GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 27 July 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-TWO)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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A

JANE ANN BARTON, Recalled

THE CHAIRMAN: Good morning. Welcome back. I trust everybody had a refreshing weekend. We are ready for another week of action.

Mr Kark.

Further cross-examined by MR KARK

B

MR KARK: Dr Barton, I do not have very many questions for you arising out of the Panel questions, but I do have a few. When you were asked questions by Ms Julien, you were asked, effectively: when do you now feel you should have formalised any complaint or when should you have formally voiced your concerns? You said you should have written to the Trust formally in 1998-1999 when Dr Reid took over. Do you remember that?

A Yes.

C

Q Because that was a year, up to that year, when you had not had proper medical cover. I just want to understand: why do you feel that you should have done that only when Dr Reid took over? Why have you pinpointed that timeframe?

A I think that we all felt, doctors and nurses alike, that, although the situation was becoming gradually more difficult, we were just containing it and we were just able to manage the rate of admissions and the level of dependence of the patients we were getting.

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I think we all perhaps hoped, when the new clinical director was appointed and when it became apparent that he would also be looking after Gosport, that there would be a proper look at how we were able to look after our patients and the resources we were given to do that. Although he was appointed in 1998, he did not start working on the ward until 1999, and those informal discussions I had with him made it apparent to me that there were not going to be more resources and there was not going to be any change – in fact, there was going to be an acceleration of the rate at which we were getting very dependent, very ill

E

patients – and then was the time to start thinking about saying, "I can't do this any longer."

Q Dr Barton, up to that time when you described yourself as holding your head above water, what change did you make to your practice or the practice on the ward to ensure that your patients' safety was kept at the right level?

A Just worked harder.

F

Q Yes.

A Because that is what you did in those days. Went in more often. Came back more evenings. Gave up more time. Which I did not resent. I did not mind doing it because I felt the patients and the staff deserved it, but it did become more and more intrusive into free time and private life.

Q But this comes to an issue, I think, that Mrs Mansell asked you about, which was who

G

was there to challenge your practice? Who guards the guard?

A That is a philosophy that did not really exist in those days. We did not do clinical audit meetings; we did not look over our shoulders at each other all the time; we were so busy getting on with doing the job and doing it well.

Q You also told the Panel that you regarded Gosport War Memorial Hospital as a community hospital. Yes?

H

A Yes.

Q In what way did that affect the level of care that you provided?
A It made it better because I was looking after my own patients and my own patients' relatives. Money was raised within the town to look after that hospital to supply it with equipment we needed and there was a force multiplier of affection for the town's own hospital and the people who worked in it.

Q Did that lead to a reluctance to return patients to the acute hospital?
A Not at all.

Q You were asked by Mr Payne about your anticipatory prescriptions. He used these words to you, I think, that it looks as if it was "one-size-fits-all". You said in respect of these patients – and I am sorry I do not have the transcript in front of me – that it was obvious they were not going to be rehabilitated and that at some stage they would need terminal care.
A Yes.

Q Is that in relation to all those patients for whom you wrote out these wide doses of opiates?
A I thought that what Mr Payne was perhaps suggesting was that it was something that I wrote up almost on arrival in case the patient was to go down that line. I tried to explain to him that you are looking at a very tiny, tiny minority of the patients who went through our wards who were chosen by the police because they were particularly different and difficult to look after, so that my what you chose to call normal range of anticipatory prescribing was something that I would consider and use when I thought the time was right for that particular patient. That is why you have seen it in several of these case and you have also seen that it was not always 20-200 mg, it was a range which I felt, in my clinical judgment at that patient's bedside, was going to be appropriate for that patient's symptoms.

Q Dr Barton, you are not saying, are you, that it was only in respect of these 12 patients that this Panel are looking at that you wrote out these very wide prescriptions?
A I am not saying that at all, but I am saying that in a number of patients whom you have not been looking at the syringe driver was probably never even given.

Q Yes, that may well be right but ----
A Because they got better, not worse.

