was causing that drowsiness.

THE CORONER: Do you know if Mr Wilson is here yet, Mr Sadd?

MR SADD: I do not know. I am sure that he would be happy if I carried on.

THE CORONER: Just point out to him that we are on the move, as it were.

A Again, if on the 16th the sole finding, as it were, was a confused or reduced consciousness level, then I would continue to say that that could well be due to the morphine alone. I think I have just said, people die from liver failure in my experience, yes they become drowsy; yes they slip into coma. But I have not had people going into pulmonary oedema, crashing heart failure. That has not been my experience.

MR SADD: The crashing heart failure you base upon the subsequent events after the 16th, or simply on Dr Knapman's entry?

A Both. So breathlessness, noisy chest and then copious amounts of secretions being suctioned off.

Q A lot of which could be associated with the consequences of hepatic coma.

A That is where I would say you need to ask a gastroenterologist because in my experience the mode of death from liver failure is not with people going into pulmonary oedema. But that is my experience with liver failure in a different context, and that is why I have to say you need to seek an opinion from someone who looks after people with alcoholic sclerosis of the liver.

Q At paragraph 7.3 of Professor Black's report, he repeats what I have just read out to you. But in the evidence that he gave at this inquest, you see there that he concludes on the report, "more than minimally contributed to the death". That is referring to Oramorph and its effects.
A Yes.

Q On reflection, having gone through the evidence again, and in the light of all considerations, his considered view was that, rather than minimally, his considered view was that it was likely to have contributed to the death of Robert Wilson. That was the effect of the dosage of Oramorph. Again do you have any comments about that or are they the same as what you told us about your concerns about the effect of the pulmonary oedema?
A It is that particular issue, the issue of the pulmonary oedema, which is making it difficult for me to state beyond reasonable doubt that that was the only cause of his deterioration.

Q Can we then go please to Professor Baker's report? Page 17 of his report, please, do you have that?
A Yes, thank you.

Q I just want you to comment first on the third paragraph down, there, and I will read it out so the jury are aware of what it is I am asking you,

> "On the use of hyoscine to reduce secretions is common practice. Opiates can suppress the cough reflex which reduces the ability to clear secretions".

Mr Wilson was on opiates. He had been on opiates since the 14th. Again, does that cause you to change or revisit your view about the cause of his decline on the night of the 15th/16th and what was then required?
A It seems to me, from my opinion of reading the notes, that he developed pulmonary oedema.

THE CORONER: The longer it goes on the more categoric it becomes.
A If your consciousness level is reduced, then a number of functions will similarly be reduced, so your ability to swallow will be reduced. So as people deteriorate they are no longer able to eat or drink. If they drink they may cough and splutter because that function is reduced. In a similar sense, opioids will reduce the cough reflex. As your conscious level reduces your ability to clear secretions goes down because you become less aware of them, so things tend to pall and then you get what is commonly called the death rattle, and the reason that it sounds awful is that the secretions are there as air passes through them, so you get a rattle. But because people's conscious level is reduced to such a degree, they are not trying to clear them all the time. They are not coughing them up or swallowing them down. Or they are obviously not strong enough to cough them up and spit them out. But the secretions as I understood it from the notes, were copious, requiring suction, and that is not usual in people

with normal retained secretions, if you like, with secretions that might occur as a result of chest infection, if you like. This seemed to be on a different scale to me.

Q Could we agree on this, Dr Wilcock? Let us see where we go. This I hope will be my penultimate question. Can we agree on this? We say, would you be prepared to accept that the consequence of the pulmonary oedema is as likely to have been the cause of Mr Wilson's death as is the dosage of morphine leading to hepatic coma?

B A I really cannot say any different to what I have put in my report. If we think that the consequences of the opioid would be that it caused sedation, either directly or indirectly by precipitating hepatic encephalopathy, and we could argue about whether it was the dose of morphine that he was on at the time of his acute deterioration, or the dose of diamorphine he subsequently received in the pump. Again in my report and as we discussed, I do not think the starting dose of Oramorph, I do not think the dose of diamorphine used in the pump was particularly appropriate and there is no documented justification for the increases in the dose

C of diamorphine in the driver as we discussed.

But outside of that, both hypoxia from heart failure could precipitate hepatic encephalopathy. His creatinine levels, his liver failure could reduce his conscious level so the main sign, if you like, of opioid excess for this particular gentleman was a reduced consciousness level. Again, I have not heard Mr Wilson's son's testimony before and that may suggest that the dose of Oramorph was sufficient to cause drowsiness on the 15th, but nevertheless on the 16th

D I believe something else happened that led to the development of pulmonary oedema.

Q Finally, page 44 of your report, Dr Wilcock, you consider there, five lines up – I will preface this question by recognising that the difficulty you have had throughout your assessment of what happens on Dryad Ward is the paucity of the record keeping, whether or not in fact the signs were taken, they are not necessarily recorded and that has made your life difficult in assessing what went on. Is that fair?

E A Yes.

Q Nonetheless you conclude at page 44 that the doses of diamorphine were excessive. Is that fair?

A Can you point me to that?

Q Four lines up from the bottom.

F A Yes.

Q And not only excessive but unsafe because they disregarded the safety of Mr Wilson.

A Yes.

Q Does the same apply to the dosages of Oramorph? Do they disregard the safety of Mr Wilson in the context of his condition?

G A Yes.

MR SADD: Thank you very much, Mr Wilcock.

THE CORONER: Ladies and gentlemen, do you have any questions?

H

Questioned by Members of the Public

A MEMBER OF THE PUBLIC: Was he given any treatments for this hepatic encephalopathy, other than drugs, for that?
A Do you mean at the time where he deteriorated rapidly?

