GOSPORT WAR MEMORIAL HOSPITAL INQUESTS

Thursday 16 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 FIFTEEN)

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.

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(In the absence of the jury)

THE CORONER: Good morning.

MR JENKINS: (Microphone not working) Can I ask about Dr Dudley?

THE CORONER: Yes, you can. He was spoken to last night. He is in fact going on holiday. It is Easter. I did detect a slight weakening from Mr Leiper when talking to me about Mr Dudley's report and I would be content to take an edited version if you can agree an edit. If not, I will leave that off there.

MR JENKINS: Why do we not see if during the day we can (inaudible words) I know that Mr Leiper will start by putting a pencil through those bits he does not want and then we can discuss it.

THE CORONER: I think that is probably right. It has been referred to and I have to deal with it so far as it has been referred to, but I do not want to take it any further if you cannot agree. It depends how heavy footed you want to be.

MR JENKINS: Can I agree that (inaudible words) and they cannot be unread and the jury should not be (inaudible) but we will deal with it.

THE CORONER: I think the issue is dealt with by Dr Wilcock when he says that the increase in creatinine is greater than he would have anticipated in any event. I think that is the significant point from my end of it and that something has happened.

MR JENKINS: The other point he made was that he did not think at the QA they had stopped giving methadone because of the creatinine levels. His opinion was they changed the antibiotics to cefalexin for other reasons and not because the creatinine levels were not right. Thank you.

THE CORONER: It is quite interesting because he was querying whether he would be required to attend and I think his wife persuaded him that not in any circumstances was the holiday being cancelled! I think we have all been in that position, have we not? We are going to start with Dr Barton, are we?

MR JENKINS: Yes.

THE CORONER: Let's get the jury in, please. Half a day tomorrow presumably is not going to be enough for you, is it?

MR JENKINS: I am not going to be long. I anticipate I shall be responding to others. Mr Sadd indicated what his position was likely to be. So far as questions for the jury are concerned, it occurred to me that it might be useful to have a short discussion today with you so that we can reflect, each of us overnight, it is often useful to know what people's first thoughts are. Obviously they may develop but it is often useful to have a short discussion so that we can reflect on it and revisit things tomorrow. That may break it up and give your voice a bit of a rest rather than you reading all day.

THE CORONER: Thank you.

(In the presence of the jury)

THE CORONER: Good morning. Everything all right? Good. We are getting there. Dr Barton, you remain on oath. Can we go to Mr Wilson, please?

DR JANE BARTON, continued

DR BARTON: Mr Wilson was a 74-year-old gentleman who was admitted to the Queen Alexandra Hospital on 21 September 1998 following a fall at home during which he had sustained a fractured greater tuberosity of the left humerus. Mr Wilson had been admitted the previous year with epigastric pain which was diagnosed as left lobile pneumonia and alcoholic gastritis with grossly abnormal liver enzymes. He was found to have a small bright liver compatible with alcoholic liver disease and indeed it seemed that he had been consuming excess alcohol for a number of years.

In the course of this admission in 1997, Mr Wilson was treated with antibiotics and diuretics but was uncooperative about diet. He was discharged after three weeks with a planned followed up in outpatients. It appears that Mr Wilson spent the night of 21 September 1998 on the A&E ward. He complained of pain and the relevant A&E record shows that he received 10mg of morphine up to 9 pm that evening.

Mr Wilson was then assessed in the fracture clinic the following day. He was reported as being "not keen" to undergo surgical intervention and following this he was admitted to Dickens Ward in the Elderly Medicine Department of the Queen Alexandra Hospital.

It appears that on admission Mr Wilson's analgesia was not sufficient and morphine intravenously 2 to 5mg was prescribed together with 30mg of codeine phosphate six hourly as required. Although not seemingly recorded on the prescription chart, a nursing entry records that the medication was subsequently altered so that the morphine was given by a subcutaneous injection with the addition of the codeine phosphate. The Barthel score assessment was made on 22 September, a score of 5 being recorded.

Although there appears to be no entry in the prescription charts, the medical notes record that on 24 September Mr Wilson was given 5mg of diamorphine, though an examination following that administration the area from the shoulder to the elbow was said to be very painful. Indeed, the nursing records show that an initial 2.5mg of diamorphine was given with little effect, seemingly requiring a further 2.5mg about half an hour later.

It seems that Mr Wilson may have had oedema and on 24 September diuretics in the form of frusemide and spironolactone were prescribed. On 25 September Mr Wilson was recorded as still being in pain and indeed he appears to have continued to have been throughout much of his stay on Dickens Ward in spite of the administration of morphine and then codeine phosphate from time to time.

On 1 October, for example, his left arm was said to be "painful +++ on movement" though he had no apparent pain at rest and that continued generally. On 4 October he was said to be still in great pain and the humerus was elevated slightly on the pillow to help reduce the swelling.

On 11 October the pain was said to remain "quite bad" in his left arm and then again on the 12th the nursing notes record that he "remained in a lot of pain when being cared for". It appears that on 29 September Mr Wilson had become very dehydrated and his renal function had deteriorated. His diuretics were stopped and he was commenced on intravenous fluids. The medical entry that day records that Mr Wilson had "impaired renal function", that his liver function was "abnormal" and he had "alcoholic hepatitis". It was also recorded that Mr Wilson was not for resuscitation in view of poor quality of life and poor prognosis. I do not know who made this entry in the records but clearly one of the medical team considered that Mr Wilson was significantly unwell with a poor prognosis to the extent that resuscitation would not be appropriate.

Mr Wilson's arm became swollen with oedema. The consultant surgeon, Mr Hand, appears to have reviewed Mr Wilson at a clinic on 6 October and reported to Dr Durrant, the GP, that the left arm was "grossly swollen", Mr Hand suspecting that this was secondary to immobilisation as well as fluid retention. On 8 October it is also recorded that his ankles were "very oedematous".

On 9 October diuretics were recommenced in view of the gross oedema with bendrofluazide being added. A Barthel score was recorded as only 3 on 2 October; by 6 October this had risen to 5. It appears that Mr Wilson had become depressed in consequence of stopping alcohol and, on 2 October, referral was made to Dr Lusznat, consultant in old age psychiatry. The note of referral in the medical records stated specifically that he was "very withdrawn and depressed". Dr Lusznat carried out an assessment on 8 October and recorded her impression that Mr Wilson was suffering with "early dementia, possibly alcohol related, together with depression". She prescribed trazadone as an antidepressant.

In a subsequent letter to Dr Grunstein, consultant in elderly medicine, Dr Lusznat stated that physically Mr Wilson was obese with his left arm in a sling and his left hand still grossly swollen and bruised. She also noted that there was also marked oedema on both legs. In relation to his mental state, she recorded that he was subjectively low in mood and objectively easily tearful. Although he had no active suicidal ideas or plans, he had said there was no point in living. Dr Lusznat confirmed her impression that Mr Wilson had developed an early dementia which could well be alcohol-related, although alternatively this might be an early Alzheimer's disease or vascular type dementia. Further on her assessment record, Dr Lusznat noted that Mr Wilson had a lot of pain in his left arm and admitted feeling low and wishing to die. He wanted to go home.

Unfortunately it seems that Mr Wilson had an unrealistic expectation of his position. The records show that an assessment was carried out the following day, 9 October, and it was felt that Mr Wilson required help with all the activities of daily living generally by two people. Specifically his conception of discharge home was said to be totally unrealistic and he was felt to be too much at risk at that time to be managed at home.

On 11 October a further Barthel assessment was carried out producing a Barthel score of 7. It appears that Mr Wilson's condition remained essentially unchanged. Attempts were made, without success, for him to have a convalescent bed and arrangements were then made for him to be transferred to the Gosport War Memorial Hospital.

Mr Wilson was seen on a ward round on 13 October and it was agreed that he still needed both nursing and medical care. It was felt that a short spell in a long term National Health

Service bed would be appropriate. He was still very oedematous. His albumin was still very low. Frusemide was added to his diuretics and renal function was to be reviewed. The nursing notes also record that he continued to require special medical/nursing care given that his oedematous limbs were at high risk of breakdown and indeed his right foot had apparently already started to break down.

A referral form was completed on 13 October with Mr Wilson recorded as continuing to be in a lot of pain and indeed the prescription chart shows he had been receiving codeine phosphate over the previous days. The referral form also confirmed that Mr Wilson's legs were very oedematous with high risk of breakdown and secondary to cardiac failure and low protein.

Mr Wilson was then transferred to Dryad Ward at the War Memorial the following day, 14 October. I believe I assessed Mr Wilson on his admission and my note in his records reads as follows:

> 14/10/98 transferred to Dryad Ward. Continuing care.
>
> History of present complaint: fracture humerus left 27/8/98.
>
> Past medical history: Alcohol problems, recurrent oedema, congestive cardiac failure. Needs help with all activities of daily living, hoisting, continent, Barthel 7, lives with wife Sarisbury Green.
>
> Plan: gentle mobilisation.

As will be apparent, I inadvertently recorded the date of the fracture as the 27th rather than 21 September. Although I also recorded the Barthel score as 7, assessments done at the same time by the nursing staff in fact gave a score of only 4. My notation "CCF" meant that I understood Mr Wilson to have congestive cardiac failure apparent from his significant oedema and indeed confirmed by the referral form which had specifically recorded cardiac failure. I do not know what records would have been available to me at that time but I anticipate some form of records would come with the patient on transfer.

Following my assessment I wrote up prescriptions on Mr Wilson's drug chart mirroring the medication which had been recorded on the referral form. Specifically I prescribed thiamine 100mg daily, a vitamin given for nutrition due to alcoholism; multivitamins once a day for the same purpose; senna and magnesium hydroxide for constipation, probably brought on by the opiate medication given for pain relief; frusemide 80mg in the morning and bendrofluazide 2.5mg once a day, both as diuretics to reduce the oedema, together with spironolactone (inaudible) mg twice a day as a diuretic which increases the efficacy of the frusemide. I also prescribed trazedone 50mg once a day for Mr Wilson's depression and paracetamol as recorded on the referral letter.

Although the referral letter made no mention of the codeine phosphate which had clearly been given to Mr Wilson over the previous days, I had felt it appropriate to provide further pain relief of medication beyond paracetamol in circumstances in which the referral letter made it clear that Mr Wilson continued to have a lot of pain in his arm. Accordingly, I prescribed Oramorph 10mg/5ml at a dose of 2.5mg/5ml as needed four hourly.

The nursing notes confirm Mr Wilson's admission with a history of the fractured humerus, the long history of heavy drinking and left ventricular failure with chronic oedematous legs. The nursing notes also record that following my assessment Mr Wilson was given 10mg of Oramorph for pain control.

The prescription charts also contain prescriptions for diamorphine in a dose range of 20-200 subcutaneously together with hyoscine 200-800 mcg and midazolam 20mg-80mg via the same route. I do not know when I wrote this up but I anticipate it may have been at the time of my assessment on Mr Wilson's admission. I anticipate I would have been concerned to ensure that there was a proactive regime of pain relief medication available in case of deterioration and with the potential for Mr Wilson to become inured to the opiate pain relief which was clearly necessary at that stage. It would have been my expectation in the usual way that the nursing staff would endeavour to make contact with me or the duty doctor before commencement of that medication if Mr Wilson's medical warranted it and if indeed it would be commenced at the bottom end of the dose range.

I anticipate I would have seen Mr Wilson again the following day, 15 October, although clearly I have no recollection of this. I have not made an entry in his clinical notes but I did recall a further prescription for Oramorph with 10mg to be given four-hourly at 6, 10, 2 and 6 and a further 20mg at 10pm in the hope of ensuring that Mr Wilson did not experience pain and distress in the course of the night.

The nursing note for 15 October confirms that Oramorph was commenced four hourly for pain in Mr Wilson's left arm. Mrs Wilson was then seen by Sister Hamblin who apparently explained that her husband's condition was poor. 20mg of Oramorph was apparently given at midnight with good effect, but it appears that Mr Wilson then deteriorated overnight, becoming very chesty with difficulty in swallowing medication.

I believe I was absent from the hospital on Friday 16 October. I think I attended a meeting in Portsmouth at the health authority in the morning and would not have been contactable. It is clear though from the records that one of my partners, Dr Knapman, came to see Mr Wilson on 16 October in my absence. Dr Knapman has recorded that Mr Wilson had declined overnight with shortness of breath and that on examination he was bubbly and had a weak pulse. He was said to be unresponsive to spoken orders.

Dr Knapman recorded oedema in the arms and legs and suspected that Mr Wilson had suffered a silent myocardial infarction. He increased the dose of frusemide in an attempt to reduce the oedema. From the nursing records it appears that Mrs Wilson was informed of her husband's deterioration and later that day Mr Wilson was said to have a very bubbly chest. A syringe driver was then commenced with 20mg of diamorphine and 400 mcg of hyoscine. It is not clear if the diamorphine was commenced following discussion with Dr Knapman or any other duty doctor, or indeed if it might have been discussed with me. It is possible that nursing staff might have made contact with me had I been available later on 16 October, but equally Dr Knapman or one of my other partners would have been available on duty.

The 20mg of diamorphine was in effect broadly commensurate with the Oramorph which had been administered, 50mg of Oramorph having been given the previous day. In view of the reported difficulty Mr Wilson had in swallowing medications, a switch to the equivalent subcutaneous medication appears to have been sensible together with the hyoscine to help reduce or dry the chest secretions.

A nursing note later on 16 October records the commencement of the diamorphine and that the reason for the driver was explained to the family with Mrs Wilson being informed of her husband's continuing deterioration.

Later that evening at approximately 10:30pm Mr Wilson was recorded as being "a little bubbly" with more secretions during the night, but it was also said that Mr Wilson had not been distressed and appeared to be comfortable.

It appears that the following morning, 17 October, the hyoscine was increased to 600mcg as pharyngeal secretions had been increasing overnight. The diamorphine was maintained at 20mg. It appears that my partner, Dr Peters, then saw Mr Wilson in the course of the day recording in the notes that he was "comfortable" but that there was "a rapid deterioration". Dr Peters was probably on duty that weekend. Dr Peters also noted that the nursing staff could verify death if that proved necessary. Clearly Dr Peters' expectation was that Mr Wilson might die shortly.

It appears that in the course of the day the diamorphine was then increased to 40 mg and hyoscine to 800 mcg with the addition of 20mg of midazolam. I do not know if that increase might have been with reference to Dr Peters, either when Dr Peters visited or otherwise, or indeed separately with reference to me.

The effect of secretions which were reported to be increasing can be very unpleasant for a patient producing a sensation of inability to breathe and the administration of a drug such as diamorphine can assist in relieving the significant agitation and distress which can be experienced from such a sensation and indeed can reduce oedema from cardiac failure. This may have been a factor in the decision to increase the diamorphine.

The nursing note immediately preceding the reference to the increase in diamorphine refers to suction being required very regularly to remove copious amounts of secretions. Further, there may well have been a concern that Mr Wilson might become tolerant of the opiates and that increase might be required accordingly. Fortunately, although noisy secretions continued at night, it seems then that the medication was indeed successful in relieving any distress. Specifically the secretions were said not to be disturbing him and he appeared comfortable.

Although Dr Peters has not made a separate entry in the medical records, the following day, 18 October, it seems that Dr Peters attended again at the hospital, there being a specific entry in the nursing records that Mrs Wilson had remained overnight and that Dr Peters spoke with her. There was said to have been a further deterioration in Mr Wilson's already poor condition. The syringe driver was apparently renewed at 2:50 pm with an increase in the diamorphine to 60, midazolam to 40 and hyoscine at 1200 mcg. That latter prescription was in excess of the dose range I have previously authorised and Dr Peters made a further specific prescription as a verbal order to enable that to be given.

Sadly, it appears that Mr Wilson's condition continued to deteriorate and the nurses later recorded that he died peacefully at 11:40 pm in the presence of members of his family.

THE CORONER: I was concerned with Mr Wilson from the very beginning that the nature of the injury is very severe. A fractured humerus like that would be extremely painful.
A I think so. An unfixed no attempt made.

Q That is the problem. But nothing is going to resolve until he has it fixed, is it? It is not going to get better.
A No.

Questioned by MR SADD

B Q Dr Barton, you will need to have to hand not only the statement that you have just read out, but the one that was read out to the jury some time ago now dated 4 November 2004. Is there a copy there with you?

THE CORONER: Is that the generic statement?

MR SADD: Yes. (Pause) Do you have a copy there?
C A Yes, I think so.

Q You will also need to have with you the medical records which I think you do have to hand and the reports of Professors Black and Baker and that of Dr Wilcock. Do you have copies there with you?
A No.

D Q Dr Barton, what I intend doing, while that is being gathered for you, I am going to go through some general issues then subsequently we will look at specifically Mr Wilson's case. Sir, I ask for your tolerance about this because I know that we are going over familiar ground but it may have some use for the jury in that it is a visual process in any event. If you feel it is being repetitious, please let me know.

THE CORONER: Oh, I will!
E

MR SADD: Can we go first, Dr Barton, to the nature of your GPs practice in 1998? The relevance of that year is that is the year as I understand it in which you became the clinical assistant in elderly medicine at Gosport War Memorial. Is that right?
A That is correct.

Q Looking at your practice at the Forton Medical Centre, again you may not know the
F answer to this but, generally speaking, how many patients were on your list then?
A Approximately 1,500.

Q And how many partners were at the practice?
A Six.

Q I do not know whether this is the right expression, were you the lead GP there?
G A I was the junior partner at that time, one from the bottom of the pecking order.

Q You set out in your statement dated 4 November 2004, which we can go to in a moment, that you had eight surgery sessions. Would your patients simply turn up or was there a booking system?
A There was a booking system but they did also turn up.

H Q You would do house calls?

A Yes.

Q Your average day at Forton would be how many hours during the week?
A A session is 3½ hours, so there were eight of those and house calls and admin work and paperwork on top of that, so that comes to 30 hours?

THE CORONER: I think the question was put specifically what was your day, not what was the principle. It is the same as asking what time did you start work, what time did you finish.
A It was enormously variable. I would generally start morning surgery at nine, having been to the hospital for an hour and a quarter.

MR SADD: We have not got to the hospital yet. We are at the inception of your taking that role. It is my fault that there is a confusion there. I am simply wanting to know prior to your taking up that role how did your day pan out. How busy was that day?
A Eight general practice sessions, one of which was a big antenatal clinic. There was a postnatal clinic. A further one was immunising babies and then there would have been five general surgeries containing approximately 24 patients.

THE CORONER: What time were you leaving home?
A Before or after I started this job?

Q Before you started this job.
A I would still go in at approximately eight in order to do paperwork before the surgery started.

Q What time would you get home?
A Generally between six and seven in the evening.

THE CORONER: Was that the question you were asking?

MR SADD: That is the question I was asking. Thank you very much.

(To the witness): You also, in addition to your weekday duties you took on, and I am quoting here from your statement of 4 November 2004, page 1, "Half (?) of the out of hours on call responsibilities" – what did that entail?
A That means instead of one night a week, one night every two weeks I would be on call from six in the evening until eight o'clock the following morning for 10,000 patients.

Q By 1998, so we are jumping 10 years on, had the practice grown?
A In size not considerably but obviously the workload had grown enormously.

Q By workload can that be simplistically described as the patient list?
A No. It is independent of the patient list. It is what you were expected to do for the patient.

Q Leaving to one side what your responsibilities were at Gosport War Memorial, in 1998 how had your practice at the Forton Medical Centre changed?
A Not a great deal. It was just busy. More elderly patients, more house calls.

Q Busier?

A Not in numbers but in workload definitely busier.

THE CORONER: The demands have changed over the years, have they not?
A They have.

Q You cannot just go into the surgery, see people and come away again.
A No.

MR SADD: Did those demands affect the amount of time that you spent doing your GP work in 1998?
A I am sorry?

Q Did those demands that had increased change the number of hours that you would spend carrying out your GP responsibilities at the practice?
A The only thing that would have changed during that time was that I contracted and paid to have part of my out of hours commitment done commercially so that I would only go on duty until 10 o'clock and then hand over to a commercial organisation until the following morning. The workload at the surgery, the number of patients and the demands of the patients remained the same as it was before.

Q I am afraid I am being rather slow. Dr Barton, I simply need to know whether the change in the nature of your practice as a GP by 1998 meant that it involved you in more hours spent as a GP?
A I tried to do what I had to do more efficiently so that I did not spend more time in the surgery.

Q So there was not any difference in time between 1988 ---
A No, time was not elastic despite what Dr Wilcock said.

Q I will just finish my question. There was not any difference in time between 1988 and 1998 in the time that you devoted to being a GP?
A Not in the hours, no.

Q Can we turn to you taking on the sole clinical assistant work in elderly medicine, the Gosport War Memorial work in 1998. Was that under a contract between yourself directly and the trust or between the practice and the trust?
A It was contact between myself and the then healthcare trust.

Q At page 5 of your statement dated 4 November 2004 you refer there, although you do not list them, and there is no criticism made about it, you refer there to a list of duties laid down for you.
A Yes.

Q Those duties therefore were ones that you were contractually obliged with the trust to carry out. Is that right?
A Yes.

Q In fact just so the jury know exactly what it is I am referring to, page 5, the second main paragraph on that page:

"Part of the list of duties laid down for me as clinical assistant was to be responsible for the day to day medical management of patients."

Was that phrase in itself defined in any way under the contract that you had with the trust?
A I do not think so.

Q Was your understanding of your role as clinical assistant in elderly medicine to be a part time post or to run equally in time alongside your GP practice?
A It was understood by my partners that it would be done out with my general practice commitments and responsibilities.