Q But I just want to have it clear, when you talk about these 12 cases and the police picking them out especially – and this is not a police prosecution, this is a GMC prosecution, you understand – you are not saying that they were exceptional because they were the only ones for whom you wrote out these prescriptions.
A I am not, no.

Q Right. What was it that you are saying which was exceptional about these 12 cases? Can we look at them for a moment? I am just going to take the first five or six. Patient A was very depressed and had an ulcerated left buttock and hip. Patient B had had a stroke and a fall. She was diabetic and incontinent. Patient C had carcinoma of the bronchus and was depressed. Patient D had a resolved UTI and dementia. Patient E had a fractured right neck of femur and dementia. Patient F, just by way of example, had a left fractured neck of femur. We know about the circumstances of all the patients in this case. What are you saying is exceptional about any of these cases?

A A I am saying that all the patients I looked after through that 12 years were exceptional in their own way. They are not bundles. They are not letters 'A' to 'F'. They were real people and they had real and difficult problems of management of their symptoms at the end of their lives.

Q That I entirely understand but you are not saying, are you, that these 12 patients were any more difficult or worse than any of the hundreds of patients that you dealt with? You
B dealt with a range, did you not?
A I did.

Q And these 12 people were within that range, were they not?
A Yes. But they stuck out for some reason. They were focused on originally by the police investigation for some particular reason.

C Q I understand that but that reason revolved, I suggest, around your treatment of the patients themselves.
A My treatment of them depended on the problems that the patients in front of me had.

Q You were also asked, I think by Mr Payne, about the position of making the decision about returning any of these to the acute hospitals.
A Yes.
D

Q I just want to ask you this in relation to any of these 12 patients. Before deciding that any of those patients were too ill to transfer, except of course for Mrs Richards, did you make a call to the hospital to find out if they could take them?
A No. I was a practising GP at the same time in the town. I was on call for my own patients most days. I was well aware what the bed state was. We did not get emails in those days, we got pieces of paper down from the Trust saying "We have a bed crisis." "We are
E not able to admit cold surgical patients." "Please do not admit patients unless it is absolutely necessary." I was not working in the vacuum of a cottage hospital; I was working in the community with the Trust all the time.

Q Yes, and that pertains, does it, for the entire period 1996, 1997, 1998 and 1999?
A It was beginning to ramp up in 1996 because continuing care was beginning to fade out even in the Portsmouth district and the bed crisis was beginning to start. It was not as
F acute as it was in 1998-99 but it was there.

Q Because of that, you never felt it appropriate to call the acute hospital to say, "Have you a bed for one of my patients? I need to return them."
A I did not feel it was appropriate to call the hospital and ask them for a bed because I did not feel that a bed would be appropriate for any of those patients.

G Q You also spoke to Mrs Mansell about the over-optimistic view by the previous hospital. We have heard a lot of evidence about that. When you first assess these patients after transfer, you accept that they are likely to be or sometimes at least they will be in a less good condition than they will be pre-transfer.
A Yes.

Q If you decide their path then and there, do you agree that there is a considerable
H danger of setting them on too pessimistic a route?

A A Yes. That is why I said on a number of occasions that we did not write out a formal plan at the time of arrival, because we needed a few days to get to know the patient, for the patient to get to know us, and particularly for us to meet the relatives and find out what their expectations and aspirations were.

Q And yet you were writing out these large variable doses.
A Because clinically, at the bedside, these patients were very ill.

B

Q You were also asked by Mrs Mansell: does it matter if there is an overdose in a patient who is dying?
A I have thought about that question all weekend.

Q Yes, I expect you have. And you answered: "That is a very good question ..." Do you think it is acceptable to overdose someone who you believe is obviously dying?
C A I think that it goes back to "do no harm" and I think that if I was accused of over analgesia or sedation rather than under analgesia or sedation, I know which direction I would wish to err. I would wish in an ideal world always to get it absolutely right for that patient, so that they were comfortable, at peace, and not over-sedated, but it is a very difficult clinical balance.