Q Not necessarily but before then as well.
A I mean, his condition was not reversible, but there may have been things that could be done to support it, and obviously reducing the alcohol which was causing the damage would be the first one; improving nutrition because often people who drink do not eat and that itself can aggravate the situation; ensuring that he was not dehydrated because dehydration can aggravate the situation. Treating any other underlying problems like infection which would aggravate the situation and ensuring that he was not on drugs that could precipitate the encephalopathy. So a lot of the approaches are what we would call supportive. He could be given a new liver again, but we are just trying to reduce the burden on the liver, if I can put it that way.

Q Was he given lactulose?
A Yes. Again, bacteria in the gut produce toxins and again usually this is not usually problematic because the liver would deal with that. If the liver is not able to deal with these toxins then again that can precipitate hepatic encephalopathy. What I do not know is whether it refers to specifically the lactulose, or basically any laxative that maintains a regular bowel action will do it. I think lactulose is the one that everybody uses, but I do not know if there is anything magical about it. I honestly do not know if there is anything magical to say about that other than actually keeping the bowels regular.

He was given laxatives. I think magnesium sulphate is a laxative and possibly Senna. But not lactulose. As I say I do not know if there is anything specifically magical about lactulose.

A MEMBER OF THE PUBLIC: You talked about checking anyone in the specifics of certain illnesses before you administer drugs for it. In your opinion, do you think that people were treated too generally as opposed to investigating the specifics of what was wrong with them on the Dryad Ward?
A It is obviously a very general question.

THE CORONER: We can only look at the 10 we are examining.
A I think it is just my approach and the approach of most people would be to say, can you correct the correctable non-drug/drug approaches? Is there anything here that we can influence in terms of how that person is feeling and in what way they may be affected by their illness, whether it is symptoms or what have you. So I think the duty of the doctor is to ensure that he has thought about that to a reasonable extent. I think what you have to do is to balance up the likely balance of pursuing a particular treatment plan and the burdens that may come along with that, as opposed to the potential benefits you might get out of it. So I think over the course of the two days, in certain circumstances where there appears to be less in the way of co-morbidity where people may, in other words, seem reasonably not too bad, brings more of an emphasis to say "Perhaps we should have looked into this. Perhaps there should have been a more thorough assessment", because in their situation it may have been worth pursuing particular approaches.

In other situations where people have significant other problems, on paper there may be things that you can do, but in practice it may not actually give them much back in terms of relief or quality of life, and in that sense the burdens outweigh the possible damage. So it is a balancing act that you are constantly having to try and get right.

Q You talked about the dosages of morphine that you would give, and when we look at the dosages that these 10 people were given. You say they were higher than what you would give. Do you think they were more generally given as opposed to --

THE CORONER: The doctor is not going to tell you anything about that. Sorry about that.
A Is there a question pending?

THE CORONER: No. Thank you, doctor. Thank you for being here and for all the help you have given.

(The witness withdrew)

THE CORONER: We were going to go on to Dr Barton, but we are going to leave Dr Barton until tomorrow and I will continue with some reading.

This is the statement of Dr Amril Mashiado, who made a statement on 16th November 2005. He says,

> "I am a commissioned officer in the Royal Air Force, the medical branch. I am a consultant in orthopaedic surgery at the Royal Hospital, Haslett, Gosport and QA. I have been in my current post since September 2004. As a consultant orthopaedic surgeon I am primarily involved in the treatment of both outpatient and operative people who fulfil the majority of pathology. This includes the treatment of fractures and collective orthopaedic problems and included hip replacements.
>
> I have been asked to detail my involvement in the care and treatment of Ruby Lake. I have no personal recollection of this patient or of my involvement of her care. I refer to the medical records kept here at the Royal Hospital, Haslett for this patient in preparation for this statement. I have been asked to comment on the appropriate entries in the operation records of this patient but as pages 54 and 55 are a record of the anaesthetic progress of this patient per-operative" –

Should that be "pre-operative" or "peri-operative"?

> "and as such have been filed by the anaesthetist who was involved in this case. I do not feel it is appropriate on my part to comment on these. Pages 56 and 57 which is an entry by myself in the operation records. It states that I performed a left, cemented hemi-arthroplasty on Ruby Lake on 5 August 1998. The procedure was performed under the direct supervision of Mr Brown(?), who is my supervising consultant at the time. The anaesthetist involved was Dr Phipps. The operation began at 14.30. In the operation notes I have documented that the patient was in the right lateral position and that I performed a hiving off(?) approach to the left hip in layers. Once the hip drive was approached the femoral neck was osteotamised. The head of the femur was extracted with the symmetric force of 3mm. Subsequently the femoral canal was prepared with a variety of levers and broaches to enable the femoral stem to be

cemented in place. Once this was performed, the hip was reduced and was noted to be stable. Subsequent to this the operative wound was closed in layers. It should be noted however that the photocopied operation notes available to me for the preparation of this statement are unreadable because of the problems with the photocopying process rather than the fact that the handwriting is illegible.

On page 56 of my post-operative instructions, where I have recommended that the patient be given further doses of intravenous antibiotics as a prophylactic procedure. In addition I had recommended prophylaxis against deep vein thrombosis and I have also suggested that the patient had a check x-ray and blood tests performed the following day. I have also suggested that the patient be mobilised when comfortable. The above procedure, ie hemi arthroplasty, is a common operation performed on patients with hip fractures".

You may remember that (?) said he did six in a day.

" This operation involves the replacement of the fractured part of the femoral head and neck with an artificial implant. Unlike conventional hip replacement operations, the (?) socket is not replaced as this is usually uninjured during the hip fracture process. In the operation notes are the relevant implant stickers from the manufacturers for the particular stem and femoral head that was used, which have been retained in the patient's records. Of note is the fact that the size of the femoral head after it was extracted was measured and found to be 43 millimetres and in fact the sticker compartment confirms that the size of the implant of the femoral head was also 43 millimetres. The end of the operation note also supplied the fact that I performed a routine closure of the hip wound and from what is visible on the photocopied operation note I used a (?) to close the facial layer and clips for the skin. Of note also is the fact that the patient had been given peri-operative antibiotics. These are given routinely just before the start of the actual surgery and a few doses post-operatively to prevent or minimise the risk of infection.