Q So you formed an assessment in 1998 no doubt that it was something that you were quite capable of managing alongside the time that you spent as a GP in your practice?
A I could at that time do it in my own time and not neglect my general practice duties in any way.

Q I think you would say that you were able to do it in your own time because of the nature of the demands at that stage in 1998 of what was expected of you. I think it is described in your statement at page 4 that the hospital was more like a nursing home.
A Yes. It was on four sites: two were actually nursing home buildings – the Redcliffe Annex and Northcote – and then there were beds on two of the wards, the male and female ward in the main hospital, so it was like covering four nursing homes.

Q Indeed you say at page 4:

"When I first took up the post the level of dependency of patients was relatively low. In general the patients did not have major medical needs. An analogy now would be to a nursing home."

A Correct.

Q You go on to say that position changed very considerably. We know that your partners would cover for you at weekends. Is that right?
A Yes, weekends and at night and in order to do that I paid them a proportion of the money I received from the trust to provide that cover for me.

Q You have read my cross-examination notes because that is my next question which is was that an agreement between yourself and your partners or an agreement between the partners and the trust?
A Originally, as far as I can remember, it was an arrangement between myself and my partners. I do not think it changed until approximately 1999.

Q It is an obvious point but in 1998 therefore that was still an arrangement between yourself, for instance, between Dr Knapman and Dr Peters?
A Certainly.

Q How did that arrangement work in practice? Would you set up a rota for doctors to go or would it be ad hoc?
A If I was not available to do the morning round because I was doing something else or I was on holiday the duty doctor in the practice from the preceding day would finish off his

night on call by popping into the two wards in the hospital so it was done on the practice duty rota and the same at the weekends, the doctor who was on duty for the practice, assuming he did his own weekend duties, would pop into the hospital.

Q We know, because we are going to come onto the fact, that the changes in the demands placed on you were significant in the hospital. Is that right?
A Yes.

Q And that those changes required some familiarity no doubt with the demands made by elderly patients in certain circumstances in critical need.
A Yes.

Q To what extent was any training provided to your GP practice for that?
A All GPs undergo 30 hours a year of continued medical education. I also attended palliative care training sessions run by the Countess Mountbatten Hospice in Southampton and there were a number of clinical assistant training sessions run by the trust for clinical assistants throughout the district which I attended over the years.

Q To what extent did you ensure that the partners with whom you had an arrangement to cover for you at weekends were, as it were, experienced to cover the critical needs of elderly patients by 1998?
A They too would be undergoing continuing medical education; they too would have attended sessions run by the local hospice and they too were doing similar sort of work in their general practice.

Q In deciding which of your partners would cover for you did you take steps to ensure --

THE CORONER: I do not know where you are going with this questioning. It is slightly suspect. Are you suggesting that others were not as well qualified?

MR SADD: I am exploring that subject, if I may.

THE CORONER: Are you going to suggest they were not qualified doctors?

MR SADD: No, of course not.

THE CORONER: Is there a doctor that you would not allow to go into the hospital?

MR SADD: No, of course not. If I may be allowed to continue, what we have here, as you know, sir, is a doctor who, over a ten year period, as I understand, establishes considerable experience in dealing with people who are ill and who are elderly.

THE CORONER: How does that equate to the experience of her partners? Is that where you are going?

MR SADD: I am just seeing whether that equates to their experience given that their home visits are not dealing with a ward where the care is becoming critical.
A Bearing in mind of course that during the same period of time all of us as GPs were looking after our own patients in Sultan Ward where you would be doing continuing care and palliative care for your own patients who had been admitted to the hospital so I would say

that all of my partners had adequate expertise to deal with anything they were faced with on Daedalus or Dryad Ward.

Q With each weekend that they covered you would there be a briefing session that you would provide both partners who were covering you for that weekend as to the patients they would be seeing on Dryad?
A You would mention something that was particularly worrying you or a particular problem but other than that you would expect the senior nurse on duty to brief them in the same way that they briefed me every morning on a very quick ward round.

Q In 1998 when you were covering the Daedalus Ward, is that right?
A When are we talking about now?

Q 1998.
A When we were still down at Redcliffe Annex. I think Dr Lord joined later on. I think it was Dr Grunstein, Dr Wilkins, Dr Logan – I had a whole series of consultants before we moved up to our new wards in the main hospital.

Q When did that move take place?
A I think it was 1985.

Q 1995?
A Was it 1995? 1994/95.

Q The only reason I say that is because you had not started until 1988.
A Very good, yes, thank you. 1994 we moved all the beds into the main hospital and a £9 million development was undertaken to upgrade the hospital and the beds were all moved up at that time.

Q So in 1994 then, it was my mistake, there was a consultant divide. Dr Lord would assist you in Daedalus Ward, is that right?
A Yes.

Q And Dr Tandy – was she already on the scene at this stage?
A Yes.

Q And she would assist you with Dryad Ward.
A Yes.

Q We assume from your November 2004 statement, page 4:

"I would also attend the Daedalus Ward round on Mondays with Dr Lord."

A Yes.

Q That suggests that that was a weekly round. Is that right?
A It was alternate.

Q Every other Monday.
A Every other Monday I had to do Dryad or Daedalus.

Q How often would Dr Tandy attend Dryad?
A Again, I would see her once fortnightly but again I am a bit vague about the dates, but she became pregnant, she went on leave and then took maternity leave.

Q That is April 1998. You are exactly right.

B THE CORONER: I believe the question was how much would she have been on the ward at that point?
A I cannot remember whether she was doing weekly rounds with or without me or whether she came fortnightly.

Q Would she have been on the ward other than for the ward round?
A No.

C THE CORONER: Is that where you were going?

MR SADD: It is. Thank you very much. You have read my notes as well. Does it follow from that, Dr Barton, that the review that you speak of, that is the review of the prescription regime, would take place once a fortnight?
A Yes.

D Q We know that Dr Reid became involved in 1999 but so far as you were concerned, looking at 1994/95, that is when Dr Lord and Dr Tandy are involved, did that system work for you? Did it cause you any concerns? Did you bring any concerns to the trust about the level of consultant support that you were receiving?
A I was reasonably content with the situation at that time. At that time the continuing care in our part of the National Health Service ceased to exist so there started to be pressure
E on patients to be not kept in NHS hospital beds but moved on to nursing homes or rest homes, so even in 1994/95 there was beginning to be more pressure on my wards, my nurses, to if you like move patients on. We knew that they were not going to stay on the wards for the rest of their days. Once their medical conditions became stable they were then looked at by social services with a view to placing them.

Q Can we please move to April 1998, the relevance of that date is the date on which
F Dr Tandy goes off on leave and you are left with no consultant cover for the rest of 1998 until Dr Reid comes to help you in 1999. Is that right?
A Yes.

Q You say that Dr Lord sought to help you out but she was already overstretched in dealing with Daedalus, is that right?
A Yes, and her other clinical commitments within the trust.

G Q So the responsibility overall fell on your shoulders.
A Yes.

Q Your job description in any event was the day to day medical management of patients.
A Yes.

H

Q That I understand the jury can infer would have meant that yours was the only medical input that they would receive.
A In hours and under the normal circumstances, yes.

Q The same system with your colleagues was still in existence in April 1998?
A Yes.

B Q Would your colleagues refer or defer to you in the management of your patients at that stage?
A In the management of palliative care, yes, they would.

Q Can you explain that in a little more detail?
A Their feeling was that I had been doing the job for eight years and that I was very experienced in the palliative care of the sort of patients I looked after and that they would C understand that usually the medications they might require at an end stage would be proactively written up for particular patients. Not for all patients obviously because we looked after thousands of patients who never needed palliative care or terminal care, but if you identified that someone was going to need palliative care it was probably quite important to make that clear to your partners who were covering.

Q Can we move to the picture then in October 1998, the month in which, as you know, D Mr Wilson was transferred to the Dryad Ward. Is the picture that the jury should have in their mind akin to the picture depicted in your letter in February 2000? I will read a paragraph from that letter. It is a letter dated 22 February 2000 and it is the fourth paragraph down:

> "I find myself without a consultant or seamless locum consultant cover for a period of a further month on one of the wards ..."

E No doubt that is Dryad, is that right?
A Yes.

Q

> "And the other consultant cannot be expected to provide anything other than fire fighting support during this time."

F Was that the picture that you faced in October 1998?
A Yes.

Q We know that the picture altered I imagine to some extent with the arrival of Dr Reid in 1999. Is that fair?
A To some extent it altered.

G THE CORONER: I have written down "improved".
A Dr Reid was taking over when he came into our trust, not only was he taking over as consultant geriatrician, but he was taking over as medical director and his admin and political workload must have been enormous, so I think the time he was able to devote to my continuing care ward was limited.

H

MR SADD: Dr Barton, just to be clear, and I am sorry if we are going over previously trod ground, but in October 1998 can we look at the collision between your GP practice on the one hand and your (inaudible) with Gosport on the other. You would be at Gosport at around 7:30?

A Yes.

Q And you would do ward rounds of about 40 beds as I understand it?

A Yes.

Q Those ward rounds would include Daedalus and Dryad?

A Yes.

Q But not Sultan.

A Only if I had a patient or my partners particularly asked me to review somebody on Sultan but not as a routine.

Q The number of patients on Dryad would be how many on average?

A 20?

Q The time that you would spend on Dryad was to some extent dictated to by the time you needed to be back at the surgery.

A Yes.

Q You would know the night before no doubt of the number of patients you were being required to see in the morning surgery the next day.

A Yes.

Q You would need to be back in good time for that.

A Yes.

Q You would spend, you think, approximately 40 minutes on Dryad – 07:30 hours to 8:10.

A Yes.

Q Then you would go back to your GP surgery to be there by nine.

A Yes.

Q How long would that surgery last?

A 11 to 11:15 and then the subsequent paperwork and then house calls 12 o'clock and then I would know from my morning ward round how many patients I was expecting to be transferred that day and I would then go back to the hospital to clerk in any admissions and to see any patients with a particular problem.

Q Would there have been an afternoon surgery?

A Three days a week there was. I would have to be back for two.

Q On the other two days what would happen?

A I had a half day on one and that was usually used for health authority or primary care trust work.

Q Approximately how much of your time midday would you spend at Gosport if I can use that shorthand – Gosport War Memorial?
A By the time you are talking at the end of 1998 we were averaging admitting four or five patients a week and each clerking and examination would take approximately 30 minutes, 40 minutes, so quite a lot of the lunch hour was spent at Dryad or Daedalus.

Q Then back to the GP surgery where you were until about seven o'clock?
A Sometimes not as late as that but if I was duty doctor, yes, until seven o'clock, sometimes a bit earlier and then I would make it understood, unless it was my half day, to the wards that if they needed me to see families who could not always make it during the day or were available in the evening then I would go back and see them.

Q I think exactly that. You say in one of your statements in spite of the pressures I think you would say that you made the time.
A Yes.

Q Is it fair to say that the most time given individually would be at the moment of transfer and clerking in – given individually to the patient.
A Yes, to the patient themselves.

Q And that would be about 30-40 minutes.
A Yes.

Q In October 1998 I think you describe the background there as having patients who were profoundly dependent.
A Yes.

Q Was that the majority of patients in Dryad at that stage?
A Probably a third to a half at any time.

Q I think you say that the demands on you were very considerable.
A They were.

Q I think you use in your November 04 statement, page 7, you were trying to do the best you could in what you describe as the most trying of circumstances.
A Yes.

Q Great demands were being placed on you and you did not have consultant cover in practice.
A And also I was well aware that my nursing allocation had not been increased either and they were finding it a struggle.

Q Is it right that so far as your perception of what Dryad Ward provided in October 1998 was that in practice it had become a palliative care ward?
A No, it was still a continuing care ward but because of the dependency of the patients per force we had to do more palliative care.

Q On 28 January 2000 when you are writing to Dr Reid you say as follows – this is the first page – do you have the letters with you?
A Yes.

Q You say as at January 2000:

"There is no such thing as continuing care nowadays and palliative care is something that I do per force without a great deal of specialised back-up."

Was that the state of affairs in October 1998 in the Dryad Ward?
A Yes.

THE CORONER: What was the date of the letter?

MR SADD: 28 January 2000. Dr Barton, would it be fair for the Wilson family and the jury to conclude that, so far as October 1998 is concerned, notwithstanding the demands placed on you, notwithstanding those pressures, the difficulty with the increasingly critical patients you did not think then that those demands placed you at any risk of providing adequate and indeed good care to the patients on Dryad Ward?
A You are trying to ask me if the time pressures that I was under were affecting my clinical care of the patients.

THE CORONER: Your ability to do it and your ability to care.
A I hope that it did not affect my ability to give the appropriate clinical care to all patients under my care.

MR SADD: Dr Barton, it goes a little further than that, does it not, because by October 1998 you had been the clinical manager or clinical assistant at Gosport for 10 years. No doubt, as you have described already this morning, you had accumulated an enormous amount of experience.
A Yes.

Q That experience matched your assessment of your ability to do the work properly.
A Yes.

Q In October 1998 no doubt you would have been aware of those pressures set against your ability to do the work properly and you did not consider that that posed any risk to the care of the patients.
A I did not feel it posed any risk to the care of the patients.

Q Indeed, had you thought so you would have taken the action you then took, unhappily and unfortunately in early 2000. Is that right?
A Yes.

THE CORONER: Presumably it is a gradual process leading up to the letter in 2000?
A Yes.

Q For the period running up to that you must have been feeling the pressure. It was not that it happened on the Tuesday and you wrote that on the Wednesday.
A It was running in parallel with the pressures going on in the acute trust – the difficulty with meeting their targets of surgical operations, having the two clear patients that were inappropriately kept up at the acute hospitals when they could be somewhere else, so that pressure was driving downwards onto me and the workload I had and the patients I had,

gradually increasing from about 1995 when team (?) care ceased to exist onwards, so it got gradually harder and harder, but we still endeavoured to do it to the best of our ability.

Q So you were a continuing care unit but you were in fact becoming more of a medical unit than a continuing care unit and it is that shift that presents the problem.
A It does because we did not have the resources with our physiotherapy a week and our occupational therapy at the same level to provide the level of care that we were expected to do and the patient and their families expected.

MR SADD: Not so great a problem, Dr Barton, that it exposed the patients under your care to risk.
A I hope not.

Q It is something that you were in the best position to assess, Dr Barton, and clearly the view you took on 19 October 1998 was that it did not.
A Yes.

Q Can we look at pre prescription, please. In October 1998 how long had that been in place?
A Since I started the job.

Q Why then did you feel it was something you were to use your phrase, and this is your statement from November 2004, page 8, obliged to adopt if in 1988 you were dealing with what in effect you describe as a nursing home?
A I think that paragraph is similarly in relation to prescribing I felt obliged to adopt a policy of proactive prescribing refers to a number of years. It does not just refer to 1998. It had been happening since 1990 for appropriate patients.

Q I have not asked the question very well. You adopted a policy, as I understand it, of pre prescription when you started the job.
A Yes, when we started when syringe drivers became available and it became apparent that you had a very useful tool for using for palliative care then part of the process of using the syringe driver appropriately was to write up the medication that you were to use it should it become necessary to use it, so it would have happened considerably before 1998.

THE CORONER: The arrival of syringe drivers through the last 20 years. I have been referred time and time again to syringe drivers and they had arrived newly in 1998-1995.
A Yes.

Q When did the come into accepted general use? Are you able to say?
A When did I start – 1990. Round about 1987/1988 the trust became aware of syringe drivers. The trust agreed to invest in some so that we could use them. There was always a constant scrabble as to where the four were and who was using them and could they have one because they are still a thousand pounds each to buy including VAT, so it is not something that you have hundreds of them lying about.

Q Get that one back from the jury then.
A Yes, do not let them keep it. It was a resource that was starting to become available to us in our continuing care practice round about the time I started the job.

MR SADD: Can you explain, please, Dr Barton, the correlation between on the one hand the arrival and use of syringe drivers and on the other hand the fact that you felt obliged to pre prescribe? Indeed, you call it in your statement of November 2004 "a practice adopted out of necessity". Where did the necessity arise in 1998?

A The necessity arose because amongst my partners even at that time there would not have been an equal willingness to write the prescriptions and initiate the syringe driver because they would defer to me with the experience of using it. The difference in 1990 would have been that we were not using it nearly as often but if it was available to us and I felt that it was going to be appropriate to use it I would write it up.

Q So your partners would defer to you on the use of the syringe driver.

A Yes.

Q Does it follow from that that they would defer to you on the pre prescription range and the titration that was envisaged for use with the syringe driver?

A Except as you saw in the case of Mr Wilson Dr Peter's felt it appropriate to increase the use of one of the drugs in the syringe driver to control Mr Wilson's symptoms, so even outside of my prescribe range they were perfectly able to change the dosage if it became necessary.

Q The way in which you explain it in your November 2004 statement suggests that in other circumstances the need to pre prescribe would not have been necessary. What would those circumstances have been?

A If you were working on Dr Wilcock's unit and you had a series of junior staff and more senior staff on the ward at all times during the day then you could titrate doses as he was suggesting should be done every four hours. You could tinker with the drugs until you felt that you had got the dosage quite right. We did not have that luxury.

Q Is it fair to summarise the use of the syringe driver as most appropriately used for those in terminal care?

A No, I had a patient who I looked after towards the end of her breast cancer who wore it for a year. She used to go to the hairdresser wearing her syringe driver. She could not tolerate any oral opiates but she could cope with diamorphine so it is a palliative care devise, not a terminal care device.

Q In the use with which it was made in Dryad Ward – perhaps I should have been more specific – was the use of the syringe driver geared to those in terminal care?

A It was geared to those requiring palliative care and a number of people requiring palliative care would go on then, yes, to require terminal care.

Q By "a number of people" do you not mean in effect all people?

A Well, no, because not all my patients went either to palliative care or to terminal care. A lot of them went to nursing homes or home or things like that.

Q You say that your pre prescriptions would be reviewed on a regular basis by consultants when carrying out their ward rounds. That is in your November 2004 statement, page 9.

A Yes.

Q Presumably you regarded this as a safeguard?

A Yes.

Q We know though that after April 1998 you did not have that safeguard.
A No.

Q Presumably though you felt that you did not need that review by October 1998. You did not think that that exposed your patients to any risk.
A No.

Q You were content to pre prescribe in October 1998 without any audit being carried out on the pre prescriptions.
A Remember that I also had a weekly visit from a pharmacist to the hospital who was looking through all the prescription charts in both wards and had the pharmacist had any concerns about the prescribing they would have been brought to my notice.

Q Page 9, please, of your November 2004 statement, the second paragraph there ---
A It may be of some significant that prescriptions by me of this nature were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was I ever informed that my practice in this regard was inappropriate.

Q Where is there reference there to pharmacists?
A There is not, no.

THE CORONER: (Over-speaking) ... mentioned it before.
A Yes, it is an additional safeguard to the consultant cover is the pharmacy cover we had.

MR SADD: Is it fair to assume that with your 10 years of experience in October 1998 the fact that there was no consultant audit of your pre prescription was not something that concerned you or at least not concerned you enough to feel that it placed your patients at any risk?
A I did not feel a lack of consultant cover about which I could do nothing anyway placed my patients at any risk.

Q Can we look next at your nursing team. You describe the nursing staff in your November 2004 statement, some of whom you have worked with for 12 years. Certainly by 1998 I imagine that would be 10 years?
A Yes.

Q And does it follow that there had been nursing staff consistently with you throughout that period?
A Yes.

Q Would it be fair to say that those individuals came to know your approach?
A Yes.

Q And indeed a phrase that you used last week by reference to your nursing staff was that you trusted them.
A It is and I did.

Q And no doubt there was mutual trust?
A Yes.

Q You worked alongside Sister Hamblin throughout this time?
A Yes.

Q She would routinely liaise with you.
A Yes.

Q Would you expect that those contacts with you so far as her notes are concerned to have been recorded?

THE CORONER: What to be recorded?

MR SADD: The contacts with Dr Barton in relation to Sister Hamblin liaising with her about patients.

THE CORONER: In the nursing homes?

MR SADD: Yes.
A To the best of her ability, given the constraints on her time as well.

Q But the constraints on her time were far less than on yours?
A Well, no because if you wanted to actually nurse patients and look after them during those years the amount of paperwork would increase exponentially with more and more forms to fill out, people to liaise with.

Q Dr Barton, that is the nature of being a nurse in the modern NHS, is it not?
A It is not necessarily an improvement though.

Q Dr Barton, just bear with me. That is the nature of being a nurse in the modern NHS, is it not? Is that not right?
A Yes.

Q You say in your statement of November 2004, page 4:

> "In the event that medication was to be increased, even within range of medication already prescribed by me, it would be usual for nursing staff to ask in advance that increase necessary or to do so after."

A Yes.

Q Is it not in fact the case that by October 1998 nurses would tell you after the event?
A It might have happened on occasions.

Q Can we look at Nurse Hamblin's statement, page 5, dated 30 September 2005. It is my mistake that I did not ask for that to be provided at the outset of my questions to you. (Same handed) I will read the passage, Dr Barton. From the bottom of page 4 she says:

"A record was always made in the drugs register showing the actual amounts of controlled drugs administered to each patient. I would always inform the doctor, normally Dr Barton, of the change in medication given and explain the reason to the doctor."

That suggests that her practice, certainly by 1998, was to tell you after the event. Was that a practice adopted by the nursing staff generally?