Q In your mind does there come a point when, because the patient is so close to death, it
D effectively does not matter if you overdose them?
A No, I have never felt that. It always matters. The patient is always your prime concern right up until the moment of death.

Q In that light, do you accept that some of these patients were, by reference to any national standard, given excessive opiates?
A I do not, because you are talking again about a national standard as applied to
E palliative care not terminal care. As you said to me, you have seen no literature on the management of terminal care, I suspect there is not any. I do not think you can do clinical trials and crossover studies and blind trials on people who are in the hours and days of death.

Q You were asked by Dr Smith about why not use an intramuscular dose when a patient had breakthrough pain and you spoke about the importance of avoiding intrusion and peaks and troughs.
F A I did.

Q You said – and again I am sorry that I do not have the transcript in front of me – that these were patients who were going down hill and who are put on the syringe driver because they are dying.
A Yes. And therefore you could be giving a dose of analgesia and anxiety relieving drug that would give you a level of comfort that you could not achieve by assessing a patient
G every hour, every four hours, and giving them injections to control their symptoms.

Q It follows from that, does it not, that you must have made the decision in relation to those patients that they were by then on a terminal pathway.
A I had.

Q You were asked specifically about Mr Cunningham and Mr Farthing and about your
H words "I would find it abhorrent to pull back because withdrawal would be very unpleasant."

A You said, "We were only able to control him just and otherwise he would have been in agony."
A Yes. This was the gentleman ----

Q Again ----
A Carry on, sorry.

B Q Are you saying that you now remember him?
A I have been living with these bundles, these cases, for all these years, and going back and back over them, but this man I do remember. I knew by then that his lungs were filling up with pus. He had a post-mortem subsequently which showed that he had lungs full of pus. Had we reduced his analgesia and his hyoscine and his midazolam, there is no certainty that he would have woken up but my goodness he would have been in agony.

C Q You were asked about Elsie Devine. You were asked: why give her fentanyl and not chlorpromazine? Before putting Elsie Devine on to fentanyl, did you consider making more urgent efforts to get her into Mulberry Ward that day?
A Mulberry Ward from my knowledge of it was not an appropriate ward for her to end her days on. Mr Pittock came down to us from Mulberry Ward to receive medical and terminal care. It would have been quite inappropriate to transfer her upstairs to a different team of people whose focus would not have been on ensuring that her death was dignified
D and pain free.

Q I think it was in relation to Elsie Devine that the consultant indicated they were going to try to find a bed on Mulberry Ward.
A Yes.

Q You disagree with that, do you?
E A Yes – as it turns out from the change in her clinical state from the morning that she started the fentanyl patch and for the remaining three full days of her life, it would not have been appropriate to move her up on to a psychogeriatric ward.

Q You were asked by the Chairman about Professor Ford's evidence about titrating the dose. Yes?
A Yes.
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Q You said Professor Ford was talking about titrating the dose and having one-to-one patient nursing care: "We gave patients comfort and dignity." First of all, let us deal with titrating the dose. Titrating the dose is not a specialist field, is it?
A No, but it is a very intensive field. You need two trained staff and you need somebody with the patient virtually 24/7 to assess their condition, assess their needs. Even to draw up the doses and bring them to the patient's bedside and give them, we simply did not
G have the level of staffing to do that on a ward of 24 people.

Q I want to ask you about the level of staffing that you had in 1996, 1997 and 1998. On average, how many nurses were there on Daedalus Ward and Dryad Ward during the day?
A I would think that there were sometimes two trained staff and four untrained staff.

Q To cover how many wards?
H A Each ward. They did not, in the day time, move between the wards: they stayed on

A their own ward.

Q We have heard repeatedly from nurses about the general excellence of nursing care.
A They were superb.

Q Yes. Patients did not suffer from a lack of nurses, did they?
A No, but, my goodness, they would have if two trained staff had been tied up titrating
B and drawing up and giving injections of diamorphine, even every four hours, let alone every hour.