On page 126 of the medical record copies is the prescription sheet and there are three doses of [whatever it is] prescribed by myself which has been initialled as having been given both on 5 August 1998 and 6 August 1998. I have also mentioned previously oral DVT prophylaxis in the post-operative instructions. These vary from consultant to consultant and in this particular case I requested it, according to Lt Col E Singer's protocols. I suspect she may have been admitted under his care initially for me to have requested this. DVT prophylaxis involves both mechanical means – ie the use of foot pumps or treatment with medication which are given as injections to work as chemo prophylaxis. These are given to minimise the risk of deep venous thrombosis, i.e. a clot in the veins and subsequently an embolism, which these patients are at high risk from following the injury and surgery.

Page 58 of the operation record is a record of the timeframe when the patient was in theatre recovery department prior to being transferred back to the ward after surgery. It records the patient being brought into recovery at 15.35 hours on 5 August and it is also recorded that she was stable and discharged to E Ward.

Page 59 of the medical records is a consent form for the operation signed by Ruby Lake on 5 August 1998. This shows that she consented to the operation for the left

hemi-arthroplasty to be performed and the consent was taken by Carl Trimble on that day.

In conclusion, Ruby Lake sustained a fracture of her left hip. She underwent a hemi-arthroplasty procedure which is a type of replacement operation. This is a fairly routine operation performed on a daily basis in the orthopaedic departments in most hospitals. However, surgery is always associated with certain risks and these risks are sometimes increased if the patient has other associated medical problems, eg heart disease, hypertension or high blood pressure, diabetes, etc. The risks of surgery are also increased in patients who are elderly".

This is the statement of Pamela Gavell. It is a statement dated 25 July 2005. She says,

"Between 1968 and 1972 I was a student nurse at St Mary's Hospital, Portsmouth where I did general training".

Do you want me to go through this or are you content to take this as read?

"Between June 1985 and April 2001 I was the nursing director to Thalassa Nursing Homes Limited. There was an increase in bed capacity at all three homes to 90 beds and that was in compliance with the 1984 and 1989 Nursing Home Act. My responsibilities included maintaining the smooth running of all three homes by liaising with all three matrons to maintain a good reputation with all local services and building relationships with the local community and potential client group.

Between April 2001 and March 2003 I was employed as a staff nurse at Thalassa. My main aim was to work together with the managers and our GM colleagues to promote the homes' philosophies".

She then goes into detail of subsequent involvement, and then,

"I have been asked to detail my involvement in the care and treatment of Arthur Brian Cunningham. Mr Cunningham was a patient at Thalassa Nursing Home in 1998. I am able to produce a copy of his patient notes from that establishment. From memory and referral to those notes I can state that in August 1998 Brian Cunningham was a patient of Mulberry C Ward, now Collingwood Ward at Gosport War Memorial Hospital. He became suitable for discharge and a vacancy at the nursing home was sought. At the time I was director of nursing at Thalassa Nursing Home and I went to see him to assess his suitability. I became aware that he had both psychiatric and nursing problems. I believe his nursing needs outweighed his psychiatric needs.

He was a 78-year old with Parkinsons and blood sugar problems. He was not on insulin. He appeared unco-operative and displayed difficult behaviour. He was settled on the ward. I remember him as quietly spoken, taking a long time to speak. I connected that to his Parkinsons disease. We agreed to take him to Thalassa Nursing Home, and on admission on 28 August 1998 it was noticed that he had a large red stapled area with granuflex on it. At the time of the pre-assessment it was my understanding that he did not have any pressure sores, however I was on Collingwood Ward the day that Brian was admitted to Thalassa and I recall having a conversation with a nurse who informed me that Brian had been on the floor all the

previous night. This probably exacerbated the likelihood of Brian developing a pressure sore, something we all try to avoid.

We decided to put him on a Quattro mattress at Thalassa. These mattresses are extremely expensive but the best for persons with pressure sores. On the whole, staff at Thalassa coped well with Brian. He was not perceived to be a management problem. His Parkinsons drugs were administered six times a day. John Allen(?), the community psychiatric nurse saw Brian at Thalassa but decided that he was quite settled and no changes were required in his psychiatric treatment. Brian's staple sore was a worrying factor but continued to be treated and dressed accordingly. He attended the Dolphin Day Hospital on 17 September 1998 when he had a swab taken from the wound. He was also prescribed 200 mg of metronidizol, one tablet three times a day. This is used to treat fungal infections.

On 21 September 1998 Brian had attended the Dolphin Day Hospital as previously arranged and was admitted to Dryad Ward. I can recall that on that day he appeared to be unwell. This may have been because of the metronidizol, which can cause nausea and flu like symptoms as a side effect. He had his chin on his chest and was not as bright as he had been. He may have had a possible chest infection or indeed the start of one. On 23 September 1998 we received a telephone call from Dryad Ward at Gosport War Memorial Hospital to report that Brian's condition was quite poorly. On 28 September we received a further call from Dryad Ward to inform us that Brian had died at the weekend".

Dr Thomas(?): her statement is dated 30 May 2005. Again she is on Mr Cunningham.

"I am employed by Eastham's Primary Care Trust as a community geriatrician for Gosport Primary Care Trust. I have held that position since 21 June 2004. We held outpatient sessions at St Mary's Hospital and at Gosport War Memorial Hospital. I was asked to detail my involvement with Arthur Brian Cunningham" –

if I miss anything you think I ought to be referring to, would you point it out to me at the appropriate time?