MR JENKINS: Can I suggest that the subsequent two lines are put to put it in context?

MR SADD:

"I would not necessarily inform Dr Barton at the time if the change in circumstances occurred to the patient at night. I would inform Dr Barton the following day."

The question still holds, Dr Barton, please, are we allowed to assume that by 1998 nurses would inform you after the event of changes in dosages?
A That is very relevant, is it not, that last sentence, particularly at night because (a) I would not be on duty; (b) Sister Hamblin would not be on duty and her senior night staff would be trusted to make an adjustment if necessary and then let her and me know the following morning. The logistics were such that we were none of us there during the night.

Q I am sorry to belabour the point, Dr Barton, but if Sister Hamblin was not on duty at night and therefore she was on duty it follows during the day, her practice was to inform you after the event of changes in medication. That is what she says at the top of page 5.

"I would always inform the doctor of a change in medication given and explain the reason to the doctor."

That suggests that it is after the event.

THE CORONER: Taking the tenses as they are, I always tell the doctor of the change in medication. It is not saying after I had done it.
A No, during the day.

THE CORONER: I take your point. It is not lost on me if that is any help, but was it a standard practice that they would change and tell you afterwards?
A No. It would have been standard at night if it was ever necessary because I was not there.

THE CORONER: Have we reached a convenient break?

MR SADD: If you wish.

THE CORONER: We will take five minutes.

(The court was adjourned for a short time)

MR SADD: Dr Barton, you were being very patient with me about this issue of understanding when your advice would be sought about the prescription levels to be given to

patients on Dryad and I had taken you to Sister Hamblin's statement and there was the exchange between myself and the Coroner as to the interpretation of the sentence that I read out to you. I am going to read on from that, the same page, and I think you say that Sister Hamblin worked daytime. Is that right?

A Yes.

Q She says as follows:

> "I would always inform the doctor, normally Dr Barton, of a charge in medication given and explain the reasons to the doctor. I would not necessarily inform Dr Barton at the time if the change in circumstances occurred to the patient at night. I would inform Dr Barton the following day. I was happy to increase the dosage of diamorphine on a sliding scale, i.e. from a small starting dose initially administered to the patient (a) to alleviate the pain, (b) to monitor its effect on them. The drugs such as diamorphine, midazolam and hyoscine normally used in the syringe driver were prescribed by Dr Barton in a range according to patients' needs as assessed by Dr Barton."

Again, it is a matter of interpretation, but the assessment of the patients' needs in the context of pre prescription – when would that assessment be carried out? On clerking in the patient?

A It would be made at the time that it became apparent to me that they were entering a phase of possibly needing palliative care, so it would not routinely happen necessarily as the patient arrived on the ward, but as you can imagine towards the end of this time you were talking about very ill people arrived on the ward and it was apparent, even on arrival, that they could quite possibly go on to need palliative care, so the understanding was that the syringe driver would not automatically be used but it was there and available should it become necessary.

Q I am sure I will be stopped if I have got this wrong but my understanding of Dr Wilcock's evidence certainly has been that the combination of pre prescribing diamorphine, hyoscine and midazolam was a combination from which you could infer, quite properly, that that patient was in terminal phase.

A The patient was in need of palliative care; that did not mean that they were terminal.

Q The use of those drugs as opposed to the pre prescription, diamorphine, midazolam and hyoscine as a combination on the syringe driver meant that as far as the clinical staff were concerned the patient had reached a terminal stage.

A The patient had reached the point of needing palliative care. The terminal stage would be a clinical assessment made of the patient irrespective of what medication you were using.

Q Would it be fair to say that as a generalisation in October 1998 the nursing staff viewed Dryad Ward as a terminal care ward?

A Very unfair.

THE CORONER: I think that is unfair and I cannot remember which one of them was quite specific about it in saying that that is not what it was at all.

MR SADD: Sir, that is why I prefaced the question by the word "fair". Can we look, just before we get to Mr Wilson, at your process of clerking in in Dryad. I think you would

accept from me that it was the first and last proper assessment that you would make of the patient.
A It was the first proper assessment that I would make of the patient. Subsequently assessments might well be briefer, more focused and also reliant on information from the nursing staff as well.

Q And you would note down presumably all that you considered relevant as to the care that that patient should receive on Dryad.
A Yes, the operative word there being "relevant". I would not do a junior hospital doctor clerking putting in every system examined and every organ looked at, but the relevant points would be noted down.

Q The relevance would include your determination as to what should be pre prescribed.
A Yes.

Q For the most part is it fair to assume – again I use the word "fair" to assume – that when you assess the majority of patients on transfer you would have a note available with you?
A You would hope that you had the notes in front of you to help with your assessment.

Q In practice rather than expectation would you have notes with you for the majority of the patients who were transferred to Dryad Ward?
A I could not tell you what the percentage figures were but we had notes more often than we did not have notes but generally when you did not have the notes was the very time when you could have done with the notes.

Q Assuming that the notes were with the patient who would have access to the notes? You and the nursing staff?
A Yes.

Q Presumably on clerking in would you go through those notes with the nursing staff or the nurse on duty with you, or would it simply be you? What would be the practice?
A It would be my task to go through the notes and see what had gone before and if necessary highlight relevant findings to the senior nurse on duty if she was available to talk to, but it was my duty to look at the notes when clerking in the patient.

Q But as you say you would not do a junior doctor assessment.
A No.

Q But presumably you would do a very basic systems examination?
A Yes.

Q And, if time allowed, you would do pulse?
A I would ask my nursing staff to do routine basic examinations like that. I did not take blood pressure.

Q Would you be present whilst they were doing those examinations?
A No, I would hope that they had been done with any luck before I arrived to clerk in the patient.

Q Would those examinations not inform your decision as to what prescriptions to ---
A They would, certainly.

Q So where would one find those examinations having been carried out?
A Hopefully in one of those endless nursing charts they have to fill out.

Q Would it include, for instance, you say that you would not take blood pressure.
A I would hope that the blood pressure would be recorded there.

Q And temperature?
A Yes.

Q And pulse?
A Pulse rate if I felt there was any reason to actually take it. I would also put my fingers to the pulse but not necessarily write it down if there was nothing exceptional about it.

Q And listen to the abdomen?
A Examine the abdomen, not necessarily to listen to it.

Q Would you do this regardless of whether or not notes had arrived?
A Yes.

Q Would you carry out a pain assessment?
A Dr Wilcock gave us the impression that there was a sort of formal chart to be filled out but anybody attending to a patient, examining them and looking at them would get a very clear impression of how much pain they are in just from being there with them. I never knew of a formal form to be filled out but you would get a strong impression of how much pain that patient was suffering.

Q We have seen notes, have we not, and you have referred to it this morning already in your statement of notes that refer to pain and we know that the notation used by doctors, presumably used by you as well, Dr Barton, is to put things like "pain ++" or "pain +++". Would those things be relevant to your assessment as to what medication to provide?
A They would be relevant to the medication that I chose to prescribe.

Q I know it is already a point that we looked at but I need to understand it. Presumably if at the moment of transfer, clerking in, you pre prescribed diamorphine, midazolam and hyoscine, you are anticipating the need for terminal care?
A I am anticipating the need for palliative care in that patient.

Q Is there any distinction in practice between ADL – that is all-task daily living – and all nursing care?
A It is totally different. ADL is part of the assessment of what the patient is capable of and his ADL was 4 as measured by the nursing staff on arrival. All nursing care is just a general instruction to give all nursing care.

Q I just wanted to understand that. Let's move now to Mr Wilson. I am sorry it has taken such a long time to get there. He is clerked in I think at lunchtime or thereabouts on 14 October.
A Yes.

Q After the long remove in time when you came to give your statements originally it would have been unfair to have expected that you could remember anything about him without reference to the medical records. Is that fair?
A Certainly.

Q In your statement you recite references to the medical records.
A Yes.

Q What you do not recite in those references is the fact identified by Professor Black, identified by Professor Baker, identified by Dr Wilcock that there had been some improvement on some issues; for instance, that the renal impairment had been cleared.
A No, I made no reference to that in my initial clerking.

Q That the dosage of medication had been, certainly from 30 September, paracetamol with occasional 2.5 prescriptions on 3rd and 5 October of morphine and then codeine phosphate. What was that indicating to you?
A That he was on level 2 of the WHO analgesic ladder.

Q What was that indicating to you so far as the hospital's view of the way of managing Mr Wilson's pain whilst he was at QAH?
A It was interesting reading through the notes that he came down with that he was still in a lot of pain, he was getting pain at night and I imagine that the state that he was in when I clerked him in that day after four hours in the hospital minibus I would imagine that he was then when I saw him in a great deal of pain, so I would have possibly felt – I know I felt – that the level of analgesia he had been receiving at the hospital might well not be adequate and needed a range of drugs prescribing so that the right analgesia was available to him as and when he needed it as he settled into the ward.

Q Dr Barton, you know that you felt that only from reference to what you did prescribe. Is that right?
A Yes.

Q You have no memory of it.
A I have no memory of it, no.

Q Can we go, please, to page 179 of the medical records and also could I ask you please to have open page 77 of the same records. Looking at your entry which you have recited in your statement – history of present complaint, fractured humerus, previous medical history alcohol problems – if we look at page 77 at the same time, the reason for admission we see is fracture left humerus. Past medical history we see at page 77 "has alcohol problem".
A Yes.

Q To that extent so far, and I am sorry it is such an obvious point, but there is no difference in your assessment to that set out in the transfer letter, is there?

THE CORONER: Yours says "Left 27/8".
A I corrected that in my statement. I wrote the date down wrong when I clerked him on that day. The difference between these two records is that this transfer letter is written by a staff nurse and it is really, if you like, aimed to my sister or staff nurse, so it talks more about

nursing procedures and requirements than it does go into any depth of the past medical history. The past medical history they just talk about leg oedema and has alcohol problems and then they go on to talk about family structure, support network, reason for transfer and summary of current health status again is very much slanted towards information the nurses needed rather than the doctor needs.

MR SADD: Indeed, it says at the top, does it not, to confirm your point, Dr Barton, the referral letter is the patient transfers internal/external and district nurse intervention.
A Yes.

Q But there is reference on that transfer to a Barthel score of 7.
A Yes.

Q Something that you replicate.
A Yes.

Q Is that something that we can assume you simply ---
A I could not ask a man who had just arrived on the ward in that state to go through the activities of daily living for me, but if you note one of my nurses assessed it, possibly even the same day, and got it to be 4 rather than 7, so my figure was taken, as you say, from the nursing transfer letter. The figure of 4 was taken by one of my nurses actually assessing him.

Q Presumably the extent of the check that you carry out for the 30 or 40 minutes that you referred to ---
A Does not include washing, dressing, feeding, continence, ability to transfer. I certainly would not do a Barthel. It is a nursing procedure. I would make sure it was noted in the notes but I would not actually carry it out.

Q But you are not under any time pressure at that point, are you?
A I did not make the time to do Barthel scores.

Q I accept entirely what you say about the Barthel scores. I am simply looking at your assessment overall and the note that you make on the transfer. There was not any pressure on time on you in making the assessment that you made on his transfer. Is that ---
A Presumably not, no.

Q It is not a question of presumably.
A Being as it was done in the lunch hour it would have been a full clerking.

Q Your thinking, as you have to and as you have described, how do I medicate this individual now that he is on my ward.
A I do.

Q You are thinking about that by reference to your assessment and the transfer note. Is that right?
A Yes.

Q You say in your statement that codeine phosphate had been prescribed but it was not on the prescription record. How were you aware of that just as a matter of interest?
A From his medical notes.

Q That is *ex post facto*, is it? It is after the event when you are doing your statement.
A I am not sure where you are going with this. Are you suggesting I did not have the medical notes when I clerked him in because I have no recollection at this time.

Q I know you do not.
A If I had the medical notes I would have seen that he had been having co-dydramol and codeine phosphate during his time up at the Queen Alexandra. If I did not have the notes you would think on that letter she has not mentioned any use of codeine phosphate which implies I probably had the notes in front of me.

Q That is exactly where I was going to get to.
A But if you are going to then go on and say well why did you not go on giving him level 2 of the analgesic ladder, why did I not go on giving codeine.

Q There is an issue about that, is there not, Dr Barton? You tell the jury, please. I do not want to interrupt you.
A No, you carry on.

THE CORONER: Try not to anticipate his questions.
A I am sorry.

THE CORONER: Most of them are predictable.

MR SADD: I can understand that most of them are.

THE CORONER: We know the direction you are going.

MR SADD: Thank you. Can we look at page 107 of the medical records? Do you have that page?
A Yes.

Q This is the prescription record at the Queen Alexandra and we have at the bottom – I know it is very obvious for you to see – a reference to administration of codeine phosphate on the night of 12th and the night of the 13th and the dosage that was given.
A Yes.

Q Is there anything in the notes that you had to suggest that the pain had worsened to the extent that Mr Wilson required stage 3 medication?
A Mr Wilson had only required stage 3 medication initially and again on 3rd and 5 October on Queen Alexandra Ward but Mr Wilson had not at that stage hardly been out of bed, let alone undergone a four hour journey to Gosport War Memorial. He had been quite immobile and resting a lot and it had been noted throughout the medical notes that he got quite a lot of pain on movement.

Q I am sorry about the repetition of my question. Is there anything in the notes to say that the pain had worsened to such an extent that he required stage 3 medication?
A Not since early on in his admission, no.

Q Do you accept that it was a significant change from that which he was prescribed on leaving Queen Alexandra?
A I do.

Q Do you accept that so far as the Wilson family are concerned they need to understand the clinical basis for this change? You say it is the fact of transferring itself that would have required medication at stage 3.
A It was the level of pain which Mr Wilson was suffering when I assessed him on his arrival at Dryad Ward that it behoved me to give him a small dose of stage 3 analgesia.

Q Did that account of what he required on transfer include your understanding of his alcohol problem?
A Yes.

Q Where do we get that from?
A From the patient's notes.

Q Where do we get from the patient's notes that you have taken into account his severe alcohol problems when prescribing 10 mg of Oramorph?
A I prescribed a range and the nurses chose to give the higher end of the range. I was aware that his liver was compromised. I was aware that in his condition any drug metabolised by the liver was a potential danger to him and that included paracetamol, all sorts of medication.

Q Where is the notice for the advice or the warning given to the nurses about the dosage that should be given?
A I did not give them a warning. I expected them to give him an appropriate dose for the level of pain he was suffering.

Q Set against his alcohol problems.
A Set against his clinical condition on his arrival at the ward.

Q Professor Black's view is that there is no clinical justification that he could find in the notes for this change. Do you accept that?
A I accept that that is his opinion. He was not faced with Mr Wilson on the ward that afternoon, so he can give a theoretical opinion about the state of pain that Mr Wilson was in but he was not there that afternoon.

Q He considers that if any was to be used it should have been used at the lowest dosage, 2.5. Do you agree with that?
A Yes.

Q You do agree with that?
A Yes, in his opinion.

Q Do you agree that in the light of Mr Wilson's alcohol problems and his liver disease a low dosage of Oramorph would have been the safer prescription?
A I prescribed what I considered the appropriate dose of morphine for his level of pain.

Q Professor Baker's view at page 15 is that other non opiate or (inaudible) medication should have been used first. Do you disagree with that?
A Professor Baker again was not there on the ward seeing to Mr Wilson.

THE CORONER: He had had the lower opiates, had he not?
A Yes, at stage 2.

MR SADD: That is actually controversial that it was stage 2 because when we explored this with Dr Wilcock yesterday in the presence of the jury the question I put to him was that there had been apparently a change from step 1 to step 3 without any intervening medication but he had been given the two single doses on the 12th and 13th overnight of codeine phosphate.

THE CORONER: Yes.

MR SADD: I know that you are by now overly familiar, unfortunately Dr Barton, with references to the BNF and the reference in particular to the prescription of morphine. Were you aware in October 1998 of the risk with someone with liver disease of prescribing morphine?
A Yes.

Q And that risk set out it may precipitate coma in hepatic impairment. Reduce dose or avoid but many such patients tolerate morphine well.
A Yes, and he seemed to be tolerating morphine well.

Q How could you know that?
A Because at my assessment the following morning and the nurses' assessment of him overnight, having had a dose at midnight he settled well and seemed more comfortable the following morning.

Q Did that then justify 50mg ---
A Over 24 hours.

Q -- of Oramorph on the 15th?
A Yes, it did.

Q On what basis?
A Because I looked at the doses that my nurses had given him on the previous day when he arrived and that night and made the assessment that that was a level of medication that was working for him. He was comfortable.

Q We know from Mr Wilson's son's statement that he visited his father on the 15th and found him, as he describes, "laid in bed in an almost paralysed state".
A I cannot make any comment on whether he was paralysed or not because I was not there but from the nursing notes it appears that they were able to see to him and that he was comfortable.

Q Dr Wilcock concludes at page 38 that the oral morphine that was given to him was excessive to his needs. Yesterday he came to the view that the prescription of oral morphine disregarded the safety of Mr Wilson given his presenting condition. Please could you comment about that? You disagree with Dr Wilcock?

A I feel that in my opinion treating the patient at that time the dose of Oramorph that he received was totally appropriate.

Q You accept that there was a risk of coma.
A I accept that there was a theoretical risk of coma.

Q And you, as I understand it, accept that the need for review was made out.
A Sorry, the what?

Q The need for a review of the medication would have been made out.
A Yes.

Q On 15 October there are no entries in the clinical records whatsoever.
A There are not.

Q You attended on the 15th because you prescribed ---
A Regular Oramorph.

Q On what basis can the Wilson family be satisfied that you carried out that review that you assessed the risk? Do they have to assume from the continuing prescription of Oramorph that that in itself makes the review implicit?
A Yes.

Q Do you accept that it appears from the records at any rate that the continuing prescription of Oramorph which Dr Wilcock considers unsafe appears not to have been given any necessary and considered thought?
A No, it was given considered thought. At review that morning it would have been discussed with the nursing staff and they would have said that the dosage was appropriate and we would continue with it.

Q Do you accept that from your statement that you read out this morning there is no reference to the risk associated with the dosage of Oramorph with his liver complaint?
A There is no mention of it in my statement written in 2004.

Q Presumably you would have been aware in 2004, as you are aware today, as you were aware in 1998, of the risks associated?
A Yes.

Q I have also taken Dr Wilcock, and I will take you, Dr Barton, to the contraindications with morphine and the cautions, but the text that reads Palliative Care:

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

Is the Wilson family entitled to conclude that certainly on the 15th you were treating Mr Wilson as in need of palliative care?
A Yes. But as Professor Black explained to us in his admirable way, palliative care can be carried out at the same time as hopeful, although the Coroner has said not cure, but general maintenance.

Q Was it a feature of your ward round on the 15th, given the number of patients that you had to see and the time pressures that you have identified with the jury, that in fact no such review would have been carried out? Can that be inferred from the absence of any record of that review in the notes?
A No. If I had not carried out a review, although I was remiss in not writing anything in the clinical notes, I would not have altered the drug chart.

Q We know that there is a controversial understanding on the part of Sister Hamblin which I am now going to take you to in her statement dated 11 June 2005 and I would have hoped, I am sorry, Dr Barton, that her statement was with you. It is my fault that it is not but can I read to you – unless you have hand one up? (Same handed) I am going to be looking at page 4 of that statement and no doubt, Dr Barton, if you do not do so now, I am sure Mr Jenkins will ask you to comment about what a spell summary is, but I am going to take you specifically to the reference at page 4 dealing with the clerking in of Mr Wilson and reading:

> "Prior to a patient being transferred to my ward, Elderly Services at the QA Hospital would ring the ward and let us know of all coming 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."

If we assume for the moment that that is a prognosis that she makes on transfer – I know what you might say about the fact that actually it is looking back after Mr Wilson's death – but assume for the moment that my interpretation is correct, would the Wilson family be entitled to conclude that the approach adopted to Mr Wilson on 15 October was an approach entirely geared at looking after him for terminal care?
A I cannot read Gill Hamblin's mind. My assessment of Mr Wilson was that he was being admitted for palliative care continuing care at Dryad Ward and it was perfectly appropriate for the Wilson family to be told, which indeed they were, that Mr Wilson was very seriously ill and was receiving palliative care. This statement was taken at a police station.

THE CORONER: What was going to change for the better for Mr Wilson?
A Nothing.

Q His shoulder, his arm, has not been treated. He has oedema ++ and he has been sent to you from QA for what?
A Continuing care. That is what they called it.

Q You are not going to do anything else, are you?
A No.

Q It concerns me greatly that Mr Wilson is a man who is almost *in extremis* without any treatment effectively to a horrible injury. One would query why he has been sent for QA. I cannot imagine why that would happen but it has happened, there is no doubt about it, but

what was going to improve his situation? That is the question in my mind. You say nothing is going to change for the better.
A Except that he is going to receive palliative care.

THE CORONER: I am sorry, Mr Sadd.

MR SADD: Presumably you would not accept the conclusion that the dosages of Oramorph on 15 October were unsafe?
A I would not.

Q Presumably you would say, Dr Barton, that you were alive to that risk and it is a risk that you looked at and considered carefully and reviewed on the 15th.
A I would.

Q Can I take you to Professor Black's report, please, and to his conclusion. At 7.3, page 19, I would ask you simply to comment on it and I will be careful what I read.

> "It is my belief that the prescription of a total of 50mg of oral morphine on 15 October following the 20mg that were given on 14 October was not an appropriate clinical response to the pain in Mr Wilson's left arm. In my view this dose of analgesia formed a major contribution to the clinical deterioration that occurred over 15th and 16 October, in particular his rapid mental state deterioration and more than likely contributed to the death of Mr Wilson."