Q Titrating doses is a basic standard medical principle, is it not?
A It is.

Q And you are saying that under your watch that simply was not being done throughout
C these three years?
A I am saying that. I was not taught it. I was not familiar with using it. I was a community doctor and a GP and it was not practical, either in general practice or even in the best nursing homes or in the continuing care, palliative care, wards where I worked. It just was not feasible.

Q And what you said about that was that when you saw how much these patients
D needed, in other words the quantity of opiates that they needed, it would have taken a long time to find out what your steady state was? Yes?
A Yes, it would have taken 24 hours.

Q That of course is based on the assumption that you got their eventual dose right at the beginning?
A Yes.
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Q Finally, I think it was the Chair asked you again about Elsie Devine and you explained why you had replaced the fentanyl with diamorphine.
A Yes.

Q But the fentanyl was applied because of this particularly acute and difficult episode?
A No. The fentanyl had been on for 24 hours when she had the particularly acute,
F difficult episode.

Q Well, there were two, were there not?
A Her behaviour was deteriorating markedly. I did not know what her creatinine was on the Thursday morning but I knew that her general condition was deteriorating markedly and I was minded to give her something – it was not an injection, it was not tablets because she was spitting them out – to control her general agitation, distress and the beginning of the
G terminal phase. The episode you are talking about is when the fentanyl had reached his steady state and I was then minded that I needed to give an anxiolytic; I needed to give the midazolam. As the Chairman asked me, I could have continued with the patch, left that on and put up a syringe driver with the midazolam in it, but I thought it was a preferable option to change over to the syringe driver and put both in.

Q Are you saying that when you started the fentanyl, it was recognised at the time that
H the patient was not necessarily in pain at all but was simply agitated?

A A And entering the terminal phase and, as I remember, Professor Ford had no difficulty with the use of that medication in that particular indication in that patient.

Q The episode that I was referring to was on 18 November when she is described as deteriorating and becoming more restless and aggressive again and refusing medication.
A Yes.

B Q And that was when the fentanyl was first put on?
A That is the Thursday, yes.

Q Was that effectively as an emergency measure?
A No; you would not use a fentanyl patch as an emergency measure but she was not sufficiently bad that she needed an intramuscular injection of anything, and she was fine during that day. When the family visited that afternoon and when the psychogeriatricians
C visited that afternoon, she was happy and waiting for her daughter.

Q You see, the following day when you started the syringe driver, which Professor Ford, you will remember, described as extremely excessive, you added 40 mg of diamorphine to it.
A I did.

Q Together with the midazolam?
D A Yes.

Q If you were simply trying to control agitation at that stage, why did you need to add diamorphine at all?
A Because I would not have taken away the comfort that the opiate was giving her in her terminal stage; I would not have just withdrawn the fentanyl patch and not given diamorphine to replace it and just put her on midazolam to replace the intramuscular injection
E chlorpromazine.

Q I am sorry; why not? What would the midazolam do to her?
A It gave her sedation.

Q Yes. It helps her with her agitation, does it not?
A But it does not help her with her terminal distress that she was obviously suffering
F from as she approach death and the reason for the fentanyl patch in the first place

Q Dr Barton, the midazolam would have cured her agitation?
A But midazolam is not a euphoric drug, it is not a comfort drug. Again, was it Professor Ford who said that even he felt that there was a place for diamorphine in terminal care for relief of other symptoms than pure physical pain. This lady was suffering mental pain and agitation and distress.
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Q So your reasons for adding diamorphine to this mix was to give her a sense of euphoria as well?
A Yes.

Q Did you consider how sedated this lady was going to become if you added diamorphine and midazolam together?
H A I did.

Further re-examined by MR LANGDALE

Q I just want to ask you something about the last matter you were asked about by Mr Kark and you were also asked questions by the Panel about the same patient with regard to Elsie Devine. What sense did it make to you, or what sense does the suggestion make to you of a patient who is on fentanyl – and Professor Ford did not criticise that – when the fentanyl is removed, not replacing some other kind of morphine? What sense is there in that?
A There would be two very major problems with that: one, she would get a withdrawal; and, secondly, she would become very uncomfortable and agitated and distressed again. It would have been cruel to remove the opiate, having once started on that path.