"Mr Cunningham was a 79-year old gentleman living alone in Radcliffe Court, Gordon Road, Gosport. This is a warden assisted flat. He had Parkinsons disease, diagnosed by another specialist. He also had a weak pelvic girdle from a war injury. He had predominantly left-sided tremors from Parkinsons disease but had peculiar transfers out of bed and chair as he had long-standing weakness in his pelvic muscles, which meant that his pelvic girdle was unsteady when he stood up. In my opinion the dose of synalad needed to be reduced as it had resulted in abnormal body movements and subsequent hallucinations. A decline in blood pressure on standing was also a side effect of synalad. Mr Cunningham did not accept this his dose of synalad needed to be rwduced, although this had been explained to him on several occasions, he felt he needed a higher dose.

He moved to three different homes in six months prior to his death, as he did not really settle in any one home. The occupational therapists were not able to put him in the adaptations that had been available to him in his own flat at Radcliffe Court. My first assessment on contact with Mr Cunningham was on 16 September 1997 when

I visited him at home in Radlett Court, Gordon Road, Gosport. As a consultant geriatrician I carried out a number of ancillary visits at the request of the patient's GP. Following my initial visit Mr Cunningham subsequently attended the Dolphin Day Unit at Gosport War Memorial Hospital as an outpatient.

I have been shown medical notes for Arthur B Cunningham. From the medical records I can confirm I saw and assessed Mr Cunningham on 10 March 1998 in my capacity as consultant geriatrician. The notes of my assessment are recorded on Mr Cunningham's notes of his attendance at the day hospital. Pages 523 and 524 of the medical notes I can confirm is a letter from me to his current GP, Dr Stewart Morgan conveying my assessment which can be summarised as follows:

My findings were that the patient had episodes of breathlessness. I considered a differential diagnosis of left ventricular failure or anxiety. My clinical examination and investigation did not support left ventricular failure. Mr Cunningham reported that his breathlessness had improved with diazepam, 2m taken three times a day. He had involuntary movements in his entire body. In my opinion this was due to the high dosage level of synalad which was used to treat his Parkinsons disease.
I recommended that the dose be reduced gradually once he had settled in at the nursing home. Mr Cunningham reported that he had been admitted to this home on 15 March 1998. I also arranged for an ECG, chest x-ray and blood test to be done.
I wrote to Dr Morgan, as per my letter at page 521 of the exhibits shows.

The white cell and platelet count were a little low but he was not anaemic. I asked Dr Morgan to arrange for a repeat full blood count in two to three months time and I also recommended that Mr Cunningham be referred to a haematologist if the platelet counts had fallen further. There is a further letter within the medical notes, page 519. This letter confirms that his chest x-ray was normal. Following this attendance on 5 March, Mr Cunningham was discharged back to the care of his GP, Dr Stuart Morgan.

I later saw and examined Mr Cunningham at Bernard Park Rest Home, Gosport, on 19 June 1998. A record of this assessment is recorded in my letter on page 491 of the notes dated 22 June 1998. I can confirm I have dictated the following letter on 22 June 1998. The letter reads,

'Dear Dr Grocott, Arthur Cunningham, date of birth 13.3.19. Dr Stuart Morgan requested this domiciliary visit on 16 June following your initial referral on 11 June. I visited Mr Cunningham at Bernard Park Rest Home on 19 June. Walking in I was most struck with the amount of weight Mr Cunningham seemed to have lost since I last saw him in outpatients on 10 March'".

This is 27 June.

"He moved to Bernard Park Rest Home at the end of April and I understand that he felt very low in spirits, but although this is still so he agrees that he is settling in and also mentioned that he did not feel he would be there much longer, and mentioned the possibility of a move to an RAF home. This was certainly mentioned last year and I am uncertain at this stage as to whether this is a realistic option for the future.
Mr Cunningham's main functional problem at present is that he finds the bed too soft and misses the pole and rails that he had in his flat which made his transfers much

easier. However, he is able to get out of bed with the assistance of one person, and although his transfers are extremely unsteady, one carer can usually manage him. He has difficulty turning over in bed at night and feels that the mattress on the bed is too soft, although this has been changed recently. He is able to use a bottle successfully three to four times at night to pass water, and denies any difficulty in micturition. He is on a soft diet. His bowels are regular and constipation has not been a particular problem. He is breathless occasionally as before, but denies any definite angina and oedema has not been a problem. He has had two falls since moving into the rest home but has not had episodes of loss of consciousness. Dysplasia is not a problem. The staff at the rest home have not noticed periods of shuffling or freezing. Hallucinations have not been a problem in the last few days, although this was so quite a few weeks after he moved in".

He then goes into the medication.

"Mr Cunningham was seen at 4.35, an hour and a half after his previous dose of levadopa and was extremely dystonic. The dystonia affected his entire body and right upper and lower limbs. He had a mild tremor in the left upper limb but had no rigidity in his limbs at all and not particularly brachiakinetic. There was no cerebrum. Transfers were extremely hazardous and he was lurching even more than before and he had to be steadied by two people although he used a stick. His voice was soft as before but there was reasonable modulation. His pulse was 80 a minute and regular. Blood pressure was 140 over 80 sitting, venous pressure was not raised. Heart sounds were normal. His chest was clear. I could not feel any masses or tenderness in his abdomen. He was very weak around the hips and the left foot dropped as before.

Overall I feel that Mr Cunningham is on too much medication. This has been my opinion since October last year. Unfortunately Mr Cunningham has never agreed with this and our previous attempts at dosage reduction were unsuccessful. I feel that his unsteadiness at present is a result of too much levadopa which has resulted in dystonia, as well as likely severe postural hypertension. He was too unsteady to check a standing blood pressure. I feel that diazepam leads to hypertonia which renders his unstable lumbar sacral spine to be more so.