Looking back now, what are your views about that conclusion in the light of what we know and you would have known at the time of Mr Wilson's liver disease?
A I do not note any deterioration in his mental state during 15 October. I note an improvement, if anything, in his mental state because he was more comfortable on the oral morphine, bearing in mind that having assessed him at 7:30 in the morning I was not available to him after that.

Q We know from the entry at 265 of the medical records on 15 October the nursing entry there:

> "Commenced Oramorph 10mg four hourly for pain in left arm. Wife seen by Sister Hamblin who explained Robert's condition is poor."

There appears to have been a marked deterioration on the 15th. Would you accept that from the notes?
A Not in his mental state. Sister Hamblin is pointing out that Robert's condition is poor. It was poor on arrival and it was not any better but she makes no comment of his mental state.

Q We know that overnight on the 15th and 16th he suffered an event which Dr Knapman concluded by way of raising the diagnosis of a myocardial infarction and we know from Dr Wilcock yesterday that at that point Mr Wilson was in inevitable decline. Would you agree with that?
A I would.

Q Do you accept from me that the increase in dosage of diamorphine would be dependent on his restlessness, distress and his pain?

A I am sorry, you would have to ask that again.

Q Would you accept from me that the need to increase diamorphine or the dosage of diamorphine would be dependent on the extent of Mr Wilson's pain and distress?
A You are talking about the morning of the 16th?

Q The afternoon of the 16th.
A I think the reason for the change of morphine used was the accompanying symptoms of drowning in his own secretions for which he needed to be given hyoscine. Hyoscine given by itself subcutaneously is a very unpleasant medication which will give hallucinations and it is generally given with the comparable dose of morphine to go with it.

Q We know that the dosages over the 16th, 17th and 18th were increased.
A Of hyoscine but not of morphine, yes.

Q Of diamorphine on the 17th but we also know by reference to the nursing records ---
A That diamorphine was not increased until later on on the 17th, on the Saturday.

Q Let's look at the nursing records, page 278. 16 October, two lines up from the bottom of that entry:

> "More secretions, pharyngeal during the night but Robert had not been distressed. He appeared comfortable."

Then on the 17th:

> "During the day diamorphine 40mg, hyoscine increased to 800mg, midazolam 20mg added. Night – noisy secretions but not distressing Robert, appeared comfortable, hot at times."

Where is the justification there for the increase of the medication in the light of the absence of any distress?
A That was why he did not have any distress because they increased the dosage.

Q But there was no distress on the 16th, Dr Barton, and yet on the 17th it is increased. Where is the indication that the 17th for the increase of the diamorphine?
A I can see no written indication here why the dose would be changed from 20 to 40 unless the nurses were concerned that he would become inured or used to the level of diamorphine and that he might then get breakthrough pain.

Q Presumably that is something that would have been checked with you on the evidence that you have given today?
A I was not available on the 16th.

THE CORONER: That was the day of your meeting, was it not?
A I was at the meeting.

MR SADD: Is it not fair simply to conclude that the approach adopted to Mr Wilson is the approach generally adopted on this ward once a syringe driver is used? You increase the diamorphine without any particular reference ---

A Absolutely not. It was always done at the discretion of the doctor with the agreement of the nursing staff if it was felt to be appropriate. You are trying to imply that the doses were put up until the patient died which is absolutely not true.

Q Dr Wilcock at page 44 of his report concludes five lines up that the doses of diamorphine were excessive and that they disregarded Mr Wilson's safety. You obviously disagree with that.

B A I do.

Q Dr Barton, could the jury conclude on the basis of your evidence by reference to the notes and the risks associated with opioid medication that you never in fact turned your mind to the risk of hepatic coma? There is no evidence on the notes that you did that.

A I was aware of the potential dangers of using strong opioids in a compromised liver but Mr Wilson's needs for adequate analgesia outweighed those potential risks.

C

Q But you recognise, do you not, that there is absolutely no note of that in the medical records?

A There is no note of that in the notes, I recognise that.

MR SADD: Thank you for your patience, Dr Barton.

D THE CORONER: What is the scale that we are talking about? You have got 40 beds. How many patients through the hospital in a year?

A Hundreds. If we were running at 80 per cent occupancy some of those beds were used for shared care, some of them were used for continuing care and a very tiny proportion that you have seen a glimpse of became palliative and terminal care. You are seeing the tip of the iceberg here of the general work that went on on both wards.

E MR JENKINS: I think it was 44 beds actually – 24 on one, 20 on the other.

MR SADD: Sir, can I say thank you for the time that you have allowed me and the Wilsons to question Dr Barton. I am sorry it has been such a long process.

THE CORONER: It is no problem at all. Anything from you, Mr Townsend?

F

<u>Questioned by MR TOWNSEND</u>

Q Dr Barton, you were taken to Sister Hamblin's statement – do you recall that – and you said quite correctly of course that you could not read her mind but can I ask for a little clarification in relation to the passage that was put to you. There is reference to a spell summary. Is it right that a spell summary was typically made out in relation to this example after a patient had died?

G A Yes.

Q If a nurse were to write down in the spell summary that there was a particular prognosis for a patient would your understanding be that that was what the nurse had gathered from the doctors or the medical notes?

A Yes.

H

Q The forming of a medical prognosis would be a matter for the doctors rather than the nurses, would it not?
A Yes.

Q The second matter I wish to deal with is the Oramorph. I do not know whether you have in front of you the drugs charts relating to Mr Wilson which is 259-263. I am looking at 263 at this stage – regular prescription has been crossed out.
A The daily review prescriptions has been altered and turned into a PRN so it is in the middle of that somewhere.

Q These are the "as required" prescriptions.
A Yes.

Q Just to remind ourselves of the chronology, on the 14th you write up Oramorph on an "as required" basis.
A 2.5 to 5ml four hourly, yes.

Q On the 15th it is turned into a regular prescription, is it not, following the experimentation with the as required.
A Yes.

Q Dealing with the "as required", you have written up 2.5-5ml – that is a standard child's Calpol spoon, is it not, 5ml?
A Yes.

Q Given the concentration of the oral solution that means 5-10mg of oral morphine, does it not?
A Yes.

Q It is written up four hourly on a PRN basis. In other words, it can be given if needed up to a maximum of every four hours. Is that correct?
A Yes.

Q We see two administrations on the sheet by the nurses: one at 14:45 and the other about nine hours later at 11:45.
A Yes.

Q Is this fair – that is consistent with the nurses not giving it at the maximum intervals, in other words four hourly, but giving what they felt was the appropriate dose within the range and then not giving it for a further period until it appeared to become necessary?
A Yes.

Q On a PRN basis you would expect the nurses, would you not, to obviously assess the patients themselves by looking?
A Yes.

Q And indeed inquire of the patient whether he or she was in pain and felt they needed oral medication.
A Yes.

MR TOWNSEND: Thank you.

Questioned by MR JENKINS

Q Can I just come back to the sessions and the hours that you worked. What Dr Wilcock told us yesterday was that from looking at the contract he understood that you were there five sessions a week. I think it did not start like that. You applied for four sessions a week.

A Originally in 1988 I was appointed to do four sessions but it as understood at that time that I was a general practitioner as well. Dr Wilcock seemed to think that as a clinical assistant you did a session, you were there for 3½ hours. I could not do it like that and the healthcare trust accepted that that was how the job was to be done.

Q I think you were the only applicant for the job so far as you understood?

A Yes.

Q And the employer will have known your experience, seen your CV before appointing you to the post.

A Yes.

Q Will they have known of your clinical commitments as a GP?

A Totally, yes.

Q Of the four sessions that you were contracted to do when you first took the job up in 1988 were some of those sessions allocated to your partners for the on call commitments – nights and weekends?

A Yes, 1½ of those sessions.

Q So the remaining 2½ sessions was the time that you had to go during the week, Monday to Friday?

A Yes.

Q You have said 3½ hours was a session. Dr Wilcock said 4 hours. People can do the maths – it is 2½ sessions. Can we look at the number of hours you are spending each week Monday to Friday you are there in the morning for up to an hour and a half?

A Yes.

Q That is 5 to 7½ hours over the week. We know that you did a ward round every week on a Monday alternating one ward then the other.

A Yes.

Q That was 3 hours or more?

A Yes.

Q Depending on the mathematics and how long you were there in the mornings that is about ten hours, 2½ sessions. If you went back at lunchtimes you would do that to go and clerk in patients. You were asked by Mr Sadd how long would that take you and I think you agreed with up to 40 minutes with him.

A Yes.

Q You told us that in the latter stages you were admitting a number of patients each week. Did you say four or five?
A Yes.

Q What we have heard is that your sessions went up from four to five a week. Why was that?
A Because it was recognised the heaviness of the workload by the trust.

Q Did they ask you to do more or did you ask them for a greater allocation?
A I asked them for a greater allocation.

Q Do you remember now roughly when within the 12 year period from 1988 to 2000 it went up?
A I would have thought round about the time we moved up to the main hospital, about 1994.

Q Of the five sessions that it was now to be was there still 1½ sessions allocated to your partners for them to provide on call for the out of hours provision of services weekends and evenings.
A Yes.

Q I do not know how relevant it is but was the pay scale rather modest for a clinical assistant?
A Yes.

Q Certainly less than, pro rata, for a general practitioner.
A Yes.

Q Because you are the lowest of the low I think in medical terms as a doctor.
A Yes.

Q Should the jury have the impression that you were working more than the hours that you were contracted for or about the right number or less?
A I was working considerably more but as I love the job and I was very fond of the people I worked with and the job I was doing I did not resent it at that time in any way.

Q You were asked by Mr Sadd on behalf of Mr Wilson whether things had changed between 1988 and 1998. I think a major change for general practices was the introduction of computers.
A Yes.

Q I do now know if that made any difference to the job you were doing so far as the War Memorial was concerned?
A No, none at all.

Q Can I ask in general terms about syringe drivers. I am going to ask you to look at this in due course. The jury have seen it and I am going to read from it, if I may. I do not know if the jury had the chance to look at this little booklet *Me and my syringe driver.* It is from a manufacturer called Grazeby and this little booklet bears the date June 1990. It says, and I am going to ask for you to comment, the question is posed:

"Will I have to change my lifestyle?"

The answer reads:

"Hopefully not. We hope that the machine will make your life more comfortable and therefore you can be as active as you want to be.

Yes, you can have a bath. Try to keep the needle site dry and keep the machine out of the water by putting it on a stool beside the bath.

Yes, you can eat what you like."

There is a picture of some chips, an apple and two bottles.

"You can eat what you feel you want to eat and a little alcohol will not do you any harm."

That will depend on the patient. Is a syringe driver intended just for those who cannot swallow?

A Not at all.

Q Going over the page, there are then little pictures:

"Yes, it is all right to go shopping or in a crowd if you want to. No one will be able to hear the machine.

Yes, you can be taken out in the car, but it is best to ask your doctor before trying to drive yourself.

Yes, you can do some work in your garden if you want to.

There is a picture of an aeroplane.

Yes, if you or one of your family learn to change the syringe each day then you may want to go away for a short holiday.

No, you do not need special clothes as the syringe driver has a holster to hold it.

Again, should we have a picture that the syringe driver was designed just for those patients who were bed-bound and terminally ill?

A Not at all. It was just a very convenient delivery system of the drugs we wanted to use for palliation.

Q There is then a question *Am I getting worse?* And the booklet says:

"This little machine is designed to give you your medicines over 24 hours, so each day your nurse will come about the same time to fill up a new syringe and check the machine. You may have felt worried when your doctor or nurse suggested using a

syringe driver. It does not mean that you are getting worse. Here are three reasons why the syringe driver is used. Not all of these reasons will apply to you:

1. Often it is used when you cannot take pills due to sickness and difficulty swallowing.

Was that one of the reasons why it might have been used for some patients on the wards that you were a doctor on?
A Yes.

Q

2. It may be used if the doctor is having difficulty finding the right dose of drug to control pain, sickness or other symptoms."

Again reference to the doctor controlling pain, sickness or other symptoms.
A Yes.

Q

3. It is used to avoid having to give injections frequently because they are painful and uncomfortable."

Was that a reason why a syringe driver was considered for some of the patients that you were looking after?
A Very much so.

Q The last thing I am going to read – there are more bits in this that the jury may want to look at again:

"Will I have it forever?

A. No, you will not necessarily have the syringe driver forever. You may only need to have it for a few days or weeks until all your medicines have been sorted out to the correct amount for you. As soon as it is possible your doctor will put you back to oral medicines but he may do that gradually over a number of days."

A Yes.

Q So far as Mr Wilson was concerned what was going to happen to his broken arm? Were there facilities at the War Memorial Hospital to pin or repair his broken arm?
A Not at all.

Q Is that likely to have been known to the medical team that transferred him to the War Memorial?
A Yes.

Q In your experience of practice, fractures of limbs rather than smaller bones, is such a fracture likely to reunite spontaneously?
A No.

Q Can we just go through your note again when you first saw Mr Wilson. It is on 14 October, quite plainly. We have heard that he had a very difficult transfer of many hours in the ambulance or whatever vehicle it was.
A Hospital transport.

Q Mr Wilson, the son, Ian, said four hours is what he told us. Effectively his father had been taken all around the houses before he arrived at the War Memorial.

THE CORONER: I think he said he was really not good with transport, did you not?

MR JENKINS: You have told the jury already transferred to Dryad Ward continuing care. You give a history that he fractured his humerus. You deal in your previous medical history with alcohol problems, recurrent oedema and congestive cardiac failure.
A Yes.

Q You comment on what help he needs, that he is continent, the Barthel score. You refer to the fact he lives with his wife at Sarisbury Green and the plan is there given as "gentle mobilisation".
A Yes.

Q You prescribe a number of things for him. I want to turn to those in a moment. Can I ask you for some of the clerking notes that we have heard of you make the comment that you were happy or content for the nurses to confirm death.
A Yes.

Q You do not say that for Mr Wilson. Why was that?
A I was not expecting him to die imminently. I knew his prognosis was very poor but I was not expecting him to die imminently.

Q I think one of your colleagues made such a note a couple of days later.
A At the weekend.

Q Dr Peters made that on 17th or 18th, Mr Wilson dying on the 18th.
A Yes.

Q You prescribed a number of drugs for Mr Wilson and I want to remind the jury of what they were and ask you why you were prescribing them. We know that he had been seen by a psychiatrist who, in addition to some form of dementia, had thought that Mr Wilson was suffering from depression.
A Yes.

Q The suggestion was made that he should be given an antidepressant and you prescribed trazodone following on from the recommendation of the consultant. You prescribed medications for his lack of nutrition. You gave multivitamins.
A Yes.

Q What else?
A Thiamine.

Q Remind us what thiamine is?

A It is a vitamin that is metabolised, made in the liver, and it would have been lacking in Mr Wilson's case with his poor liver function.

Q We have heard that he had put on a lot of weight after his admission to hospital and it was not because of what he was eating but it was fluid that had accumulated.
A Yes.

B Q Can we consider the mechanism that would have led to an accumulation of fluid – the gross oedema that there was in his limbs.
A There would have been a couple of factors. His albumin was low so that would cause oedema to build up in the limbs but the major process going on in him was that he was in congestive cardiac failure. His heart was failing to pump adequately efficiently both sides of the circulation so he was building up fluid in his tissues and in his lungs and that was held at bay only by the three diuretics that he was taking, but he had put on something like 9 kilos
C before he came down to the hospital.

Q The implication from that is that that was all fluid.
A Yes.

Q The oedema – the swelling.
A Yes.
D

Q You prescribed three diuretics for him.
A Yes.

Q Did you also prescribe for constipation?
A I did.

E Q Senna was one drug and is it magnesium hydroxide?
A It is. That was a continuation from what the hospital had decided to use for him.

Q Did you write him up for any pain relief at that time and, if so, how?
A I wrote up paracetamol.

Q Was that to be given or was it an as required prescription?
F A It was an as required.

Q We have heard that you wrote him up for Oramorph.
A I did.

Q What you said in your statement – do you have the prescription in front of you – the Oramorph sheet? It is page 262 out of 642 pages. The Oramorph was written up as required
G when you saw him on the 14th.
A Yes.

Q You told us that although you have no memory of it, if it is right, as we have been told, that the transfer had been a very difficult one he was in poor shape. Can one draw the inference that if he has got a broken arm transfer in a minibus where he may have been strapped in perhaps sitting next to either another patient or next to the side of the minibus
H might have caused him difficulty?

A Agony.

Q Certainly pain. When you are doing an assessment of him on the 14th should we take that as a general review of his history or is that a snapshot?
A It is both.

Q Mr Sadd said that you had not, in your note of 14 October, made reference to previous analgesia. Would you normally do that?
A It was not relevant. The snapshot would be more appropriate than a review of what he had had before.

Q You were asked about the Oramorph and you were stopped from indicating why it was that you would have prescribed Oramorph because you said you did not recall seeing Mr Wilson on that occasion. Are you able to complete the inference for us – why would you have prescribed Oramorph at that time?
A Are you talking about the 14th on arrival?

Q Yes.
A Because of the state he was in on arrival and the discomfort he was in.

Q What you wrote up, I think looking at the prescription itself, is between 2.5 and 5ml of a solution of Oramorph with 10mg in each 5ml.
A Yes.

Q In other words, that on an "as required" basis you were giving authority for him to be given 5mg, up to 10mg.
A Yes.

Q If a drug is written up on an "as required" basis, if that drug is to be given to the patient how does it happen?
A It is made by a nursing assessment that he needs the drug. There is no direct reference to me at that point.

Q What would you anticipate would happen if the nurses think that a patient who is written up for pain relief but they do not think he needs it?
A They would not give it.

Q If the nurses think that the patient may well need it, would they offer it?
A Yes.

Q Or do they say to the patient you must take this?
A No, they would offer it.

Q What we know from the prescription sheet is that Mr Wilson is given the larger dose, 10mg; in other words, 10mg/5ml strength. He is given it at 2:45 in the afternoon on the 14th and he is given it again nine hours later just before midnight.
A Yes.

Q Are you able to help us why he would have been given the larger dose – the 10mg – on each occasion?

A Because the nursing staff felt that was appropriate to his condition.

Q Questions were raised about why you did not prescribe some other form of pain relief. You wrote him up for paracetamol on an "as required" basis. Was it something for the nurses to assess what level of pain he was in?
A Yes.

B Q If it was felt that paracetamol would be appropriate or sufficient would you expect that Mr Wilson would have been offered paracetamol rather than Oramorph?
A I do.

Q I want you to look at the BNF on the question of which forms of pain relief may have cautions where there is hepatic impairment if someone's liver is as damaged as Mr Wilson's was?
C A All of them.

Q Let's start with aspirin, page 219 in that book.

THE CORONER: Is anybody going to disagree with you if you tell us?

MR JENKINS: I do not think so. Aspirin – there are cautions for hepatic impairment and
D also, to the extent that it is relevant, renal impairment.
A Yes.

Q If you go over the page and look at paracetamol, again cautions for the use of paracetamol where there is hepatic impairment, where there is alcohol dependence and also again to the extent that it is relevant where there is renal impairment. There are a string of other drugs: co-codamol, co-dydramol, co-proxamol – all of which contain paracetamol.
E A Yes.

Q Each of which for the same reasons would have a caution attached to the use where there may be hepatic impairment or a history of alcohol dependence.
A Yes.

Q Let's come on to morphine salts, page 223 in that book. There is a caution for hepatic
F impairment.
A Yes.

Q Also again, if it is relevant, for renal impairment.
A Yes.

Q There had certainly been a history of renal impairment although that may have been
G minimised or reduced at an earlier stage.
A Yes.

Q Codeine phosphate is a morphine salt, page 226. Exactly the same caution applies, morphine salts.
A Yes.

H

Q Were there other options for pain relief for the level of pain that Mr Wilson was assessed as being in that were not contraindicated or where there were cautions?
A None.

Q Again, where does your duty lie as a doctor looking after someone who was in pain?
A To give them adequate pain relief.

B THE CORONER: Can we stop for a couple of minutes?

MR JENKINS: Of course.

(The court was adjourned for a short time)

C MR JENKINS: If we just go on in the history of Mr Wilson, on the 15th you told us that you wrote him up for regular Oramorph. On the 14th you had written "as required" for Oramorph and it had been required. It had certainly been given to him on a couple of occasions.
A Yes.

Q What we have heard in respect of morphine salts is that although there is a caution attached to using it in cases of hepatic impairment, Mr Sadd read out, some patients may tolerate it well.
D A Yes.

Q On the 15th, although you had not made a clinical note, we know that you have written up the Oramorph, we know you were there. We know that you were dealing with Mr Wilson's case because you had read all his notes.
A Yes.

E Q Again should we understand that you will have discussed how he was getting on with the nursing staff and it was as a result of those discussions that you changed the prescribing of Oramorph to a regular dose.
A Yes.

Q Subsequent to that we know that there was a view taken by Dr Knapman the next day, the 16th, that this was a possible silent myocardial infarction, a possible serious deterioration
F in his liver condition and there was a marked downturn in Mr Wilson's condition.
A Yes.

Q We have heard Dr Wilcock's view as to the cause of death. I do not think I need ask you about that. We know that the syringe driver was commenced on the afternoon of the 16th after Dr Knapman had seen the patient.
A Yes.
G
Q You did not see Mr Wilson again.
A No.

Q You did not see him after the 15th.
A No.