Q Because the suggestion is being made, as I understand it, by Mr Kark, that when the fentanyl was stopped, you should only have put her on midazolam?
A Yes.

Q Titration: you have said you were not taught it. I would just like you to enlarge on that. What do you mean by that? You have explained why it was not really practical, in terms of what was involved and what was required so far as resources were concerned, but you said you were not taught it. What does that refer to?
A I suppose I mean that any postgraduate teaching courses or any refresher courses that I attended during the time that I was doing palliative care in those days was very focused on what you did in the community. It was not appropriate to teach us how it could be done in a tertiary centre of excellence or in a hospice environment where you had the staff and the resources to administer your opiates in a different way. So the teaching I was given was always aimed towards how to manage these people in the community and of course when the syringe driver came on to the scene, it made life extraordinarily easier, both for us and for the district nurses working for us, because we could offer analgesia and sedation and whatever else, throughout the 24-hour period.

Q In relation to that, going back to 1991, before the hospital development took place in '93, we have been looking at that period of time and what Dr Logan had to say to nursing staff and others in relation to concerns that were being voiced then; was titration being practised then under Dr Logan, do you remember?
A Before the 1991 meeting?

Q In 1991?
A We were using syringe drivers. We were titrating with the syringe drivers. Before I took over that job, I would imagine that the GP responsible for each of those patients in that unit would have to come in and write up four-hourly, intramuscular diamorphine to be administered by the nursing staff until his or her next visit the following day. I cannot remember back that far but I imagine that is how we had to do it until we had a delivery system that allowed us to take out the peaks and troughs and assess the situation throughout a 24 hours.

Q Did Dr Logan ever say to your suggest to you that instead of administering subcutaneous analgesia by means of the syringe driver with a dose range that you should be titrating out for a period of time?
A No, absolutely not.

Q You have answered questions about these particular 12 cases and I am not going to go back over the general remarks that you made in response to questions, but you were making the point that apart from these 12 patients which this Panel is considering, there were a number of other patients who you would have written out an anticipatory prescription for.
A Certainly.

Q In terms of numbers generally, what are we talking about? Is it possible to give us any idea? Are we talking about tens of patients or hundreds?
A I would think approaching hundreds over the 12 years that I was doing the job.

Q You indicated that was important to bear in mind that in a number of those cases the anticipatory prescription was never used.
A Certainly,

Q In what circumstances did that happen?
A The patient became peaceful and died without the need of any medication at all. Professor Ford suggested that on an acute ward only between 30 and 50 per cent of patients needed terminal sedation or analgesia, and I would imagine that those figures would very much be mirrored on our continuing care wards.

Q Taking up from that particular matter with regard to anticipatory prescriptions and anticipatory prescribing generally, you have been asked questions framed in a way that there is a decision made by you that a patient is on a terminal path, and so on. You said in answer to one of the members of the Panel that it is not a case of you, the doctor, putting the patient on the death pathway or the terminal pathway; you are on it because the patient is dying. I would just like you to explain that. What do you say to any description given in terms of your decision as to putting somebody on a terminal pathway?
A We did not do that. Patients were dying. We were aware from 24/7 observation by very experienced nurses that these patients were reaching the end of their life, either very quickly or very slowly. They had reached the point when they were dying, and that was at the point at which you would then consider using the anticipatory prescribing.

Q Actually using it?
A Actually using it, yes.

Q Because obviously everybody at some stage enters a terminal pathway of some kind in their lives. What was it you were endeavouring to do when patient had in your view reached that stage when you saw to it that these drugs were administered?
A We were endeavouring to make that period of passing, however short or long it was, as comfortable and dignified and peaceful as we possibly could.