I agree that Mr Cunningham is depressed since his move to Bernard Park Rest Home. I felt that his short term memory was worse than before, because he was quite repetitive. In addition, functionally things are difficult for him as it is not as well adapted to his needs. He had quite a few implements that he could use. He still has his electric wheelchair but I gather this is downstairs. I have taken the liberty of reducing his levadopa. Further I have also phased out the timings to regular four hour dosing during the day so that this will provide us with a base line from which to make further adjustments. His therapeutic regime now consists of co-caraldopa. I have asked the rest home to offer 2.5 mg of diazepam if he requests it. I hope that the diazepam can be reduced gradually in the future. Mr Cunningham has agreed to these changes in his medication. I should mention that his records have been misplaced and I am sending you a copy of my outpatient letter of 10 March which mentions the dose of caraldopa he was then taking, and also his reluctance to reduce his dose further. If you wish further copies of the correspondence, please let me know and I will be happy to send them to you. We will need to ascertain whether Mr Cunningham is going to remain at Bernard Park for the next few months, as it would be rather

pointless fitting rails if he is to move in the near future. I agree that Mr Cunningham is depressed but feel a referral to Dr Banks for an assessment of his mental state could be deferred until the dose of levadopa is reduced as much as possible as it is the excess levadopa that is causing his hallucinations. Mr Cunningham has agreed to day hospital attendance and I hope they are able to help him this time round. Yours sincerely',

B And it is signed by Dr Lord. It then goes on to summarise her assessment.

"He has apparently lost weight. He was depressed, had poor short term memory. He had reported visual hallucinations. He had involuntary movements affecting his entire trunk, right upper and lower limbs with a mild Parkinson tremor in the left upper limb. Mr Cunningham now requires the assistance of two people to transfer safely out of bed. I have also recorded the fact that in my opinion the dose of Synamet was too high and leading to the involuntary body movements. I also felt that it was likely that he had severe postural hypotension. He was too unsteady to obtain blood pressure readings when standing. I was concerned that diazepam may have led to the reduction in tone in the pelvic girdle muscles and a further contributory effect as to why he was unsteady on his feet. I agreed with Mr Cunningham to reduce his co-paradopa as detailed in my letter. I also recommended that the dose of diazepam may be reduced gradually. Mr Cunningham mentioned to me that he intended to move to an RAF home. As such it was not possible to be certain whether he would be remaining at Bernard Park. As a result of this uncertainty the occupational therapists had not yet fitted the equipment that had been installed at his home address at Radcliffe Court. This equipment had been specifically designed for Mr Cunningham to enable the safe transfer and mobility around his flat. I referred him to Dolphin Day Hospital for a multi-disciplinary assessment of his functional needs and for other adjustments to his medication. However, I notice that recorded in the letter at page 241 of his medical notes show that on 25 June 1998 Mr Cunningham had moved to Somerville Close, Gosport. The letter of 22 June 1998 sets out my recommendations to the staff at Dolphin Day Hospital. The letter reads, addressed to Sister Stewart,

C

D

E

'I would be grateful if Mr Cunningham could please attend once a week. He is extremely dystonic now and has lost a lot of weight. I would like the following done, please, Us and Es, liver function test, calcium and glucose, thyroid function tests and blood count. Lying and standing blood pressure done at each visit. His severe dystonias are a problem. Reduce the 6 am dose of co-careldopa from 25 to 110 in the first instance. Also check with the rest home whether there are episodes of shuffling, freezing and rigidity. Check with the rest home as to the frequency of diazepam. They are documenting this in a book which Mr Cunningham signs as he has phoned his relatives saying he is being drugged up. Could the physiotherapist please assess him? Could the occupational therapist please see him at Bernard Park Rest Home with a view to a more suitable bed and rails. Mr Cunningham has said himself that he is unsure as to whether he will stay at Bernard Park and will need to check this with the social worker before adaptations are put in. If his mood remains low he may need assessment by Dr Flax. Many thanks'".

F

G

Added in handwriting is,

H

"Panels please phone GP to find out current address and if DVH. I was going to book him in Dolphin Day Hospital for 6 July 1998 but will wait to hear from SPW.

My next contact with Mr Cunningham was on 20 July 1998 when I reviewed him at Dolphin Day Hospital. I confirm my written entry is recorded on page 637 and 638 of the medical notes. The letter that I dictated on 22 July 1998, pages 478 and 479 of the notes, relate to Mr Cunningham's attendance on 20 July 1998. I can confirm that I dictated the following letter dated 22 June 1998 to Dr (?).

'Details of diagnosis. Parkinsons disease stable. Weak pelvic girdle from old injury. Stable. Low white cells and platelets. Likely dysplasia. Weight loss. Element of depression with deteriorating memory. Has not been able to settle in rest home and nursing homes in the last couple of months. Mr Cunningham attended Dolphin Day Hospital today. He has been doing so since 6 July and the opinion of the therapists and nursing staff is that both his Parkinsons disease and transfers are stable overall. He was able to do this with one nurse. He still tends to jack-knife on transferring from sitting or lying down position, but overall his stability does not seem to have deteriorated very much. His weight today is even lower at 67.2 kg. Blood pressure was 130 over 65 lying down, 180 over 110 on standing. He was low in mood and his short-term memory is certainly much worse. He was dystonic, as before, tremors were a problem in the left upper limb more than the right and he had mild to moderate rigidity in the upper limbs. There was no dystonia and Mr Cunningham himself denies hallucinations now. He mentioned a difficulty with dystonia. He is able to feed himself at the day hospital and usually finishes his main meal as well as pudding without any observed difficulty. He should continue with synamet, [drugs stated] sulpadol and diazepam. I have arranged for a speech and language therapist to assess his swallowing as I wonder if he is safe with liquids.