H

Q Syringe driver commenced on the afternoon of the 16th after Dr Knapman's attendance. Subsequently Dr Peters, and the jury will remember the gender realignment of Dr Peters just to identify her, Dr Peters saw the patient I think the following day on the 17th.
A Yes.

Q Did Dr Peters make an adjustment in the prescribing regime? I think she wrote on the prescription sheet.
A Increased the hyoscine dose.

Q Again, we have heard that there were a lot of secretions in the chest and you have told us that the use of diamorphine can alleviate considerable discomfort in someone who may feel they are drowning if there are a lot of secretions in the chest.
A Yes.

THE CORONER: Did Professor Black refer to that? I know he said all kinds of things. I just wondered if he referred to that specific point. I cannot remember.

MR JENKINS: I cannot recall. We will check our notes. What we did hear from Dr Wilcock was the reference to median doses.
A Yes.

Q "Median" I think is a term that statisticians use.
A Yes.

Q He talked about median doses across a wide range – what the average I think is the word many of us would use – for patients right at the end of their lives.
A Yes.

Q He was looking across all the patients that he deals with and he gave a figure of I think 30mg. These patients, the ones that the jury are concerned with ---
A Are not median patients.

Q What you have told us is that there were thousands of patients that passed through the War Memorial Hospital two wards that you were dealing with over 12 years.
A Yes.

Q I do not know if you can give us a ballpark figure but what sort of number of patients? What sort of ranges of patients would there be who would be terminally ill or receiving palliative care on those two wards?
A It could have been no more than 10 per cent towards the end.

Q What proportion of patients – what sort of numbers are we dealing with – who might be receiving medication through a syringe driver?
A Hundreds over the course of 12 years of the thousands who went through the wards.

Q I think you told us this morning that you had four syringe drivers.
A When we began, yes.

Q Can I come to the last issue I want to deal with and that was off licence prescribing. We were told about Fentanyl by Dr Wilcock. Reference was made to licences that may be

granted for specific types of medication. I just want to get your understanding of licences, what the considerations are about a licence and whether you are allowed to prescribe off licence? What is a licence?

A A licence is granted to the drug company for manufacturing and selling of a particular pharmaceutical product but it is understood in many fields of medicine that drugs are used in particular circumstances out of licence.

B Q We saw it, did we, with the Fentanyl patch that Mr Leiper produced the manufacturer's documentation which suggested that Fentanyl should only be used for patients who had had opiates before and yet when we looked at the British National Formulary that was clearly anticipating the use of Fentanyl patches for patients who had not had opiates before.

A Yes.

C Q Is that ---

A It is a typical example.

Q The British National Formulary – is this right – was clearly anticipating a drug being given off licence?

A Yes.

D Q Is there anything to prevent a doctor prescribing a drug outside the licence?

A It is understood that it is done. There is nothing to prevent us doing it.

Q Are there certain branches of medicine where it is done quite regularly?

A Palliative care come to mind; paediatrics certainly, but all of us in every day practise will come across occasions where we go out of licence.

E Q To take paediatrics, I think very few drugs are licensed for use in children.

A Yes, because the basic research has never been done – could never be done.

Q You would not get ethical approval to do it, drug trials on children.

A No.

Q So the licence does not extend to use with children.

F A No.

Q You have also said with palliative care.

A Uh-huh.

Q Should we understand that it is not at all uncommon for doctors using opiate drugs as one example to be prescribing outside the terms of the licence for a drug?

G A Not at all rare.

MR JENKINS: Thank you very much. That is all I ask.

MR TOWNSEND: So far as the BNF guidance in relation to Fentanyl is concerned, Dr Barton, you can confirm that in 1998 the BNF suggested that Fentanyl was appropriate for chronic intractable pain due to cancer.

H

A And I was using it out of licence and that was understood in the Wessex Guidelines that ---

Q I am simply asking you to confirm what was included in the BNF in 1998, that its indication was for chronic intractable pain due to cancer. Is that correct or not?
A Yes.

B MR JENKINS: I think the highest dose of diamorphine given to any of the patients with which the jury are concerned was Mr Pittock was 120mg, although the range of medication that you might have written up extended way beyond that and is it relevant at all, do you think, that we should compare with that the highest figure that Dr Wilcock talked about which was just under 2 grams, 1980mg, I think, on a daily basis.
A Yes.

C MR JENKINS: Thank you.

THE CORONER: Doctor, thank you very much. What we will do now is break for lunch and I will come back and read to you all afternoon.

(The witness withdrew)

D MR SADD: Sir, you wanted a reference for Professor Black to the hyoscine. The only reference that I could find, and I have gone through the evidence he gave before the jury, it is not particularly well canvassed there but page 18 of his report, paragraph 6.10, appears to be the only reference I can get. I give that to you for your notes.

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

E MR LEIPER: Sir, I wonder whether I might raise the question of timetabling which need not detain the jury but very briefly for my own purposes.

THE CORONER: Yes, we are going to have to look at it and we might as well do that now. You might as well stay as it may affect you. I had anticipated that we would deal with a lot tomorrow. I will read what I can this afternoon. I will then carry on reading tomorrow until you cannot stand it any longer. We will finish reading tomorrow. We can do any mopping F up exercises, take submissions on Tuesday – we will talk about that more – and that will give the jury a day off on Tuesday and so it takes the pressure off us and the pressure off them. I will then sum up to the jury on Wednesday if that is what you think is going to fit in. Does that make sense?

MR LEIPER: Sir, yes.

G THE CORONER: You were going to get on your feet anyway.

MR LEIPER: I was, sir, and again it is a matter which does not concern the jury.

THE CORONER: Plan on having Tuesday off and when you come back on Wednesday you are going to hear from me again, I am afraid. We will see you back at two o'clock.

H (In the absence of the jury)

MR LEIPER: It is in relation to the Dudley report. I have had the opportunity to take instructions in the course of this morning. Could I ask you to have a copy of it in front of you while I outline what the families' position is?

THE CORONER: Yes.

MR LEIPER: Sir, the families' position is that if it is to be read they would like you to highlight the following four issues. I will explain what they are.

THE CORONER: Is my understanding of this correct that this document is going to be agreed or is this still in the pipe?

MR LEIPER: Can I just explain what the families' position is in the first instance? They are anxious that sir should draw to the attention of the jury if the document is to be read firstly that a copy of the statement of Dr Barton was provided to Dr Dudley when it was not given to the other experts. Sir will see that it is recorded in the documentation on page 4. Sir will also see that in relation to the documentation that was provided to Dr Dudley on page 4 that he was provided with no copy of the Wessex guidelines. The relevance of that is in relation to his comments in relation to the propriety of the drug regime which was given.

On page 7, three lines from the bottom, it reads:

> "On that date, 16 November 1999, laboratory results revealed a marked deterioration in Mrs Devine's kidney function."

Sir has heard evidence to the effect that those results were not available until lunchtime on the 18th and that is the matter of enormous significance so far as the family is concerned and that passage will, in our submission, confuse the jury and they would like it clarified that those results were not available until lunchtime on the 18th, as Dr Barton has confirmed in evidence.

The final point is in relation to paragraph 8.5 on page 11. Sir sees the paragraph beginning: "Death from renal failure ...", three lines down there is in brackets "reference 4". Code A would wish, sir, that if you are to read it you should make clear when reading that passage that reference 4 is a reference, as appears on page 12, to a study of dialysis discontinuation and palliative care. If sir could make that quite plain when reading that passage, the family in those circumstances would be content that should sir want to read the whole of the report that can be done. I would hope those requests are relatively modest.

THE CORONER: Thank you very much indeed. I am grateful to you for that slight shift. Is there anything else arising from that?

MR SADD: Not arising from that, sir, but you will be pleased to know that so far as Mr Wilson's brother's statement is concerned, Mr Wilson is happy that that is read. There was originally a reticence about that being read, but he is quite comfortable that it should be read.

THE CORONER: What is your brother's name?

MR WILSON: Neil.

MR SADD: Sir, I wonder if I might ask as a matter of manners and courtesy to you whether I might be released this afternoon?

THE CORONER: Certainly, and any of the other advocates that feel that they do not need to be here I am more than happy if you want to leave.

MR LEIPER: Does that apply in relation to tomorrow as well? Tomorrow is going to be simply a reading day.

THE CORONER: Yes, unless anybody has got any business to do tomorrow. Far be it from me to suggest that there will no be any applications at 10 o'clock but let's see how we get on and if you want to give it a miss then I am more than happy to carry on without you.

MR JENKINS: Can I just echo your sentiments with regard to the Dudley document. It is certainly helpful that Mr Leiper and the Code A Devine family deal with matters in that way. I hope those sentiments are passed on.

THE CORONER: We will adjourn for lunch.

(Luncheon adjournment)

MR JENKINS: Can I just say (inaudible words) that she need not stay for the rest of the day. I think she may not be here tomorrow.

THE CORONER: I have no problem with that at all. Can we get the jury in, please? I will start with Mr Wilson and then go on to Professor Dudley and then work through them all.

MR JENKINS: I do not think he is a professor yet.

THE CORONER: Dr Dudley. I am promoting people left, right and centre here. If I noticeably miss anything out, in particular with Gill Hamblin, if you could just throw something at me.

MR TOWNSEND: Sir, I anticipate that you are going to make a comment about her inability to attend and clarify in relation to her? I would be most grateful

THE CORONER: Certainly.

(In the presence of the jury)

THE CORONER: The statements you have this afternoon are all those that are admitted under rule 37 under one guise or another. The first one I will deal with is Mr Wilson's brother, Neil Wilson.

NEIL WILSON, statement read

He made a statement on 13 April 2004. He makes a statement with regard to Robert Caldwell Wilson who was born on 8 March 1923 and died on 18 October 1998.

"Although not my biological father, Robert Wilson was my dad and someone I always see in that light. Dad was born in Glasgow. He was one of several children, I do not know the exact number. I never met my grandparents and I do not know how old they were when they died or how. I did meet Aunt Maisie, Dad's sister, but I think most of his siblings had died by the time I would have been old enough to remember them. I am not aware of any illness within Dad's side of the family. I was one of seven children.

As a young man, Dad joined the Royal Navy and saw active service in World War II. He served 22 years in the Navy working as a deep-sea diver. He left the Navy as a petty officer. Having left the Navy he worked for the civil service as a milkman, a bus driver, and an inspector. He ran a fish and chip shop and finally re-qualified as a wood machinist. I would describe Dad as a fit and active man during his life.

Dad was quite a heavy smoker for most of his life. He started at the age of 11 and smoked 80 a day. At the age of 66 Dad just stopped smoking one New Year's Eve but he did like a drink. He started drinking at about the same age as he started smoking. When he was drinking heavily it would be 10 pints a day. As he got older he would drink spirits. For the vast majority of his life he was an alcohol. He was able to cope with it. I think out of all the children I was one of the closest to Dad."

You may remember that Mr Wilson pointed that out.

Mum and Dad got divorced in the early 1980s and I joined the Army. I served with the Green Jackets, the Signals and Airborne which Dad was very proud. From the mid 1980s Dad remarried a lady called Gillian. She was considerably younger than Dad by about 30 years. Of all the children I was the only one Dad told about the wedding. Although I was unable to go, this amongst other things has caused fallout within the family. We were not a family that has constant rows; we just do not have a great deal to do with one another.

In about 1996 Dad had his first stay in hospital. He had a fall which I think was as a result of his drinking. He hurt his shoulder and was admitted to QA in Portsmouth. I saw Dad in hospital and he was to remain there for three or four weeks. While he was in hospital Dad had treatment for his shoulder and was also put on a diet. Dad was about 5'7" tall and weighed 18 stone. Whilst I had been working, Dad had been a strong man but since he had stopped he had gone soft and spread out a bit.

Very delicately put, is it not?

Dad returned home to Sarisbury Green after he left hospital with his wife, Gillian. Dad and Gillian got on well. The house was only three doors from the local club and Dad seemed quite content with his lot. He was quite comfortable financially. I would always see Dad at weekends and speak to him during the week on the phone. I was having more contact with Dad than the rest of the family.

In September 1998, Gillian was away on holiday leaving Dad at home alone. I tried to get hold of Dad several times at home but had not been able to do so. In the end I phoned the social club and was told that Dad had been taken to QA having had a fall.

This time no one else in the immediate family knew. Things were left to me to sort out at the hospital. I think I told my Mum who made sure everyone else knew.

When I got to QA Dad was on a ward. He had an injury to his right shoulder and hip from the fall. Although fed up, he was quite lucid and able to hold a conversation. He was quite tired and fed up. Dad did not want to be in hospital for as long as he had been last time. He did not like the food and was not eating that much. The doctors and nurses were being quite strict with him about his diet. Dad clearly did not like being told what to do. He was moved to a quieter room towards the rear of the hospital. That was a mixed room. It was also a geriatric room. It was a good deal quieter.

Whilst he was at the QA Dad was on a very mild pain relief. I think he was on paracetamol but it almost had to be forced upon him. I could tell from visiting Dad that he was in some pain and discomfort but it was not in any way extreme.

Over the first few days Dad was quite down. He started making plans for his funeral stating what his wishes would be. Dad thought that he had been put in the ward to die. However, one of the nurses in charge started giving him some direction. She arranged physio and social support with regard to rest homes and rehabilitative care. Dad began to realise he would be leaving QA and probably going into rehabilitative care somewhere prior to going home.

Whilst in the QA there was talk about changing his front room at home so he did not have to go upstairs. I and the rest of the family saw some light at the end of the tunnel. I was fully expecting Dad to go home at some stage in the future. Whilst at QA, Dad had several visits from a social worker and I also spoke with this person about the best options for Dad. In the end it was decided that the best place for Dad would be Gosport War Memorial Hospital. It was quite close to his home, other family lived nearby and the plan was that this would be a stepping stone onto a nursing home.

I think it was Sunday 11 October 1998 when I last saw Dad at QA. It was the day before he was going to be moved to Gosport. Dad was his normal self. He would do the crossword in the paper and crack the odd joke. He was still poorly from the fall and was not as mobile as he had been but generally he seemed well and happy.

I spoke with a male doctor whose name I do not know. The doctor said that Dad had had a shock from the fall and would need to make some life changes. He would need to continue losing the weight and come off the booze. The doctor said that another fall at his age with the weight could cause immense problems and could kill him. However, there was an upside that if Dad changed his ways the future was positive.

Dad was moved by minibus to Gosport on Monday 12 October ...

MR JENKINS: That must be wrong. He did not get there until 14 October.

THE CORONER: It was not a two-day journey, was it?

MR JENKINS: No. We are about to hear another date two paragraphs down which again cannot be right because Mr Wilson was not at the Gosport War Memorial until the 14th.

THE CORONER:

> "Dad was moved by minibus to Gosport on Monday 14 October. I went and saw him on the same evening. I do not know the name of the ward he was on. There were five or six other people in there. It was in the late afternoon when I got there and I was told that Dad was asleep. I went and saw him for a few seconds. I could see he was asleep so I left some bits and bobs at the end of his bed. Later that evening I got a phone call from sister Tracy saying that someone had told Gill that Dad would not make it to the weekend. This came as quite a shock but to be honest I am not a hundred per cent trusting of Gill. She is an attention-seeker and an alcoholic. Also Dad had been so well the day before this reduced my fears. My daughter, who was four months old, had only just been out of hospital a few days herself so I had a lot on my plate.
>
> On Tuesday ..."

I presume that would be 15 October?

MR SADD: I do not know the days of the week but it cannot be Tuesday 13th.

THE CORONER: No, whatever it is.

> "... I went to Gosport War Memorial Hospital. Dad was laid out on the bed. He was still in the ward but seemed totally out of it. I could hear his breathing was very laboured and he was gurgling. I have had quite extensive first aid training the Army and it sounded as if his lungs were filling up with fluid. I asked a nurse who seemed to be in charge if I could speak with the doctor. The nurse told me that the doctor only came once a day and would not attend as the doctor had already spoken to Gill. I expressed my concerns about Dad's position and why he was on a general ward. The nurse told me he was being cared for and was on pain relief. I felt this was odd because Dad had been on minimal and manual pain relief whilst at the QA. The nurse explained that Dad was on pain relief to make him more comfortable. She did not tell me what he was on but it was being administered by some sort of drip.
>
> I was not happy with what I was being told and made my feelings clear to staff. Ian, who was also at the hospital, was clearly very upset. I then spoke to another female nurse who seemed to be in overall charge. I think she was either a South African or a Kiwi. I asked her what was happening. She replied "His kidneys and liver are not functioning properly". I said, "It sounds as if he is drowning from a bag full of fluids." She said, "That's right, but he is being treated for it." I asked why he was not on a lung drain and if his liver and kidneys were not working why was he on medication that was sending him into a coma? The nurse said that I would have to take that up with the doctor. I knew the doctor was a lady and she was local but I do not know her name nor did I ever meet her despite several attempts over the following days. The nurse told me that Dad did not have long to go. She was kind in the way that she did this and said that Dad would be put in a private room. At this stage I began to accept that Dad did not have long left. I phoned some of the family to tell

them. I also phoned my sister, Lesley, in America so that she could come over and see him. I wanted sometime alone and I went home.

I went to the hospital on Wednesday 14 ---

It should be 16th – whatever it is, it is day of entry plus two.

B MR JENKINS: The suggestion earlier on that Mr Wilson was on some sort of drip on the second day does not accord with what the jury has already heard.

THE CORONER: Can we just ignore days and just say sometime afterwards?

"I had hoped to see the doctor but she had already gone. Dad was now in a private room. I spent sometime with him but there was not a lot I could do. Dad did not
C respond to anything I said or did. Ian was spending quite a lot of time with him so I left them to it.

Over the next few days all the family went and saw Dad at the hospital. The nurses were speaking to Gill as his next of kin which left the rest of us in the dark. Gill was drinking heavily through this period and was unable to communicate between us and the nurses. By the evening [of whatever day it was] no one expected Dad to live
D beyond the weekend. It was as if the nurses had made this decision.

Dad did not change much until Saturday [whatever day it was]. I had gone to the airport to collect Lesley from America. On the way back Gill phoned and said that Dad would not last much longer. I got to Gosport as fast as I could arriving at about lunchtime. Most of the family were there. We all stayed until the evening at which point Lesley said for us to go. She would call if things changed. Although Dad was
E still in a coma, it appeared to all of us that he knew Lesley had arrived.

Having gone home in the evening I got a phone call in the early hours of 18 October from Tracy to say that Dad had died. I went to Gosport. I think all the family were there. Lesley was dealing with the nursing staff. She told me that her and Karen had been asked to leave the room and upon their return they had been told Dad had died.

F I dealt with the registration of the death. The cause of the death was shown as renal failure. I do not recall who signed the death certificate. I also arranged Dad's funeral. Dad was cremated at Portchester in accordance with his wishes."

He then raises certain points that (inaudible words).

Elsie Devine, you may remember, Dr Dudley made a report and I need to say some things to
G you about Dr Dudley before reading his report to you. The point with Dr Dudley is that he had a copy of Dr Barton's statement that you have heard before he prepared his report in relation to Mrs Devine, so he was aware of what she was saying. He also was not given a copy of the Wessex Guidelines so he would not have been aware of what they said.

Other points that I need to raise with you I will raise as we go through. He concludes:

H

"Mrs Devine was an elderly frail lady who had a plasma cell dyscrasia manifested by the presence of an IgA Lander paraprotein amyloidosis. In addition she had the nephrotic syndrome of progressively deteriorating renal function probably as a consequence of renal amyloid. In the nine to 12 months prior to her final hospital admission she had suffered with chronic memory loss and had become unable to look after herself. She was admitted as an emergency to hospital with an acute confusional state for which no cause other than multi-infarct dementia and severe renal impairment could be found.

After a period of stabilisation her clinical condition worsened with severe renal failure and worsening agitation and restlessness. Although it may have been possible to stabilise her condition with relatively simple measures, this would not have materially changed her prognosis as death was inevitable.

She was treated appropriately in the terminal phase of her illness with strong opioids to ensure comfort and calm to enable nursing care to maintain her dignity.

He says he was asked to prepare a report on the instructions of DS Dave Growcock of the Hampshire Constabulary. He was asked to consider the following issues: beyond all reasonable doubt was Mrs Devine dying due to her failing renal condition? If she was beyond all reasonable doubt dying from renal failure, would any simple measures that were available and appropriate have had any reasonable chance of making a difference? Would the acute confusional state that Mrs Devine developed be in keeping with dying of renal failure? At the time when Mrs Devine's renal failure declined, would a better assessment of identifying appropriate treatment options would have had a reasonable chance of stabilising or improving her situation? Would the actual confusional state be untypical of someone dying of renal failure? Asked to make a comment on the use of strong opioids to calm, keep comfortable and enable nursing care in someone dying of renal failure who is not in obvious pain?

He then details his curriculum vitae and documentation. You do not want me to deal with any of that, do you?

MR JENKINS: Just that he is an NHS consultant in renal medicine and has been since 1995. Thank you.

THE CORONER: Sequence of events prior to admission:

"Mrs Devine is an 87-year-old lady who was referred to Dr Logan, consultant physician in geriatrics, on 9 March 1999 because of increasing ankle swelling and abnormal blood tests, including a creatinine of 130mmol/l. The normal laboratory range for females given as 45-90 mmol/l.

In the past a diagnosis of mild to moderate congenital cardiac failure and hypothyroidism had been made. At the time of referral she was taking a combination of water tablets (diuretics), co-amilofruse 5/40, one or two a day, and thyroxin 100 mcg a day.