Q Questions have also been asked of you in relation to overdose of a patient. Did you ever consciously or deliberately overdose, that is the word that is being used, a patient?
A Never.

Q How would you recognise or determine when a patient was on subcutaneous analgesia if a patient was receiving too much in the sense of there being an overdose? How would you recognise that at the bedside?
A I suppose it is a very difficult picture. When somebody is dying anyway and all their organs are shutting down and they are drifting in and out of consciousness, are they

over-sedated? I suppose if they were deeply unconscious, you might say "we are giving too much of the sedative or too much of the opiate; we will reduce the dosage" but the process of dying is so closely mirroring the bad effects and the good effects of the opiates and the anxiolytics are so close to what you are trying to achieve that it would be difficult to be absolutely sure.

Q It has been clear on all sides, including Professor Ford, that the administration of subcutaneous analgesia in the form of diamorphine and midazolam in appropriate case carries with it a side effect or the risk of a side effect.
A Yes.

Q And Professor Ford has made it clear, as indeed have others in this case, that in a patient who is dying, they are on the terminal pathway, the effect or the risk of side effects is something that is looked at rather differently because they are dying. Is that your view?
A Yes. It is otherwise known as the double effect. You accept that the patient's life may be shortened by the drugs you are using but you are prepared to accept that for the benefits that that is bringing the patient.

Q Because if you do not ?
A Because they will take a few hours or days longer to die but it will be in agony.

Q Then the question please about which you were asked some questions with regard to anybody challenging --- I appreciate you said it was not a case of challenge, it was a case of discussions about decisions, but let us keep with the expression challenging. Who would challenge your decisions? First of all, there is you as a GP. Are you making significant decisions with regard to patients in your ordinary professional life as a GP?
A Every day.

Q Is there anybody there who is required to or you feel is necessary to challenge your decisions, the important decisions you are making about patients?
A We are required to challenge ourselves. We are required when we meet as a partnership or as a professional body to talk about critical incidents and significant events and bring them to each other and talk about how a situation was managed and whether the result was appropriate. At that time, I do not remember there being any similar set-up within the hospital, and not in general practice either. It is really a more recent phenomenon – audit and significant events and critical incidents.

Q At that period of time, this is in the 1990s, the time that we are talking about, in terms of patients who were not in hospital and who were receiving syringe drivers to supply medication, did you prescribe patients in that situation?
A I did.

Q Was that involving prescribing subcutaneous medication?
A I was.

Q Would that also involve the administration subcutaneously do diamorphine?
A It did.

Q When you made your decision as a GP that one of our patients ought to be receiving diamorphine by means of a syringe driver at home for example, what was the process there, because obviously it is a pretty important decision?
A It is a very important decision, so it was a decision that was made with the patient, the patient's family and the district nurses, because they were the people who were going to be setting it up and charging it and renewing it every 24 hours. So it was a decision made, if you like, at the patient's bedside, in the same way that it was done in the hospital.

Q I would like you to enlarge on that in terms of this issue of whether anybody should have been available to challenge your decisions. What actually happened when you were treating a patient of yours, as a GP, who in your view required diamorphine administered by a syringe driver without them coming into hospital; what is the process?
A You would have your district nursing service already visiting that patient regularly; they would be helping the family with nursing procedures. They would be assessing the patient, in the same way that my nurses at the hospital were assessing patients; they would be assessing the patients in their own home but obviously not 24/7. There would then be a meeting, a discussion, between all the people involved that the method of analgesia now needed to be a syringe driver and it would be set up by the community nurses.

Q So once that had happened would you be prescribing a range of diamorphine to be ---
A Yes, we had a green card and a white card that stayed at the patient's home so although I was writing an ordinary FP10 prescription for the family or the district nurses to get hold of the drugs, they were written up and they were prescribed on the equivalent of a drug chart in the patient's home with a range on it, nought(?) to 20mg to 200mg.

Q So who would be deciding in an instance like that when and by how much the dose should be increased since there was a range on the prescription?
A The district nurse charging the syringe driver the next time would do it in consultation with me.