Following Mr Cunningham's consultation with me, I had a phone consultation with Dr B Banks, consultant in old age psychiatry and was informed that he is being admitted to Mulberry Ward on 21 July. I will be happy to review him there and will let the speech therapist know of his admission so that he can be seen on the ward. I have discussed with Mr Cunningham today that it was in his interest to try and settle in the new nursing home that was found for him, although this may not be called perfect to his eyes. He continues to mention the RAF home in East Sussex as his preferred option for placement, but I am not too sure as to why he is unable to go there. Mr Cunningham will need a house and furniture to be adapted for him and will also need a great deal of help in the transfer. Unfortunately this cannot be put in place until he has a permanent place of residence. This has been explained to Mr Cunningham today. Yours sincerely'.

The notes of my assessment as set out in this letter to Dr Pocock, which can be summarised as follows:

The problems are as listed in my letter. He was transferring with the assistance of one person. His mood remained low. His short-term memory was poor. He was on a lower dose of co-careldopa, but with no deterioration in function. I was informed by Dr Banks, the consultant psychiatrist, that Mr Cunningham was being admitted to Mulberry A Ward on 21 July 1998 for assessment. He remained keen to move to the RAF home in East Sussex. I note an entry in the clinical records on page 70 at 3.15

on 24 July 1998 recording a telephone conversation between me and Dr Charles, which is recorded as follows:

His Parkinsons is very stable at present. He gets a lot of problems with dystonia, hallucinations and also hypertension if the dose is increased. He has always wanted more but we should continue with the current dose. Dr Lord will see him on Monday. Mr Cunningham informed.

This records my preceding and subsequent contact with the patient. I can confirm that I have written the following entry on page 74: Seen at Mulberry A. He is sitting at table eating porridge on his own. Subsequently observed to be buttering and eating toast. A bit slow and some tremor but no particular problems observed".

That gives the details of the examination.

"Mobility problems are mainly due to his weak pelvic girdle from an old spinal injury. ED is stable overall. Suggest high protein diet, weekly FBC, CT safe doses co-careldopa. If however night-time stiffness persists, try (?) at 10.

At pages 105 to 107 of the medical notes there is a letter from me to Dr Banks detailing my ward visit on 27 July.

'Dear Vicky, Mr Cunningham was reviewed on Mulberry A on 27 July at Dr Charles' request as he has wished the dose of careldopa to be increased. I visited at 8.45 am and he was at the breakfast table with two other gentlemen. He was observed to be eating porridge on his own. He subsequently buttered his toast which he was able to swallow without any obvious dysplasia or brachinesia. Mr Cunningham had not been observed to have any particular day time stiffness but I note from his medical notes that there has been some stiffness at night, although this seemed to be improving. Clinically he had mild cogneal rigidity in his upper left limb, a tremor to the left more than the right. He was not dystonic as before. There was no evidence of any stuttering or freezing. The doze of careldopa has been reduced as he had problems with severe postural hypertension, hallucination and dystonia on a higher dose. Investigations of last week confirmed normal renal function with a very low serum albium of 26. However, a couple of days later, 22 July, his urea had risen to 11, creatinine 101, electrolytes were normal, (?) spuriously raised at 47. Thyroid function tests are normal. His white count remains low but stable at 2.9. Haemoglobin is normal at 14. MCB 93.5. Platelets stable around 100. PSR is 18.

I do not feel that further action need be taken about his neutropaenia and thrombopsychopenia. I feel that he will need weekly full blood counts at present. I feel his pulmonary input should be increased aiming for two litres a day. I have also mentioned him to Ruth Deverill, speech and language therapist so the dystonia can be formally assessed as he may benefit from thickened fluids rather than thin fluids if this is difficult. I feel that his present dose of co-careldopa 110 should be maintained at five a day. If night time stiffness is still a problem toward the end of the week, I would suggest that this is increased to co-careldopa CR 250 at 10 pm and the 110 omitted. As this does cause more problems with hallucinations the dose will need to be reduced back again.

Overall Mr Cunningham's Parkinsons disease is no worse and his transfers continue to be difficult mostly due to the war injury which has resulted in considerable weakness to the pelvic girdle. I will be happy to review when appropriate".

She then summarises the letter, sees him eating his breakfast. The co-careldopa dose had been reduced because of previously reported hypertension, hallucinations and abnormal movements. Blood tests show low albumin indicating poor nutrition and a mild reduction in white cells and platelets.

"I recommended that we increased his daily liquid intake aiming at two litres. I referred him to speech and language therapist. Also recommended weekly full blood counts. I left the co-careldopa unchanged in the day time but there was a recommendation that the night time dose be increased from 110 to 250. Mr Cunningham's Parkinsons syndrome symptoms had not worsened. I can confirm I have written the following entry,

'Elderly medicine 27 August 1998 reviewed. One catheterised today for retention of urine. Quite full now. Parkinson's disease has deteriorated. Cannot comment without reviewing medical notes. Not really mobile. Will not wheel himself in chair. Eating better. Weight 69.7 kg on 8 August 1998. Continue same dose of aldopa as increased dose may be required but I feel this carries a significant risk of worsening his mental state. Could occupational therapist here please liaise with Eileen Kettlewell, occupational therapist, as Mr Cunningham will require rails by his bed. Will need post-discharge visit to nursing home. Leave catheter in for now. I will arrange further follow-up at Dolphin on 14 September 1998 to monitor PD, FBC UEs and weight. He should be discharged to the Thalassa Nursing Home now. Document weight before discharge".

Then she goes on to explain that. She dictates the following letter on 1 September 1998, to Dr Banks, consultant in old-age psychiatry:

"I reviewed Mr Cunningham on Mulberry A on 27 August. He is due to be discharged to the Thalassa Nursing Home on 28 August. He had problems today with retention of urine. Had a residual volume of 1900 ml and a further 800 ml was entered this afternoon as well. He denies constipation. He is eating better. His weight as in early August had improved to 69.7 kg. He is much better in his mood although apprehensive about the discharge tomorrow. His Parkinsons disease seems a little worse. He had a little increase in stiffness but I gather it now takes one or two people to transfer and is not really mobile. Although he released the brakes on his wheelchair, he does not wheel himself either.