She was seen on 1 April 1999 in the Elderly Medicine Clinic by Dr Ravidrain (?) specialist registrar to Dr Logan. A number of investigations were performed which

revealed the nephrotic syndrome which is a condition whereby excessive amounts of the blood protein albumin leak through the kidney into the urine resulting in a low blood albumin level. As a consequence, fluid retention occurs characterised by swelling of the ankles as in Mrs Devine's case. Her kidney function had also deteriorated with her creatinine rising to 150mcg – micro whatever they are – millimoles. An ultrasound of the kidneys had been performed and was reported to be showing both kidneys to be slightly small, the right measuring 8.7cm and the left 8.4 cm. No other abnormality was identified and the chest x-ray was normal. Blood tests also revealed the presence of IgA Lander paraprotein quantified as 5.9gls. Her urine however tested negative for Bence Jones protein often found in a condition known as myeloma."

That is where I think myeloma is ruled out.

"Following a clinic visit on 15 April 1999, Dr Logan referred Mrs Devine to Dr Tania Cranfield for a further opinion on whether the paraprotein was associated with a haematological malignancy such as myeloma with a nephrotic syndrome related. In his referral letter he noted that Mrs Devine was moderately frail but very bright mentally.

Dr Cranfield assessed Mrs Devine in the clinic on 13 May 1999. She went on to perform a bone marrow biopsy, an aspirate which revealed no evidence of myeloma and although plasma cells were prominent, they made up only 6 per cent of the nucleated cells present. There was no lytic lesion on the skeletal survey although this did show generalised osteoporosis. On the basis of these investigations, Dr Cranfield felt that there was insufficient evidence for a diagnosis of myeloma to be made. She referred the patient to Dr Judith Stevens, consultant renal physician, in view of Mrs Devine's deteriorating renal function and for an opinion on the cause of the nephrotic syndrome.

Dr Judith Stevens reviewed the patient in a clinic on 8 June 1999. Her opinion was that in view of the small kidneys it is likely to be a long-standing glomerulonephritis rather than a new problem. Glomerulonephritis is a condition resulting in damage to the filtering units of the kidneys usually associated with blood and protein loss in the urine. A modification in Mrs Devine's diuretic tablets was suggested. In her letter she noted "She is a rather frail old lady".

The patient was further reviewed by Dr Cranfield in clinic on 28 July 1999. In her letter she noted that Mrs Devine's leg swelling was much better controlled on the increased dose of diuretic tablets. She noted that a further laboratory staining of the bone marrow biopsy revealed the presence of amyloid. She also noted that the patient's kidney function had worsened further with her creatinine rising to 192.

Mrs Devine was reviewed again by Dr Stevens in clinic on 7 September when Dr Stevens noted that the oedema (swelling) extended up to the patient's knee. A further increase in the dose of diuretic medication was recommended.

The sequence of events following admission to QA.

Mrs Devine was admitted to QA on 9 October 1999. A referral letter from Dr Smith, the GP, from the health centre, Osborn Road, Fareham, reported that for two days she had been confused, aggressive and wandering. A copy of the medical records provided to me from the day of her admission are illegible but from the discharge summary and the remainder of the medical records I can determine that she was treated for a possible urinary tract infection and given intravenous fluids. She remained very confused and aggressive and had a mental test score of 3 out of 10 reflecting significant cognitive impairment. A creatinine of 201 was noted. This indicates advanced renal failure calculated creatinine clearance of 14 (inaudible words) because she was continually confused and aggressive, refusing medication and physically harming staff she was treated with haloperidol, an antipsychotic sedating drug.

On 14 October she was seen by Dr Taylor, clinical assistant in old age psychiatry, who recorded that since January of that year Mrs Devine's family had noticed a decline in her memory and was no longer able to look after herself. She concluded that it was likely Mrs Devine had dementia with an acute episode of confusion secondary to urinary tract infection. Mrs Devine scored 9 out of 30 on a mini mental state examination reflecting definite cognitive impairment.

Because of Mrs Devine's son-in-law's ill health and requirement for treatment in London, her daughter was not able to care for her. A recommendation that she be referred to the social services for residential care in a home that had experience of dealing with memory problems was made. A CT scan of the head was performed with sedation on 18 October and was recorded as showing involution and ischemic changes only.

The patient was assessed by a local consultant physician in geriatrics on 19 October who thought her suitable for a rehabilitation programme and made arrangements for her care to be transferred to Gosport. On 18 October her creatinine was recorded as 201.

Sequence of events following admission to Gosport.

On 21 October 1999 Mrs Devine was transferred to Dryad Ward, Gosport War Memorial Hospital under the care of Dr Reid, the consultant in charge. The plan recorded in the notes by Dr Barton at the time was for the team to get to know Mrs Devine, assess her for rehabilitation potential and probably place her in a rest home in due course. She was noted to be mildly confused, mobile, able to wash with supervision and dress herself as well as being continent. A mini mental state examination of 9 out of 30 was recorded. Elsewhere in the notes it is recorded that Mrs Devine was quite confused and disorientated. I am not able to identify from the signature on the notes by whom this entry and others elsewhere were made. However, Dr Barton identifies these entries in her statement as being made by Dr Reid. Mrs Devine's creatinine is recorded at 187 on 22 October and as 200 on 9 November. By 15 November the patient's condition had apparently deteriorated and Dr Reid notes that she had become very aggressive at times and very restless requiring the use of thoridazine, an antipsychotic drug, used to calm restless patients.

The patient was receiving treatment for a suspected urinary tract infection although a midstream urine sample had revealed no growth. A referral back to Dr Lusznat was requested and made the following day. On that day, 16 November, laboratory tests revealed a marked deterioration in her kidney function ---

FEMALE SPEAKER: Sir, that is the amendment – it was on the 18 November when the results came back after the Fentanyl patch had been applied.

THE CORONER:

--- and that showed a rise of creatinine level to 360. That is 18 November.

She was seen on 18 November 1999 by a locum staff psychiatrist who noted that the patient had deteriorated and had become more restless and aggressive. She was placed on the waiting list for Mulberry Ward.

On 19 November Dr Barton's entry in the notes records:

> "marked deterioration overnight, confused and aggressive. Creatinine 360. Fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs subcutaneous analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable. Am happy for nursing staff to confirm death."

The nursing notes on 19 November record that the patient's condition had deteriorated markedly over the previous 24 hours and that she had become extremely aggressive refusing all help. Chlorpromazine had been given intramuscularly, an antipsychotic drug used to calm restless patients, and a syringe driver consisting of 40mg of diamorphine, 40mg of midazolam had been commenced at 9:25 at 9:25. Mrs Devine died on 21 November 1999.

Mrs Devine had progressive renal failure. The presence of a nephrotic syndrome would indicate that there was damage to the filtering units within the kidney. It is possible that this was due to an unrelated glomerulonephritis, none specific terms for inflammation within the glomerae or sieving units as suggested by Dr Stevens. However, it is more likely that it was directly related to the underlying IgA Lander paraprotein. IgA is one of five classes of antibody protein produced by plasma cells within the bone marrow and lymph glands. Different plasma cells produce different types of IgA antibodies resulting in a mixture within the blood referred to as polyclonal – derived from many different clones of plasma cell.

Occasionally for reasons that are poorly understood, a plasma cell divides and multiplies to an abhorrent (?) degree resulting in an abnormal collection of identical plasma cells producing the identical antibody type – in this case IgA Lander. Using biochemical techniques the excessive amount of anomalous identical antibody type can be identified in the blood. As this protein is derived from one individual clone of plasma cells it is referred to as monoclonal immunoglobulin or paraprotein. Such an expansion of monoclonal plasma cells is abnormal. At one extreme the number of abnormal plasma cells proliferating in the bone marrow is excessive and suppresses the other normal plasma cells as well as destroying the bone itself and lytic lesions

causing an elevated plasma calcium level. This is a malignant condition known as multiple myeloma and, if untreated, results in death. At the other extreme the number of abnormal plasma cells is low. The number of normal plasma cells is maintained and the bone is not destroyed. The significance of the abnormal clone is uncertain and the patient remains well without treatment for years. This condition is known as monoclonal gammopathy of uncertain significance.

Between these two extremes is the condition of smouldering multiple myeloma which has some but not all of the features of multiple myeloma but probably represents an early stage of this condition. This group of conditions is known as plasma cell dyscrasia.

A component of the monoclonal immunoglobulin, known as the light chain, may join together and become deposited particularly in the walls of the blood vessels."

Is this meaning anything to you? Not a lot, no.

"It is known as amyloidosis and can be identified from a biopsy of an affected tissue or organ. In the setting of paraprotein, amyloid can be thought of as a malignant condition with a prognosis similar to that of multiple myeloma. Within the kidney, amyloid is deposited in the sieving units damaging them resulting in protein leaking into the urine and a kidney dysfunction."

The significance of this of course is that Dr Wilcock refers to it and this is where his information comes from.

"Further examination of Mrs Devine's bone marrow biopsy demonstrated the presence of amyloid. It is more likely than not that the cause of Mrs Devine's nephrotic syndrome and renal impairment was due to the deposition of amyloid within the kidneys rather than a long-standing glomerulonephritis.

On 20 January 1999 Mrs Devine's creatinine was 130 with a normal laboratory range for females given at 45 to 90.

Using the Cockford and Gault formula I calculated creatinine clearance, a measure of glomerulo filtration rate was 22.3ml/minute, the normal rate being 80-120, [so it is considerably reduced]. Its value reflects moderate to severe renal impairment. Over the course of a year there was the progressive rise in her creatinine reflecting a progressive deterioration in renal function. By 7 September 1999 it had risen to 203. During her admission to QA, her creatinine varied between 161 and 201. During her admission to Gosport War Memorial Hospital it varied between 187 to 200.

On 16 November her creatinine had risen to 360 reflecting a marked deterioration in renal function signifying a severe renal failure. It is probably that an unidentified infection was responsible for the deterioration in the patient's condition and renal function. Intravascular volume depletion (dehydration) associated with inappropriate diuretic use is less likely given the stability of the patient's weight. Fluctuation in weight over a short period of time is a good indicator of changes in body fluid status.

Mrs Devine was admitted as an emergency to hospital with an acute confusional state for which no cause other than multi infarct dementia and severe renal impairment could be found.

Opinion

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

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

If Mrs Devine was beyond all reasonable doubt dying (inaudible words) would any simple measures that were available and appropriate have had any reasonable chance of making a difference?

It is difficult for me to comment on her diuretic therapy as I cannot read her drug chart clearly. However, the patient's weight chart shows no marked change in weight to suggest significant fluid depletion. In my opinion any simple measures such as stopping diuretics, the use of intravenous fluids and/or antibiotics were unlikely to have had any significant effect on the eventual outcome. Although her clinical condition may have improved or stabilised for a few days, a further deterioration culminating in her death was inevitable.

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

Mrs Devine appeared to have a chronic confusional state which had acutely worsened resulting in her admission to QA. During this admission and after her transfer to Gosport 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.

At the time when Mrs Devine's renal function declined, would a better assessment have identified appropriate treatment options that would have had reasonable chances of stabilising or improving her situation?

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 the simple measures such as stopping diuretics, the use of intravenous fluids and/or 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.

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

Death from renal failure is usually characterised by increasing drowsiness leading to coma. However, in a proportion of patients renal failure is characterised by an acute confusional state."

He refers to the text from which he takes that is the Dialysis Discontinuation of Palliative Care

B "As such, an observation would not be untypical in a patient with terminal renal failure, particularly when a previous chronic confusional state exists.

Comment on the use of strong opioids – to calm, keep comfortable and enable nursing care in someone dying of renal failure who is not in obvious pain.

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

He then repeats the various certificates to say that he is the expert and that is his evidence.

Frieda Shaw

D MR JENKINS: Could you just remind us which patient this is?

THE CORONER: I will as soon as I get there. Frieda Shaw is on Cunningham and Sheila Gregory as well. This is Cunningham. We will take this statement and then move on to Sheila Gregory so I am going to bounce you backwards and forwards, but once we come to the summing-up I will take them all deceased by deceased, so it will be person by person.

E Frieda Shaw makes a statement on 15 March 2005, says she is a registered general nurse, Nursing and Midwifery Council number given, qualified as a registered nurse for the mentally handicapped in 1975 at Lennox Castle Hospital, Lennoxtown, Glasgow. Further qualified as a registered general nurse in 1977 and took an 18 month registration course to achieve that. Had a variety of positions in the nursing profession.

F March 1992 began work as a D grade staff nurse at the Redcliffe Annex which formed part of the Gosport War Memorial Hospital. In 1995 I believe this unit was closed down and all patients transferred to Dryad Ward, Gosport, together with the staff. I have worked at the hospital since then and in 1995 I qualified as an E grade staff nurse.

G My role and responsibilities include taking charge of the ward in the absence of senior staff. I supervise healthcare support workers and junior staff. I also have a responsibility for the training of student nurses who are on ward placement. I have not heard of the term "the Wessex protocol".

H Dryad Ward consists of 20 beds and primarily consists of elderly patients over the age of 65. The majority of these are fully dependent on nursing care and are usually in the ward for a four to six week period. I have received on the job training in the use of syringe drivers. I believe I first used these in or around 1992. I have also attended study days in connection with the manufacturer's requirements relating to their use.

She tells us what they are.

> The only person who can authorise the use of drugs administered through a syringe driver is a doctor. In the early years it was policy to allow up to three different drugs to be administered by a syringe driver in one dosage over a set period. That policy has now changed.

Do you want me to deal with the formalities of (inaudible)?

> I have been asked to detail my involvement in the care and treatment of Arthur Brian Cunningham. I can vaguely remember him and from referral to entries in his medical notes I can confirm that I was shown as the named nurse for him that he was not admitted by me. I can confirm at page 871 of the notes in an assessment sheet which details the following patients' understanding of the condition: communication, elimination, nutrition, pain, vital signs. This is my writing on page 872 which is a continuation sheet. I have both written my name as the assessor and signed name – I dated that 22 September 1998.
>
> In the notes it is the Barthel ADL index for the patient Arthur Cunningham. The patient's name is not written by me but the rest of the form is in my hand. The form is dated 22 September 1998 and the Barthel index indicates the patient's dependency on nursing staff. It is a recognised method of assessing the patient's care. Arthur Cunningham scores none, meaning he was totally dependent on nursing staff.
>
> The nursing care plan
>
> The problem is that the patient requires assistance to settle for the night. The desired outcome is for the patient to have a peaceful night and wake feeling refreshed. The evaluation of that would be nightly. Nursing action would be to offer a hot drink, attach a night bag to the catheter, arrange pillows in preferred positions he likes to lie on his side and assist him to change his position overnight.
>
> Page 876 of the notes is nursing care plan for night time assessment. I do not work nights and it would be unfair for me to comment on this.
>
> On page 877 in his notes is the Waterlow pressure sore prevention treatment policy dated 22 September 1998. Not in my writing at the top of the page but the figures are in my hand. The form is used in relation to pressure sores and the following headings should be considered: patient's build, weight and height, skin type and visual risk areas, sex, age, continence, mobility, appetite, neurological deficit, major surgery, trauma, medication. Those are the headings (inaudible) the likelihood of pressure sores.
>
> Arthur Cunningham's score was 20 which is known as a very high risk of pressure sores.
>
> Page 878 of the notes is a lifting handling risk calculator. This form is not often used and indeed has not been completed.

21 September 1998, under the problem subheading I have written "large sacral sore present on admission". She has signed the entry. Desired outcome subheading I have written to aim to promote healing and prevent further breakdown. I have written that that should be done daily. Nursing action – clean with normal saline, apply Paranet and Allevyn, secure with Hyperfix.

25 September she has written removed Granuflex dressing and signed the entry. A further nursing entry on 24 September – dressing renewed using Paranet covered with Allevyn secured with Hyperfix. 25 September dressing renewed using Bordered Granuflex.

Page 881 is another nursing care plan for Arthur Cunningham. The problem is described as "blister to heel, superficial grazing to both ankles". The desired outcome is to aim to promote healing and prevent further breakdown. The evaluation date was four to five days. Nursing action – clean if necessary with normal saline. Apply Duoderm dressing and change dressings every four to five days and she has signed the entry.

Then goes on 22 September Duoderm applied to both areas. 24 September dressings intact. 22 September the problem is described as "requires assistance with personal hygiene due to Parkinson's disease. Desired outcome is to achieve acceptable hygiene standards. Nursing action – daily bed bath, bath shave, ensure hair, nails, ears clean. Report any changes in skin condition. Apply Diprobase to any areas of dry skin and ensure privacy at all times.

Another nursing care plan on 21 September ...

You may notice that these are going backwards. It is just to make sure that you are paying attention.

"Catheterised on admission. The desired outcome I have written to keep the catheter patent and prevent infection to be done daily. Points out the catheter bag emptied.

Page 837, medical notes, a prescription sheet for the patient Arthur Cunningham. I can confirm that on 25 September at 10:15 I administered 60mg of diamorphine, 1200 mcg of hyoscine and 80mg of midazolam through a syringe driver."

That is her statement for him.

Sheila Gregory

The statement for Sheila Gregory is dated 11 July 2005 and she recounts her history again.

I have been asked to detail my involvement in the care of Sheila Gregory who was a patient on Dryad Ward at Gosport who died on 22 November 1999. At that time I was an E grade staff nurse and my roles and responsibilities were as previously stated. My supervisor at the time was Sister Gill Hamblin.

From memory and referral to entries made in Sheila Gregory's medical records I can state the following:

13 September 1999 seen by Dr Reid on round. Continue inhalers changed to nebulisers. I have then signed the entry. The entry relates to a ward round by Dr Reid conducted on 13 September 1999 and is recorded in the clinical notes written by Dr Reid. Continue means to continue with the care as before of Mrs Gregory, the only change being to commence a nebuliser instead of an inhaler. That would have been a change in the drug regime and the way that they were taken. Prior to 13 September 1999 Mrs Gregory was using an Atrovent inhaler, an (inaudible) inhaler. This was changed to ipratropium nebuliser, a budesonide nebuliser."

Any of you asthmatics? You have probably got some of those.

I am unable to say why these drugs were prescribed. An inhaler requires you to breathe in the medicine in a particular manner. To be able to do this the patient has to be able to understand instructions. Also the patient is required to be able to breathe quite deeply. A nebuliser is given via a mask and the drug to vaporise by machine allowing the patient to breathe naturally.

The next entry is 20 September 1999, seen by Dr Reid for FBC U&Es. Again this relates to a ward round by Dr Reid and corresponds with a clinical note on page 68.

Dr Reid has requested FBC U&Es (full blood count and urea and electrolytes) in the morning. I have no idea why Dr Reid asked for the blood count for Mrs Gregory. It can be used to monitor or indicate all manner of things – infections, illness or organ impairment.

On 8 October I have recorded "continues to feel nauseous at times, small amount of diet taken, remains in bed of own choice." Nauseous means to feel sick. Mrs Gregory would have been encouraged by the nursing staff to mobilise although she remained in bed of her own choice.

On 18 October seen by Dr Reid to discuss nursing home with family. The entry relates to the fact that Dr Reid at that time thought that a nursing home placement would be suitable and that the nursing staff should discuss this with the family. When this would have been done the patient would have been referred to social services. At that time the plan was for Mrs Gregory to be returned to be discharged to a nursing home.

On 20 November I have recorded spoke to Pauline, next of kin. She is happy to discuss with social worker, can be contacted at night or weekends. Social services would have to get involved with Mrs Gregory's placement as they would be aware of the availability of homes. They would also be of help in the financial aspect of the care.

On 19 November 1999 I had given Mrs Gregory a 40mg dose of frusemide at 15:30 intramuscularly. This prescription had been verbally prescribed by Dr Barton, written out by Sister Hamblin. Dr Barton subsequently signed the prescription.

From looking at an entry on page 239 dated 19 November I presume that the frusemide was prescribed for shortness of breath but this entry is written by Sister

Hamblin. On 22 November I have recorded 17:20 died peacefully. I have signed the entry and continued no carotid pulse, no radial pulse, no heartbeat when listening with a stethoscope, no visible respiration, no inspiration sounds of breathing when using stethoscope, no pupil reaction to light. That is verified.

It would be normal for the nursing staff to verify death if it was expected and the doctor had written words to the effect of "I am happy for nursing staff to confirm death". This was normal practice during periods when there was no medical cover for the ward in the hospital. Medical cover was only available during Dr Barton or the consultant's ward rounds or during surgery hours when you could phone Dr Barton's practice for her or the duty doctor. They would either advise on the phone or come to the ward. Dr Reid would conduct ward rounds either weekly or every fortnight. He would conduct them with Dr Barton and the senior nursing staff on duty. He would visit every patient, discuss their care and treatment. Any problems with those present, exams the patient's notes and prescription charts, the patient and then treat them if necessary, i.e. prescribe drugs or other treatment. He would also make an entry in the clinical notes. His round would last at least a couple of hours but would also vary every week.

Dr Barton would conduct her ward rounds every morning. She would walk around saying "good morning" to all the patients. Any problems for any patient would be highlighted by the nursing staff to Dr Barton who would then deal with the problem. Dr Barton got in between 7:45 and 8 am and was gone for her morning surgery. She could be in for only five minutes if there were no problems brought to her attention. She also did a ward round on Daedalus Ward at that time.

Going back to Cunningham, we have got Barbara Sharon Ring. Her statement was made on 4 March 2005.