Q Did the patient have any input as to the increase?
A Yes. You are still talking here about palliative care. You are not talking about terminal care. At a point when the patient became terminal then quite probably they were not able to make the decision themselves and then the decision would be handed over to the nurse and the family.

Q So the patient in such circumstances would be indicating – just to take an example – that their pain was still not controlled ---
A Yes, absolutely.

Q --- there would be, as you would expect, some discussion between the patient and nurse ---
A Yes.

Q --- and there would be some sort of increase?
A Yes.

Q Was that something you would become aware of after the event in such circumstances?

A I would quite probably become aware of after the event, if I was not available at that particular time then the district nurse had the ability and the right to increase the dose if she felt it appropriate.

Q Leaving aside that particular question and turning back to patients at Gosport War Memorial Hospital, in terms of your decisions as to what was appropriate in terms of, focusing on subcutaneous analgesia, would it be the consultants to whom you would look for supervision in terms of whether your decisions were right wrong?
A What consultant?

Q Was there anybody else to challenge your decisions, apart from the consultants?
A No, only the family.

Q You were asked a question about end-stage dementia, and you were asked to indicate what it was, in effect. Professor Ford gave evidence about this at Day 23/7 when he was asked about it in relation to the patient, Patient E, Gladys Richards, because we may be able to remember – I am not asking for people to turn it up – that Dr Banks described her at some stage, before she ever got to Gosport War Memorial Hospital, being end-stage dementia.
A Yes.

Q Professor Ford was asked about that in his evidence, end-stage illness with severe dementia, and he said:

> "A I think to most geriatricians" – describing end-stage dementia – "that would be describing someone who has severe dementia, and in the latter stages one sees increasing frailty, less activity, less food intake, often the patient develops further wasting and becomes more withdrawn, and one is anticipating they will die within a relatively short period of, say, weeks from usually bronchopneumonia or other complications."

Is that a picture you would agree with or not?
A Both for Mr Pittock and Gladys Richards, yes.

Q That general description?
A That general description. It is almost like a slow inexorable process of the actual dying process that you see more quickly in other conditions, but it happens over a period of weeks and months rather than hours and days.

Q So that is frailty, less activity, less food intake, developing further wasting and becoming more withdrawn?
A All of those.

Q All those signs?
A And then superimposed on top of those sometimes very bizarre behaviour patterns, like the screaming and the hanging on to the bars and those sorts of things. Presumably, again, control mechanisms in the brain have shut down.

Q You were asked a question about Mr Packman, and I just want to deal with the situation in terms of when you saw him because I think you said in your evidence that when you first saw Mr Packman you thought he was probably dying, is that right?

A A Yes.

Q Perhaps we can just register the fact, as the patient history shows, perhaps if you just get the patient history for Mr Packman, please, so we can deal with it. I am focusing on when it was you first saw him: if we look at page 10 of the patient history for Mr Packman do we see there the date of his admission to Dryad?
A Yes.

B

Q He was admitted on 23 August, as we will remember it was Dr Ravindrane who dealt with the admission, that is his review note there.
A Yes.

Q In terms of your seeing him I think we go on to 26th, is that right, on page 13?
A Yes.

C

Q We can see there that you reviewed him – we have been through this more than once – is that the time you are referring to, the note on page 13 says:

> "Seen by Dr Barton this afternoon; await results of haemoglobin. Further deterioration etc. Verbal order from Dr Barton ..."

D An instant dose of diamorphine was given at 6 o'clock that evening: is that the time you are referring to?
A Yes.

Q We can see over the page, on page 14, the note of your review that day:

> "Called to see male; clammy; unwell, etc."

E

Yes?
A Yes.

Q That is the occasion you are talking about?
A Yes.

F Q Lastly this, in terms of transfer back, an issue which has been raised with you more than once, when you got a patient who was ill, and it is being suggested that you should have transferred the patient back to the referring hospital or maybe to another acute ward on another hospital, what comes first, calling up to see if there is a bed available or deciding whether the patient should go back?
A The latter.