In the long term he may require more levadopa, but I am not keen to do this at this stage as I feel it would upset his mental state and may make settling down at Thalassa more difficult. I feel that discharge tomorrow can go ahead as planned, and feel that the deterioration in renal function is due to his retention of urine. I hope to contact the occupation therapist as regards assessment at Thalassa Nursing Home on discharge as I feel he will need adequate rails to help with his transfers. I also hope to review him at the Dolphin Day Hospital on 14 September to monitor his Parkinson's disease, weight, urinary retention, full blood count and renal function. With best wishes, yours sincerely'.

This letter details my assessment of my visit to Mr Cunningham on Mulberry A Ward on 27 August 1998, which can be summarised as follows:

Mr Cunningham had been catheterised for urinary retention with a residual urine volume of 1900 mls. This is a significantly large volume of urine to be retaining within the bladder. His nutrition and weight have improved to 69.7 kg. His mood was better although he was apprehensive about his discharge to Thalassa Nursing Home. I recommend that he continue the existing dose of co-careldopa as a higher dose would worsen his mental state. I recommended that the occupational therapist should review him for rails by his bed following the discharge. The catheter was to remain in for the time being and that his weight should be documented on discharge. I am advised that there should be discharge to the Thalassa Nursing Home on 28 August 1998 but I should see him at the Dolphin Day Hospital on 14 September 1998 to review him.

I confirm that I dictated the following letter on 23 September. The letter reads,

'Dear Dr Procock, re Arthur Cunningham: Mr Cunningham was first reviewed at Dolphin Day Hospital today and has a large necrotic sacral ulcer which was extremely offensive. There was some abrasing of the skin around the necrotic area but also a reddened area with a black centre on the left lateral (?) His Parkinson's disease does not seem any worse and mentally he was less depressed but continues to be very frail. I have taken the liberty of admitting him to Dryad Ward at Gosport War Memorial Hospital with a view to a more aggressive treatment to the sacral ulcer as I feel that this will now need acerbine in the first instance.

The social worker has been contacted so that his place at Thalassa Nursing Home can be kept open for the next three weeks. Mr Cunningham has agreed to the admission. Let me know how he gets on, yours sincerely'."

There is a copy of that sent to Dr Banks, consultant in old age psychiatry. She then writes the following note in the hospital notes on 21 September 1998 and she explains her medical notes:

"Mr Cunningham was seen at Dolphin Day Hospital, blood pressure lying down was 110 over 70, a relatively low reading for Mr Cunningham. Pulse was 84 beats per minutes which was a normal reading. Weight documented at 69 kg. I observed that he is very frail. Examined his mouth and found evidence of unswallowed tablets which I have ascertained had been given earlier. I also noted that he had a large necrotic sacral sore that was foul smelling. 'Necrotic' means that it is basically dead tissue. In this case it was covered with a thick black scar. There were also abrasions noted on both buttocks which I illustrated.

Left lateral maliosis refers to the outer aspect of the left ankle. He had a small black scar on this site and there was some surrounding redness. I began to feel that his Parkinsons disease had worsened. My diagnosis: sacral sore sustained in nursing home. Parkinsons disease. Old back injury. Depression and an element of dementia. Diabetes condition was continued by diet alone. Catheter advised for urinary infection.

My finding was as follows: stop the [laxative], Metronidizol, which he was taking early, it is unlikely that this would have adequately penetrated the necrotic tissue in the sacral ulcer. The amalodapine was discontinued as blood pressure was low. Admission was arranged to Dryad Ward at Gosport War Memorial Hospital where a bed is available. I recommended aspen cream for topical use on the sacral ulcer and that he be nursed on his side to relieve pressure on the ulcer. I recommended that he be put on a high protein diet to help improve his nutrition and help wound healing. As the ulcer was extensive he would have a significant degree of pain for which I recommended Oramorph. I prescribed 2.5 mg to 10 mg to be given orally as required at intervals of four hours. I documented this prescription on page 752 on the prescription drug charge.

I felt that the nursing home bed should be kept open for the next three weeks in order to establish whether Mr Cunningham would be well enough to return there. Mr Cunningham formally agreed to the admission. The day hospital staff were also instructed to inform the nursing home. Dr Banks, consultant psychiatrist and his social worker were at the admission. I have noted that his prognosis was poor.

Whilst the treatment plan was aimed at maximising the prospect of an improvement in Mr Cunningham's condition, I recognised that his general condition was very poor. He contributed to the development of large pressure sores. I felt that he was unlikely to recover. I cannot find any further entries by me in this patient's records that I had any further contact in Mr Cunningham's care. If there is a change in the patient's condition, the medical staff can either alter the patient's medication and dosage as necessary without reference to the consultant, unless in the opinion of the medical and/or nursing staff, further consultation or input is required".

I think at that stage we will stop.

MR LEIPER: Can we raise at least one matter after the jury have gone?

THE CORONER: Certainly. Members of the jury, you may now go home.

(In the absence of the jury)

MR LEIPER: Sir, this is with regard to Dr Dudley. What you said was that we could refer to Dr Dudley.

THE CORONER: What do they prefer?

MR LEIPER: I would prefer Dr Dudley's statement to be read, or part of it. The other point is this, what Dr Buckhalt(?) was saying is that trimethiprin had been given at an earlier stage and it was drawn to his attention that the creatinine levels were elevated, which were at the same time or thereabouts that the trimethiprin was given in the other hospital. His point was, well, if there was a link between the trimethiprin and the raised creatinine at an earlier time, and then there was another link between the trimethiprin at the War Memorial Hospital and the raised creatinine levels in the final period, Dr Wilcock wanted to draw our attention to the fact that the levels were about 200 at the QA, and 360 at the War Memorial Hospital.