Barbara Sharon Ring

I am currently employed as a team leader for Homecare for the Elderly; that is to say people over the age of 65 run by social services. I am in charge of the rapid response team for the Fareham and Gosport Home Service. I trained as a student nurse between May 1976 and 1979 and qualified as a State Registered Nurse in May 1979. Between these dates I worked for Portsmouth and South East Health Authority. I worked both at St Mary's and Portsmouth Royal Hospital. Between 1983 and 1986 I was employed part-time working two night duties per week as a staff nurse at Thalassa in Bury Lodge. These are both nursing homes for the elderly and are in Gosport in Hampshire.

FAMILY MEMBER: Excuse me, sir. Who is talking?

THE CORONER: Sharon Ring. We are talking about Cunningham.

FAMILY MEMBER: Cunningham, I have got that. Who is the person?

MS BALLARD: It is Sharon Barbara Ring.

THE CORONER:

"Around 1986 I ceased nursing and ran my own business. Early 1990 until September 1991 I was a clerical officer. In September 1991 I reapplied for a nursing position with Portsmouth Healthcare Trust. I was successful in my application and I began work at Redcliffe Annex, the Avenue, Gosport. It is a long stay unit for people over 65.

She was then required to re-register with the United Kingdom Central Council for Nursing and Midwifery and health visiting. I was employed part-time as a grade D registered general nurse. In the period I worked at Redcliffe Annex I worked along with Gill Hamblin, grade G, RGN, and ward manager Sue Dunne, senior staff nurse F Grade RGN and Lynne Barrett, Grade E RGN. As a Grade D RGN (registered general nurse) I was junior staff nurse and as such always worked with a senior staff nurse.

During the period I worked at Redcliffe Annex I read the *Nursing Standard* and *Nursing Times*, both publications concerning nursing and healthcare and in doing so updated my knowledge. I should say at this time that the annex was part of the Gosport War Memorial Hospital. I worked 9 until 3. My responsibilities were to support untrained and junior staff and to be supported by staff senior to me.

I have been asked about entries relating to Arthur Cunningham. There are three entries dated 26 September written by me. Dr Barton wrote the prescription for diamorphine, hyoscine and midazolam. All three of these drugs were put into a syringe driver by me. The syringe driver was already in place and I would have recharged it for 24 hours over 26 September through to the 27th.

She tells us what a syringe driver is. By this date I was an E grade registered general nurse, senior staff nurse, and fully trained in the use of syringe drivers. I can say by reading page 837 that Dr Barton prescribed for Mr Cunningham parameters of 40-200mg of diamorphine, 800mcg to 2mg of hyoscine and 20-200mg of midazolam all to be given over a 24 hour period. I can say at 11:50 on 26 September 1998 I mixed 80mg of diamorphine mixed with water, 1200mcg of hyoscine and 100mg of midazolam. They were all compatible to go into the syringe driver. This was all in accordance with standard medical practice.

As a senior staff nurse I would stand in for the ward manager or the more senior staff nurse above me in the ward. I was in effect in charge of running the ward and this would include the administration of medication to patients. Each of the above entries was initialled by me at the time. I have also been asked about other entries. I can confirm the entry on 25 September and the first entry on 26 September are mine. The entry on the 25th says "All care given this am. Driver recharged at 10:15, diamorphine 60mg, midazolam 80mg and hyoscine 1200mcg at a rate of 50 mmol. That is a fluid measurement. The son was present at the time of report. Carer also visited."

The entry on 26 September says "Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. Mouth care given. Driver recharged at 11:50. Diamorphine 80mg, hyoscine 1200mcg, midazolam 100mg. No phone call from the family this am. Mrs Selwood phoned to enquire on condition. All medication given

to Mr Cunningham was within those parameters set by Dr Barton. Any increases in the administration of medication would be discussed between the doctor if available and the senior nurse. If the doctor was not available the decision based on staff experience and qualification as well as the patient's condition would be determined by the two trained staff on duty.

As regards the use of syringe drivers, I would say that a small butterfly needle is inserted below the skin and the driver applied. The stomach is normally the place of insertion due to the fact that it is the easiest place to put it.

I have been asked why the diamorphine was increased to 80mg on 26 September and who made the decision to increase this dosage. I assume the increased dosage was because of increased pain and the decision would normally have been the doctors although if the doctor was not available two trained members of staff who knew the patient could have made that decision provided it was within the prescribed parameters which it was. This increase would have been over a 24-hour period is not excessive."

Do you want to take five minutes?

(Short adjournment)

(In the absence of the jury)

MR JENKINS: Sir, you raised one matter before lunch about Professor Black and had he said anything about the sensation of drowning and the use of diamorphine.

THE CORONER: Yes.

MR JENKINS: Mr Barker, who was sitting behind me, has typed up all his notes. He has got 99 pages. Can I tell you the two entries that he has marked up – I can tell you them now or tell you later, whichever suits.

THE CORONER: If you tell me now.

MR JENKINS: He was asked questions by you – this is the third page of the notes of 99, so for those who have a note this may help them identify it. He said: "You must be clear what symptoms you are treating. You have not just using diamorphine to treat pain. It is agitation, distress, a sense of drowning. It is extremely useful. You try to titrate the dose to deal with the symptoms. You try to relieve pain and keep the patient comfortable." He talked of drowning on one other occasion and that is when I was asked him questions about Dr Petch's view. Dr Petch said, and I quoted to him that Dr Black of said Dr Petch, he was asked: "What is your view of a substantial dose of 20mg diamorphine and 40mg of midazolam to treat pulmonary oedema and the sensation of drowning?" and this is part of my question. He, Petch, said that that was appropriate and desirable. Answer from Professor Black: "You will get a range of opinion. I would have started at 10mg. I may have increased. I would have wanted to get on top of the symptoms but she was a very frail lady. So you had asked, "It is an emotive question but it highlights what is going on with the patient." Professor Black said: "I did not come up with the phrases." I take him to be meaning the drowning sensation.

"I did not come up with the phrases but in heart failure it is (inaudible) feel. It is very upsetting."

THE CORONER: Thank you very much for that. You know how things stick in your mind. I just could not place it. Thank you.

(In the presence of the jury)

THE CORONER: The next statement is the pathologist that undertook the post-mortem examination of Mr Cunningham. That is the only case out of the ten that you have got where there was a post-mortem examination.

FAMILY MEMBER: Who is the person?

THE CORONER: The person is Dr Yasir. The person we are dealing with is Cunningham.

FAMILY MEMBER: I know it is Cunningham. I am talking about the doctor.

THE CORONER: It is Dr Yasir Hamid. He goes through his qualifications of which there are many and varied. He gives his histopathology experience, surgical pathology, cytopathology. Attended several coroners' inquests in Portsmouth giving evidence based on post-mortem findings, their interpretations and formulation of the cause of death.

DR YASIR HAMID

"In my capacity as a pathologist I conducted a coroner's post-mortem examination on Arthur Cunningham born on Code A at Queen Alexandra Hospital on 2 October 1998. A death certificate has been issued which included bronchial pneumonia and Parkinson's disease as the cause of death. However, Mr Cunningham's stepson disputed these causes and requested a post-mortem to which the coroner agreed. I do not recall this post-mortem but I produce the Portsmouth pathology service autopsy report on Mr Cunningham cause of death bilateral bronchial pneumonia. My remarks are as follows:

The deceased suffered from clinical Parkinsonism for several years. This was complicated by dementia which had jeopardised management. He had been immobile and bedridden and consequently developed a sacral bed sore. Immobile and bedridden patients are also known to be prone to bronchial pneumonia, an infection which has led to the death of the deceased. In my opinion death was due to natural causes.

Any disease leading to death is deemed to be a natural cause.

He gives examples of unnatural causes. He says:

On examining Mr Cunningham's heart I found a blockage disease of two out of three arteries that supply the heart. This blockage disease is up to 80 per cent of the tube circle; that is to say, advanced disease. This disease will cause heart muscle death due to the lack of blood supply. The heart muscles showed past evidence of muscle death but no evidence to suggest a recent episode that would have caused death.

On examination of the lungs both lungs were heavier than normal. The reason is that air spaces were filled with fluid and the small airways filled with pus as an inflammation due to infection. Pus is a product of the inflammation due to the infection as well as the fluid. The main consequence is the lack of oxygen supplied to the body which will ultimately cause organs to fail. According to my post-mortem I would have no knowledge of the drug regime of the deceased which was prescribed whilst in hospital. I do not recall any of this information and I can only rely on the report I have produced. As a result of those findings I believe the cause of death was due to infection in both lungs; in our medical terms bronchial pneumonia."

We can move on now to Robert Wilson.

Christian Buehler (?) doctor, presently employed clinical fellow registrar in medicine at Brighton and Sussex University Hospitals, statement dated 25 July 2005. Details his experience. He says:

"From 1 April 1998 to 30 September 1998 I was senior house officer in medicine at the QA Hospital Portsmouth. My responsibilities were acute general medicine for the elderly on call, one in four full shift, general medicine for elderly clinics under consultant supervision, day to day care of acutely unwell elderly patients, palliative care patients and long term care patients, supervision and teaching of the house officer.

From November 1998 to 1999 and June 2001 to 1 August 2002 I worked as a locum registrar.

On Tuesday 14 June I was referred to police exhibits and medical notes relating to Robert Wilson. I can say that Mr Wilson was admitted to QA on 22 September 1998 with a fractured left humerus. He stayed there until 14 October 1998 when he was transferred to the Gosport War Memorial Hospital, Hampshire, for continuing care.

Firstly with reference to the entries on page 8 regarding resuscitation status, I confirm that my entry of 23 September 1998 reads "Yes" for resuscitation. On 29 September reads "No". Yes means that if the patient stops breathing attempts should be made to resuscitate. Conversely, no means not. Usually on admission "Yes" applies. However, as the patient is reassessed during their time in hospital regarding their health it may become "No" as in this case. "No" is when doctors assess that the process of resuscitation is unlikely to be successful. In this case the doctor in question would speak with the relevant consultant to ensure agreement. The family of the patient would also be spoken to with regard to the decision made.

Resuscitation

Nurses observe the patient. If the patient has no pulse then the resuscitation team are called. The nurses start the resuscitation process at once. This would involve cardiac massage and mouth to mouth. The team then try to establish why the patient has stopped breathing or their heart has stopped and act accordingly. This is the resuscitation protocol. Having observed Mr Wilson between 23 and 29 September

1998, I decided that due to his physical condition – I believe he was an alcoholic – he would not be resuscitated if he stopped breathing at any point.

On 23 September and 24 September 1998, Mr Wilson was given 5mg of morphine. This is a moderate amount of this opiate to administer for painkilling. I did not give this. I believe it may have been my junior, Dr Peres, who I think has now left.

B

He last had morphine on 31 October 1998, again of 5mg. In the case of a broken bone, as in Mr Wilson's case, in my experience the patient will complain of pain. This is normal as the ends of the bone may rub and cause discomfort. I would not increase the dosage from 5mg as the patient would be less mobile and the fact is I would want him mobile in order for the healing process to commence.

C

Opiates have a strong analgesic effect and the more you give the less mobile the patient. Cancer patients who are seriously ill can tolerate huge amounts of morphine and whilst being treated may progress to 30mg twice a day given orally. This would have been reached on the analgesic ladder starting with perhaps 5mg and increasing as their level of pain heightened. There is a conversion scale for dosages orally given morphine vis-à-vis those administered subcutaneously or intravenously. The amount given orally is higher because of its effect.

D

At page 13 of the notes it indicates that on 29 September 1998 I would be reviewing Mr Wilson's resuscitation status. I believe I have already explained this.
Mr Wilson's notes shows there was evidence of alcoholism. His renal function, i.e. his kidneys, were not working properly. His liver function was affected. This whole page was written by me. I noted not for resuscitation in view of poor quality of life and poor prognosis. I also noted that he was suffering from alcoholic hepatitis.

E

On 1 October 1998 in a ward round with the registrar he agreed the dose status regarding resuscitation for Mr Wilson. I can say this as if he had not agreed with my decision then "Yes" would still have applied.

Referring to further pages entry of 8 October 1998, I can say that Mr Wilson had psychogeriatric review by Rosie Lusznat, the consultant psychiatrist. She noted early dementia and depression on Mr Wilson's part. She prescribed 50mg of trazodone.

F

If a patient's liver is damaged caution has to be exercised in the administration of opiates as this can make the patient feel ill. This is noted in the British National Formulary protocol book updated every six months."

MR JENKINS: Can I ask you to read the next sentence to yourself because I do not know whether it is correct.

G

THE CORONER: It is not relevant.

"In my opinion as the patient's condition improves the administration of diamorphine should cease because its effect is to make the patient drowsy and less mobile than may be desirable.

H

Trazodone hydrochloride is given for depression and anxiety.

The notes record that Mr Wilson declared that he drank six double whiskies a day and smoked 40 cigarettes. I have written plethoric face and a red face. The skin at the base of the fingers was contracted which is indicative of alcoholism although equally it could be familial (family trait).

Gynaecomastia is the development of breasts in a man who drinks excessive amounts of alcohol. It was noted that one and a half year's ago in hospital with a heart problem. Also noted spironolactone for heart disease medication. He was administered thiamine, i.e. vitamin B, which is given to alcoholics. He had a deficient diet due to his alcoholism and thiamine would have helped this.

Mr Wilson's state of physical health was such through alcohol abuse that if his health deteriorated to the extent that he were to die it would not be unexpected in the near future."

That is his statement.

We then have Dr Lusznat, who is the psychiatrist who sees Mr Wilson.

DR ROSIE LUSZNAT

"In 1987 I qualified as a specialist in psychiatry. In October 1978 to March 1980 I was employed as a house officer at University Hospitals in Germany. Held the position of consultant psychiatrist since December 1989."

Asked to detail her involvement with Robert Wilson, she said:

"I do not recollect this patient. I note on page 172 of the medical notes a request was made for the patient to be seen by a psychiatrist. I can confirm that I have written the following entry on page 175:

8 October 1998, psychiatrist review.

Thank you for asking me to see Mr Wilson who presents with a history of heavy alcohol intake over the past few years. His current admission was precipitated by a fall resulting in a fractured left humerus. On examination today he also presents with low mood, a wish to die and disturbed sleep ? secondary to pain.

His short-term memory is slightly impaired. My impression is that Mr Wilson suffers with: (1) early dementia; (2) depression. I suggest one sedative antidepressant to raise mood and sleep. I have taken the liberty of prescribing trazodone 50mg morning and night.

I am aware of impaired liver function but this would be a concern with all antidepressants. I shall arrange follow up by our team once we know to where Mr Wilson is going to be discharged."

She then signs it.

A mini mental state examination was done, a standard test of memory and general brain function conducted by trained staff. A person scoring 30/30 has good memory, someone scoring 5/30 has very poor memory. Mr Wilson scored 24/30. This shows he has a slightly impaired memory of brain function. The whole test includes orientation and concentration in addition to memory.

She then describes the various terms that she used:

> Antidepressant given to lift the patient's mood. Taken the liberty of prescription to be taken at night to improve the patient's sleep.
>
> I would have reviewed the patient's notes and test results. In an ideal world the safest option is not to prescribe any medication due to his impaired liver function. However, in order to promote/assist the patient's sleep and general well being I have decided to prescribe an antidepressant as I believe that the risks of not treating his sleep disturbance and depression are greater than the risks of prescribing trazodone."

It is that balancing exercise again.

> "I confirm that I have written the following entry in the prescription chart as shown on page 114 of the exhibits. The entry reads as follows:
>
> > Trazodone 50mg start date 8 October 1998 at 2200 hours. Route (circle) means to be given orally.
>
> I have drawn a line across to indicate the starting date which is to commence on the 8th. However, I note that trazodone was not started until the 9th. I did not prescribe any other drugs. I can confirm I have dictated the following letter on page 117 dated 15 October 1998. This letter relates to my ward visit of 8 October to see Mr Wilson at Dickens Ward QA. The letter is addressed to Dr Grunstein who was the referring doctor. Further copies were sent to the patient's own GP, Dr Durrant, and the appropriate community psychiatric nurse Kit T (name). [They have got to be from Sri Lanka]
>
> Dr Grunstein – Dear John,
>
> Re Robert Wilson
>
> Thank you for referring this 75-year-old man who I saw in Dickens Ward on 8 October 1998. I understand that he was admitted on 22 September 1998 following a fall during which he had fractured his left humerus. I gather he had been drinking heavily prior to the fall and that this had been the pattern for the last five years. I am aware that he had also been admitted in February 1997, again following a fall and a diagnosis of alcoholic liver disease was made.
>
> During this current admission he had become rather sleepy and withdrawn and had appeared low in mood. His nights had also been disturbed. I gather that on the physical side he has a raised MCV, impaired renal function, active alcoholic hepatitis and hypothyroidism. He was treated with IV fluids and gradually improved. He is

now eating and drinking well and appears much brighter in mood. His most recent Barthel score was 5.

Background history

He was born in Ayrshire but has lived in the south of England for the past 60 years due to his career in the Navy. He has one sister who died three years ago in a road traffic accident and two step-siblings from his mother's first marriage. Unfortunately his own father left the family when he was very young and his mother struggled to bring up her five children on her own. There is no history of mental illness or dementia. He himself has been married twice, the first marriage ending in divorce 16 years ago. He had three sons and three daughters from this marriage and there was also one adopted child. His second wife also has a daughter from a previous marriage and I gather from the notes that she tends to drink quite heavily too.

Mr Wilson has been a regular drinker since the age of 20 but his alcohol intake according to his own account has increased greatly over the past five years or so. He used to drink rum but more recently switched to whisky. [He has had to change his drinking habits – is that the expression?] He denies any past psychiatric problems. He lives in a council house with his second wife.

Current medication

Thiamine 100mg daily; multivitamins two tablets daily; senna, two tablets bd; magnesium hydroxide 10mg bd, paracetamol 2 tablets qds.

On examination

Mental state – he was sitting by his bed, appeared calm and was friendly and cooperative throughout my visit. He was slightly deaf and it was difficult to understand him due to the degree of dysarthria and his strong Scottish accent. His speech did, however, seem coherent with appropriate answers. He was subjectively low in mood and objectively easily tearful but also able to smile. His thought content was appropriate and there was no evidence of delusions or hallucinations. He did not express any active suicidal ideas or plans but did admit there was no point in living. His insight seemed well preserved.

Assessment of his cognitive functioning revealed full orientation in place, partial orientation in time and a mildly impaired short term memory. His score on the MMSE was 24 out of 30.

Physically he was obese with his left arm in a sling and his left hand still grossly swollen and bruised. There was also marked oedema of both legs. I gather his mobility remains poor.

In summary, it seems as though Mr Wilson may have developed an early dementia which could well be alcohol related. Alternatively this might be an early Alzheimer's disease or vascular type dementia. In addition he seems to have developed a depression and it is difficult to say whether this was preceding his increased alcohol intake or whether it has developed since withdrawal.

Suggestions for management

I think Mr Wilson will benefit from antidepressant treatment and I have taken the liberty of starting trazodone 50mg at night both as an antidepressant and as a night sedative. I do of course hope he tolerates it in view of his liver and renal failure. Trazodone could be increased as appropriate in 50mg increments.

On the practical side, he may well require nursing home care, though at the moment he is strongly opposed to that idea. I shall be happy to arrange follow up by our team once we know when and where he is going to be discharged."

She then signs that.

"This letter summarises my assessment of my examination of Mr Wilson on 8 October 1998 and also provides details of his history.

Vascular type dementia is the deterioration of brain tissue related to poor blood supply. I have written I do of course hope he tolerates it in view of his liver and renal failure. I refer to the possibility that the impairment of liver and kidney function could lead to Mr Wilson tolerating trazodone less well than if he were a fit person. This is intended to alert the medical team responsible for his care that monitoring of any possible side effects is important."

She then says she had no further dealings with him.

Again, with Mr Wilson you have got Colette Billows, a statement made on 9 January 2006. A statement in relation to Robert Wilson, pages 77 and 642 of his records, she deals with Mr Wilson's transfer form when he left Queen Alexandra Hospital being transferred to Gosport. She says she has written and signed the form 13 October 1998.

The form shows Mr Wilson's personal details including his next of kin showing that he was admitted to QA on 22 September 1998, discharged on 13 October 1998 and that the consultant in charge in this case was Dr Grunstein, his GP was Dr Durrant. Reason for admission was fractured left humerus.

"I noted he had an alcohol problem. Lived with his wife in a two-bedroom house. Prior to his admission he was independent, had two sons, neither of whom got on with Mr Wilson's wife. There was continuing nursing care needs. His Barthel score was 7. This is a scale of 1 to 20. It is an assessment of how independent a patient is and how capable they are of caring for themselves. The score is on bowel and bladder movement, toilet use, grooming, feeding, transfer, i.e. moving about, dressing and bathing and 7 is a low score. I noted that Mr Wilson still had a lot of pain in his arm and had difficulty in moving requiring specialised nursing. Re his low protein, he was on protein drinks. His legs were very oedematous (swollen) and that he was at high risk of breakdown secondary to cardiac failure and low protein. He was also at high risk of self-neglect, starting to retake alcohol again, needs 24 nursing care until arm is healed."

I still wonder what they thought was going to happen to him.

"I wrote in his medication and compliance that he was taking 100mg of thiamine, multivitamins one a day, senna two twice daily, magnesium hydroxide 5-10ml, paracetamol 1 gram four times a day, trazodone 50mg daily, frusemide 80mg daily, spironolactone 50mg twice daily, bendrofluazide 2.5mg daily. She says thiamine is vitamin B. Senna is given to alleviate constipation. Magnesium hydroxide, paracetamol a painkiller, trazodone an antidepressant, frusemide a diuretic, as are spironolactone and bendrofluazide."