THE CORONER: The point he was making was that they were elevated and one might accept that they were elevated but they were elevated far more than one would have expected.

MR LEIPER: So if there is a link between the trimethiprin and creatinine, and that has not been established, Dr Wilcock's view was that we would need to hear from an expert then I think the report of Dr Dudley should be read. He still wanted to point to a significant difference and that showed in Dr Wilcock's view certainly, a continuing deterioration. If one were to call Dr Dudley – I do not say that that has to happen – but if one were to call Dr Dudley he could certainly deal with it. As matters stand, Dr Dudley certainly refers to the fact that Mrs Devine was being treated with medication for her suspected urinary tract infections. The only drug that was being given was trimethiprin and one reading of his statement is that certainly Dr Dudley was aware of this.

So he is aware of what the family's concerns are about Dr Dudley's report. The key concerns are that he appears to base his conclusions, at least in part, on the raised blood level, the creatinine to 360, and we have heard expert evidence to the effect that there may be a link between the raised creatinine level and trimethiprin, and that is an issue which has to be addressed.

The second issue is that he bases his conclusions to a large degree on the episode of agitation on 19 November and he appears to be of the view that that is capable of one explanation and that is agitation associated with renal failure. We have heard that there is an alternative explanation to that, which I believe is that that may be attributable to having received four times the appropriate dose of diamorphine equivalent. Those are clearly two key issues which informed his conclusion and invited the expert evidence that we have heard. They may be two conclusions or facts upon which it is not safe to provide the conclusions which he has.

As you are aware there are a number of other unsatisfactory features in relation to the Dudley report, not least the reference to Elsie Devine having had multiple myeloma and the provisional Dr Barton's statement. Can we be realistic about what can be done in these circumstances? We would ask that if you are minded to read it, you should underline what the family's concerns are in relation to the report and secondly, the refutation of the agitation on 19 November is an indication of an explanation. If sir is content to draw those reservations to the attention of the jury, the family is content that the report should be read.

There is one final element of the report, that the family have reservations about his reference to the administration of (?) having been entirely appropriate in the circumstances. That is something that is clearly unsupported in the light of Dr Wilcock's evidence and that is a reservation the family would like drawn to the attention of the jury before it is read.

THE CORONER: Do you have any view, Ms Ballard?

MS BALLARD: Sir, as to the concern that Dr Dudley seemed to be saying that Mrs Devine had multiple myeloma, I think it is a misunderstanding of what he is actually saying on pages 8 and 9 of his report. To try and put paragraph 7 into some sort of summary form, it appears he is saying that Mrs Devine had progressive renal failure. There is evidence of damage to the filtering units within the kidney. He disagrees with Dr Stephens as to the likely cause of that and he says that it is likely to be caused by IGA, lambarda paraprotein. He goes on to consider and detail what the paraprotein is evidence of and what her blood tests have shown,

and he concludes that blood tests can show a range of responses in the body. At one end there is the malignant condition of multiple myeloma and at the other end is a condition of, to use his abbreviation MGUS. He says those are two extremes and he says that in his view there is evidence of a condition of "smouldering multiple myeloma", which is not multiple myeloma.

So suggestions that he is saying that she had multiple myeloma is inaccurate on the basis of what this report is saying. I think that is very relevant if you are considering how accurate his report is without actually asking him to be present and clarify it in any detail. It is also, with regard to what he says, I drew to your attention very early on in these proceedings, on page 7 that Mrs Devine had been treated with antibiotics. He had seen the relevant prescription charts. He would have been aware of those charts, which antibiotic she had been prescribed and if any doubt is to be put on his interpretation on that point, great care must be taken.

As to the final point raised by my learned friend Mr Leiper that administration of opiates is entirely appropriate, that is his view. It is a view which is different to Dr Wilcock. It is not a view which is necessarily of no greater authority. It is a view of the prescription of opiates within his specialism and Dr Wilcock accepted that there are differing opinions.

THE CORONER: He has spent two days saying that.

MS BALLARD: Yes. He said it may be based on historical approaches, more relevant at the time that these patients were being treated. But nonetheless that is his view and it would be clearly wrong to clarify that in any way without having him here to do the clarification himself.

THE CORONER: Mr Leiper, you want to reply?

MR LEIPER: Just in reference to my learned friend's last point, the reason why Dr Wilcock was called is that he has the expertise in relation to the dosage of analgesia and Dr Dudley --

MR JENKINS: Sir, if it is felt that there should be any attempt to place caveats on Dr Dudley's report, that should happen (inaudible)

THE CORONER: I am not going to read his statement. It is inappropriate for me to do so. There would have to be interpretations. There would have to be understandings. The report being read is going to do nothing but raise questions. I do not think it contributes substantially to the task the jury has and I would leave it out of account.

MR LEIPER: Sir, can I ask you to reflect overnight on whether it would be possible to call him? What we felt from Dr Wilcock is that Dr Wilcock would defer to a renal specialist and suggesting that the court needed to hear a renal specialist. I agree. I think the court does need to hear from a renal specialist. The one we have got is Dr Dudley. He is familiar with the case. He has written the report. I heard what you said about your wish to read it out or not but I would strongly urge you to ensure that inquiry is made as to his availability. If we know that he was available, on for instance, Tuesday of next week, it would certainly be possible to call him and it would be in keeping with the object the inquest has set itself.

THE CORONER: I need to do a balancing exercise. I will find out if he is available and able to assist us and take it from there. Right, we will adjourn now until 10 o'clock tomorrow.

(The court adjourned until 10.00 am on Wednesday 8 April 2009)

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