We will go to Marjory Wells, again on Wilson. This is Marjory Jane Wells, registered general nurse. She gives her experience and says:

"I joined Gosport War Memorial Hospital as an enrolled nurse in February 1987 initially on the nightshift. At that time there was just a female and male ward based on Florence Nightingale wards – long wards with beds on both sides. I worked two nights a week over the course of the next few years. Between 1993 and 1995 I undertook a conversion course at QA School of Nursing in Cosham. This enabled me to qualify as a registered general nurse Grade D. I transferred to QA in 1996 or 1997.

In 1997 or 1998 I applied for and was accepted as a Grade D staff nurse on Dryad Ward at Gosport. I commenced work there on a day shift pattern. Early shift was from 7:30 to 16:15, late shift was 12:15 to 20:30. My responsibilities included the care of patients on the 20-bed ward, supervision of junior staff, administration of all drugs and liaison with the multidisciplinary team, doctors, physios, social workers and other nurses. I also kept relatives of patients informed of the care that was being given. My line manager in 1998 was Gill Hamblin.

I received both training and certification in the use of IV drugs. I completed a study day at QA in Cosham. I was night staff then. I have heard of the term "Wessex protocol" but do not recall what they are. I am familiar with the analgesic ladder.

With regard to syringe drivers I received on the job training in respect of their use. I also attended a study day with McMillan Nurses at Rowan's Hospice in Portsmouth. I then prepared a basic training pack for the ward and also obtained a video from Graseby, the manufacturer, in the use of syringe drivers.

The named nurse is the nurse in charge of several patients and one who completed care plans and spoke to relatives in depth if necessary.

I believe my tour of duty in 1998 when I went full time was 30 hours a week working from 7:30 until 13:30 and from 2:15 to 8:30."

Slipping from the 12 hour clock to the 24.

"I have been asked to detail my involvement in the care and treatment of Robert Wilson. I have no recollection of this patient but from referral to entries in the medical nursing notes I can state the following:

In those notes on page 261 is a prescription chart. I have administered 10mg/5ml of Oramorph at 1800 hours on 15 October. That is 10mg Oramorph on 15 October at 1800 hours.

The doctor will write up what time the drugs should be given and in this case it was shown as 6, 10, 14 and 1800 hours. It has been written up another dose at 2200 hours. This is not written in stone, however, and these times may change as long as they are at least four hours between.

I have looked at the Dryad Ward controlled drugs record book and confirm that I administered 10mg of Oramorph at 1955 hours on 15 October witnessed by Carol Arnold. There are many reasons why the drug was given at that time but I cannot recall that now.

Page 261 – I see that I have administered 10mg of Oramorph at 1000 hours. I have again looked at the controlled drug record book and confirm it was administered at 10:05 on 16 October. It was witnessed by a nurse with a signature I do not recognise. Oramorph is an opium-based controlled drug, it is given orally, not used in a syringe driver. I have looked at the prescription chart on page 260 and administered spironozole (?) 50mg at 1800 hours on 15 October and at 0900 hours on 16 October. However, there is a cross in that column to indicate that the doctor does not require that dose to be given.

I have also administered trazodone 50mg. The dose is shown as 50mg given at 1800 hours on 15 October. I administered magnesium hydroxide 10mg at 1600 hours on 15 October. I have also administered frusemide 80mg at a time not specified but probably in the morning after the consultant's round.

Dr Barton usually did her ward round at about 8 o'clock daily. She would visit each patient. She did not do weekends or bank holidays as far as I can recall. The consultant's ward round was about once a week.

Page 265 of the notes, which is the patient summary, I have written on 16 October 1998: "seen by Dr Knapman am as deteriorated overnight. Increased frusemide to 80mg daily for ANC. Wife informed. Will visit this morning." I have signed the entry."

In 1998 she gives her name as it was then. Would you have known any of the names of the nurses?

FAMILY MEMBER: Mrs Fernando.

THE CORONER:

"Spironolactone is a drug but I cannot remember what it is used for. Trazodone I believe is for alcoholism, magnesium hydroxide is used for indigestion and for the bowels. Frusemide a diuretic. ANC is all nursing care."

You will recall that Dr Knapman saw Mr Wilson. This is his statement. He is Anthony Charles Knapman, qualified at Bristol University in 1966. He is a general practitioner.

ANTHONY CHARLES KNAPMAN

"During the past 10 to 15 years the partners covered when necessary for Dr Jane Barton who acted as a clinical assistant in elderly medicine at Gosport War Memorial Hospital. I probably worked one night in six; that is to say on call. However, at weekends I would go in both days for emergencies and ward rounds. My role as a GP is to administer appropriate medication to patients as their illness required according to their symptoms.

I have been referred by the police to an exhibit, being medical notes for Robert Wilson born on 8 March 1923, who died on 18 October 1998. I can confirm the entry on page 179 at 642, dated 16 October 1998, is mine. It reads: "Decline overnight with sob (shortage of breath). o/e bubbling, i.e. fluid on chest. Weak pulse. Irresponsive to spoken orders. Oedema ++ in arms and legs. ? silent MI, indicates he may have had a heart attack or deterioration of his liver. ? deterioration liver function. Increase frusemide to 2 x 40 om." That is to say, increase his frusemide to two 40mg in the morning. Frusemide is a diuretic prescription drug.

I note that Dr Peters wrote on 17 October 1998 that the patient was comfortable but rapidly deteriorating and nursing staff to verify death if necessary. I have been referred to a ward controlled drugs record book from Dryad. On 14 October 1998 Wilson was written up for 10mg/5ml of Oramorph. He had two doses, one at 14:45 hours and the other at 23:45 hours. I can say that all I wrote him up for was an increase in frusemide. I believe the reason I was called was due to Mr Wilson's fluid retention. I cannot comment on his other drugs.

I can say that on his transfer to Gosport War Memorial Hospital Mr Wilson was being given 2.5mg morphine intramuscularly every four hours by referring to his drug chart.

Referring to pages 258-262 of the notes, I see that Mr Wilson was prescribed paracetamol, hyoscine (an anti nausea drug). He was not given these. He was administered frusemide, spironolactone, bendrofluazide and diuretic drugs. He was given trazodone, an anxiety antidepressant. He was given thiamine vitamin B multivitamins. Thiamine is given to alcoholics. Mr Wilson was given magnesium hydroxide, a laxative, senna for loosening his bowels. He was given Oramorph, which is morphine in liquid form. This is an opiate given for control of pain.

On 15 and 16 October he was given 10mg three doses on each day and one dose on the night of 15 October of 20mg.

I see on page 262 he was switched to diamorphine, the last dose of Oramorph being given on 16 October at 1400 hours. He was transferred to a syringe driver and 20mg over 24 hours given on 16 October.

On 17 October in the afternoon his dose was increased to 40mg and on 18 October increased to 60mg. The parameters set by Dr Barton were 20mg to 200mg. This is a relatively small amount for someone in pain. I refer to the 200mg. Mr Wilson was only ever on 60mg for one day and that was the day he died. He was also given

hyoscine to dry up his secretions and midazolam to combat anxiety. In my opinion none of the doses were excessive.

My role on the ward was to see any patients referred to me by nursing staff and to deal with their medical problems appropriately. I never spoke with any of Mr Wilson's family."

B Do you want to go on and do the lot this afternoon? How are you feeling? Have you had enough? Shirley Hallman and Gill Hamblin are the two – I cannot remember who that is.

MS BALLARD: Gregory, sir.

THE CORONER: We will do this one last and then we will take Hamblin and Hallman tomorrow. Pem (?) Misra, statement of 21 July also in relation to Sheila Gregory.

C "I am a retired consultant orthopaedic surgeon."

He gives his qualifications.

"I have been asked to detail my involvement with a patient, Sheila Gregory, born on

D **Code A**

I can confirm that on 16 August 1999 I was employed as a consultant orthopaedic surgeon at the Royal Hospital, Haslar. I do not remember the patient. From referring to the medical notes at page 62 I can confirm that on 16 August 1999 I conducted a ward round in my capacity as consultant orthopaedic surgeon. I was accompanied by Dr West."

E He tells what the notes say:

"To clarify the notes, the ward round was being conducted prior to surgery to prepare Sheila Gregory for the operating theatre. Her right leg was marked with a skin marker pencil. Consent for the operation was obtained. The operation was conducted the same day, 16 August 1999.

F From referring to medical notes, I note that on 16 August I supervised and assisted in the operating theatre at Haslar with a dynamic hip screw procedure to Sheila Gregory who had suffered a fractured neck of femur. It was a routine operation with no complications. The operation involved inserting a five hole plate with a 75mm screw for fracture fixation. Two drains were fitted into the wound to assist with drainage of fluid. At the completion of the operation the patient was placed on E3, an orthopaedic ward. I can confirm that on 17 August 1999 I conducted a postoperative ward round.

G That entry on page 62 of the medical records reads as follows:

"WR Mr Misra, well post op. Plan 1 – check x-ray today. 2) FBC U&E."

The plan was to ensure that the x-ray was seen and recorded. The full blood count was to check postoperatively mainly the levels for haemoglobin. Urea and electrolytes – this was to assess her electrolyte balance sodium potassium levels.

H

As a result of this request a report detailing the patient's full blood count and urea and electrolytes was obtained which is as follows:

Haemoglobin – normal for a person of this age, white blood count normal, platelets again normal. Sodium slightly low. Potassium (inaudible). Bicarbonate normal. Urea normal. Creatinine satisfactory though slightly raised. These results were within the normal limits for someone recovering after an operation.

In referring to the medical notes, I can confirm that I conducted a ward round on 19 August which reads as follows:

Two days after the operation afebrile (?) normal temperature, mobilising slowly, encourage oral fluids.

From referring to the medical notes I can confirm that I conducted a ward round on 23 August. The entry I believe is written by Surgeon Lieutenant Mackay which reads as follows: 152 post at DHS progressing well. Can only walk with assistance. Feels generally well in herself. Plan: (1) continue gradual mobilisation; (2) refer to Gosport War Memorial Hospital for period of rehab.

To clarify this entry, the patient has progressed well since the operation. There were no complications with regard to the right dynamic hip screw procedure. The plan was to transfer the patient to Gosport for further rehabilitation. The plan was to transfer the patient to Gosport for further rehabilitation. Requested that a consultant geriatrician assess the patient for transfer and rehabilitation.

I note that Dr Tandy, the consultant geriatrician, examined and assessed Sheila Gregory on 23 August 1999. I can confirm that until 25 August 1999 I conducted a ward round with Surgeon Lieutenant Mackay. The entry reads as follows: "Nine days postoperatively, mobilising slowly and assistance from physios. Awaiting transfer to GWMH. Temperature 37.5. Plan as above. CXR – chest x-ray – MSU (midstream urine) examination; FBC, full blood count. ESR – erythrocyte sedimentation a process involving a centrifugal check to ascertain if there are any infections or chronic conditions."

I can confirm that on 31 August 1999 I conducted a ward round with Surgeon Lieutenant Mackay and the entry reads as follows:

"WR Mr Misra. ROS (removal of suture) wound healing well. Mobilising slowly. Awaiting bed at Gosport. Temperature 37.5 marginally raised, otherwise well. Cough – no cough. Chest clear. Plan: encourage oral fluid intake. Repeat U&Es tomorrow. Stop oral abs (antibiotics)."

The patient had a marginally raised temperature, her chest was clear, there was no evidence to suggest a deep venous thrombosis. That and chest infections are the two most important postop complications where checks are conducted. I note that the patient was on erythromycin, an antibiotic which was commenced on 27 August 1999. I had no further dealings with this patient after this date.

To summarise this patient she was an elderly lady who had a routine right dynamic hip screw operation with no serious complications. She stayed in hospital for approximately two weeks during which she was mobilised with the help of a physiotherapist. She was given precautionary treatment for a DVT and chest infection. Her medical records show she was transferred to Gosport on 3 September 1999 as planned."

Anything arising from any of that? Then in the absence of anything else, shall we call it a day? We will have short morning tomorrow and you can start Easter early and have a longer one in that sense. Thank you very much. See you tomorrow.

(The jury were released to the following day)

THE CORONER: I note Mr Leiper is not here, Mr Sadd is not here. I just wondered if there was any mileage in perhaps exploring the type of issues that you want the jury to deal with.

MR JENKINS: I would find it very helpful myself to hear your initial view. You will know perhaps that I am in chambers with Mr Sadd and Mr Leiper and I can promise you that any view that you express I will pass on to them.

THE CORONER: I think the areas of concern are the clinical regime at Gosport. I think that has got to be a concern to me and to the jury. The degree of supervision; the fact that it is a GP unit I think may have affected the regime in the hospital – the input of the consultants – I wonder if that was sufficient and whether there was enough involvement? That concerned me.

I think the question of appropriate opioids, whether the dosage was appropriate, whether the medication – I did not know how to put this – played a material part in death. I have been thinking about this mainly at unreasonable hours of the morning because I do not know how to put that in a way that is non-judgmental. It seems fairly significant, being perhaps the most significant factor for the jury. I want them to go with a series of sequential questions that have yes/no answers. That is incredibly difficult. In order to achieve a narrative verdict that is going to be meaningful we need to have that as a series of questions that are progressive.

You may have other matters that you think are significant and Mr Leiper and Mr Sadd may well have matters that they want to put in that I suspect I am going to throw out as not being appropriate, but we can have that argument on Tuesday.

MR JENKINS: Of course. Can I just give an instant response to what you have just put to us. My own view is that the principal function of the jury here is to determine the cause of death.

THE CORONER: That is the first thing that they are going to have to do with each one.

MR JENKINS: Indeed, what was the cause of death? Secondly, what led to the death? There may be factors which did not lead to the death but which involved the way in which the doctors dealt with them, any prescriptions that were issued. It is certainly my view at the moment that if any prescribing for the patient or administration of drugs did not play a role in death well then it should properly fall outside.

THE CORONER: That is why I put the question. The problem that the jury has got is what actually is their function. It really is to say why these people are dead. We have got the causes of death and they are going to have to make a decision on a direction from me and that will be fairly arbitrary in the light of the expert evidence that we have had and, let's face it, my 20 years' experience of dealing with death certification. I think the regime at the hospital has got to be part of their consideration as a progression. If they answer No to any of these questions, that is fine, there is no difficulty in saying that no it did not play a part in it, but how they came about their death is really what we are dealing with.

MR JENKINS: My initial response is that if this were an inquest where Article 2 was engaged then of course a wider inquiry in what circumstances would be appropriate. Article 2 is not engaged and that was something that you identified and with which I certainly agreed at an early stage. It meant under two months for the inquest rather than more. My first reaction is that it is not necessary to determine by what means these patients came about their death. To go into a commentary or a factual recital of the allocation of resources to the specific ward and the War Memorial Hospital that the patient was treated ---

THE CORONER: No, I do not want to do that. I want to say did it have a material effect? It is building a picture of these people died. There is criticism of the drug regime; there is criticism of the dosage. I want to be able to either knock that on the head or say there is some argument about it if the jury is convinced that that is a significant factor.

I think they are well able to do that. It is how you phrase it. I do not want a great long narrative verdict. I just want them to complete a questionnaire, a tick-box.

MR JENKINS: I understand. Forgive me for offering this now – it is not the argument but if there is to be argument it will follow later but I offer it up so if you are lying awake, sir, in the wee small hours for the next few days you will have my thoughts to cogitate on.

THE CORONER: Will that be a good thing or not?

MR JENKINS: Let's hear what I have to say. What I am suggesting is that it would be ideal if the jury were to say of a particular patient, let's say Mr Smith, that he at the age of 91 had a fall at home and broke his hip, that he was admitted to the Queen Alexandra, subsequently discharged after treatment and admitted to the War Memorial Hospital. He died on such and such a date and the jury then give their verdict as to the medical cause of death. That may be it. They may say that he had been treated in the time leading up to his death with drug A and drug B administered by syringe driver, but if they find that that was not playing a role in the death it would be inappropriate for the jury to start saying whether if the drug had not been involved in the death whether it was appropriate or inappropriate. We are here primarily to establish cause of death and by what means the patient died and if a drug had been prescribed, we know that the range was never used to the full extent ever.

THE CORONER: That is right.

MR JENKINS: For the jury then to say well he was prescribed in a range that was inappropriate does not assist.

THE CORONER: I think that is exactly right but that which was administered.

MR JENKINS: That is a different question. If the jury find that the drug that was administered did not play a role in the death, it is not appropriate, I would suggest, for the jury to be saying whether that was administered was appropriate or not.

THE CORONER: So you would put that as the first question.

B MR JENKINS: I would start off with a recitation of ---

THE CORONER: I have *"The deceased was an inpatient at Gosport Royal Memorial Hospital, was receiving opioid medication by syringe driver at the time of death."*

MR JENKINS: Yes. He died because of this or that reason.

C THE CORONER: We will have an inquisition which will be the standard inquisition that we now produce and instead of boxes 3 and 4 being completed, it will say *"see attached"* and what I anticipate is that I will attach to the inquisition the questionnaire or however it is to be done.

The only reason I say a questionnaire is because I believe that we need to deal with all ten of these in the same way. I will invite the jury to consider all ten at the same time. I am not D going to send them out with one and get them to come back because I think they need to work through all of them because each one will give them a take on the others. Does that make sense? It enables them to think them through in the same way so that they are not going off on a tangent and then wondering if they should have changed their mind.

MR JENKINS: I know Mr Leiper's work in progress, if I can put it that way – I know he was taking further instructions and I am sure, even though he is absent, he would not mind me E saying that his schemer questions for the jury involved at an early stage was the prescription appropriate? Was the administration appropriate? Then it goes on to look at did it contribute to the death? What I would say would be quite unfortunate is if we have a case where the drug was not involved in the death, did not lead to the death, did not play a contributory role or causatory role in death, that the jury should already have said it was an inappropriate dose.

F THE CORONER: That is a question of putting the questions in the right order, is it not?

MR JENKINS: It is. If the death was not contributed to by any drug or any treatment that was afforded, then we should stop at that point.

THE CORONER: It is like the natural cause inquest, is it not? Once you reach natural causes you should not really inquire any further because what you have decided is you are G effectively *functus officio*. I think in this case I want to achieve at the end of the day that which will enable the families to move forward within the scope of the inquest. It is not the avenue I would have chosen but it is the avenue I have got and it is the avenue down which we have had to go. Against that background I want to be able to say the drug regime is completely irrelevant in this death and if the jury say no, the drug is not relevant, then fine. That is a question of which order you put the questions in.

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MR JENKINS: Just for the sake of people who are listening, when you said "I want to be able to say the drugs are completely irrelevant", you are saying *if* that is the case.

THE CORONER: Yes.

MR JENKINS: I do understand.

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THE CORONER: If that is all we can do for these families then ...

MR JENKINS: I understand. May I say for my part I found that very helpful just to air the issues that might be relevant.

THE CORONER: How I have dealt with it in the past is I have invited questions to be put into the format and I have then struggled to put it as being judgmental or leading to questions

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of culpability or liability.

MR JENKINS: That is what lawyers are here for to help you. Whether they do help is a decision for you.

THE CORONER: That is right. I think if we can work in that way. Is that all right?

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MR TOWNSEND: Yes. Sir, I endorse what both you and Mr Jenkins have said. It is a question of getting the order right so that one does not stray in an individual inquest into the irrelevant.

THE CORONER: It is very easy for juries to be put off on tangents and the amount of information they have had – I hope I can martial *marshal it in my summing-up – if any of you have anything that is going to help me with my summing-up I would love to receive it

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but I have my own notes and I have put those in working order but I will need to put each individual death into chronological order, or at least the statements into chronological order for the jury if I get it right.

MR JENKINS: I say this rather tentatively but I would hope that the statements given by Dr Barton give a chronology to each of the ten cases. I think there are one or two factual errors that have been identified during the course of the hearing, certainly during the course

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of the evidence. It is a summary – I know that it can be used together with a police summary of each of the cases to give you a history which may assist the summing-up process.

THE CORONER: I will do a standard summing-up in the way I would normally do it.

MS BALLARD: Sir, possibly to assist with the summing-up just for my own purposes, I am conducting a little table here of various issues and evidence on those, clearly not to address

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you on the facts at all but you have invited if documents may be useful, so if you would like that I can always forward its transmission to you.

THE CORONER: That would be very helpful, thank you.

MS BALLARD: I am a little troubled by the suggestion of inviting comments on the clinical review in place at the time when this is not an Article 2 inquest.

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THE CORONER: No, the question in my mind is should there be a question on there for the jury whether that would affect them in how it is dealt with. Fine, make a submission to me. It is just how my mind is working at this stage and what would be relevant from my point of view if I were doing this without a jury.

MS BALLARD: Thank you.

B THE CORONER: Let's do 10 o'clock in the morning and with a bit of luck we will be finished by 11:30, depending on what you have to say to me tomorrow. Are you all coming tomorrow? [Yes]

MR JENKINS: I will be here, sir, but I do not know if Mr Sadd is. We will not be discussing law obviously tomorrow.

C THE CORONER: No, that will be Tuesday and I am hoping that we can deal with the summing-up in its entirety on Wednesday, which might be a push, and so the jury out first thing.

MR JENKINS: I will pass on the conversation we have had to Mr Leiper and Mr Sadd.

D THE CORONER: I have cancelled my sitting week on Monday or is that pessimism?

(The court was adjourned to the following day)

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