G Q Would there be in any sense, in your view, of calling up the hospital concerned before making that decision, to see whether they had a bed available?
A None, at all.

Q If, in your view, a patient should be transferred back what would you do in terms of seeing to it that they were?
A I would do exactly as I did in the case of Gladys Richards, I would write a letter to the
H consultant who had seen her; I would contact either him or his registrar and I would say "This

patient needs to come back to you". I would make it so but I would know that it was going to be difficult, but it would not stop me doing it if it was appropriate for that particular patient, as it was for Gladys Richards that day.

MR LANGDALE: Thank you Dr Barton, that is all I ask you. Sir, those all the questions I have.

THE CHAIRMAN: Thank you very much Mr Langdale. I do not know if you want to take a break now. It is a little early but it would probably be a convenient time.

MR LANGDALE: Mr Jenkins is going to be dealing with forthcoming witnesses today, and certainly tomorrow. I think he is indicating that a break now might be sensible.

THE CHAIRMAN: Very well. We will take 15 minutes now, please, ladies and gentlemen.

(Short adjournment)

THE CHAIRMAN: Welcome back everyone. Mr Jenkins.

MR JENKINS: I will call Isabel Evans, please. The Panel will recall the name if they go back to folder 1/tab 6, the name is there a few times.

ISABEL EVANS, Affirmed
Examined by MR JENKINS

Q (After introductions by the Chairman) Would you tell the Panel your full name?
A Isabel Evans.

Q Is it Mrs Evans?
A It is, indeed.

Q I think you qualified in nursing as long ago as 1961?
A I did indeed.

Q I think you went through a number of changes in your jobs over the years, but you retired in 1996, is that correct?
A That is correct.

Q I think in 1966 you started work at the Gosport War Memorial Hospital as a staff nurse in what was then an accident and emergency department?
A Minor injuries, yes.

Q I think you later, towards the end of the 1970s, became ward sister in the female ward at the Gosport War Memorial Hospital?
A That is correct.

Q And subsequently, in 1988, you became matron?
A Yes.

Q You eventually became Patient Care Manager, is that right?

A A Yes.

Q Which was the role you fulfilled until you retired in 1996?
A By the time I retired in 1996 I was actually the Hospital Manager.

Q Can you tell us, when you were Patient Care Manager what was the extent of your responsibility?
B A In that role I was responsible for all nursing, catering and domestic services within the hospital.

Q We know that some clinicians had responsibilities across not just one but several hospitals: did you have responsibilities outside the Gosport War Memorial Hospital or were you just confined to that hospital?
A Just to that hospital and obviously the annexes that were attached to it.
C

Q At that time, 1990-1991, what was the extent of the Gosport War Memorial Hospital and any annexes? Were there several wards?
A Yes, you will have to forgive me because at that time we were doing a rebuild of the hospital but if my memory serves me correctly we still had the two wards, the male ward and the female ward.

D Q Was there still a minor injuries unit at that point?
A There was still a minor injuries and an outpatient department.

Q Was there an operating theatre back then?
A Yes, there was. I confess I cannot remember what date the operating theatre closed but I think it was possibly still open at that time.

E Q We have heard that there was at least one annexe and one of them was known as Redclyffe?
A Yes, we had two annexes, one was Redclyffe and one Northcote Annexe.

Q Was that an annexe on the same site or was it on a different site?
A No, a different site.

F Q Can you tell us when you took control as Patient Care Manager of the Gosport War Memorial Hospital as a whole and the Redclyffe Annexe, how were things going on the nursing side at Redclyffe?
A At first all appeared to be well but at that time the only problem we were probably experiencing was getting staff. But it was very difficult at the general at that time; a lot of the nursing staff were going into nursing home because, quite frankly, the pay was better.

G Q I understand.
A Which was reflecting on us, particularly the annexes, because they were small units. They were not attractive to nurses who were looking to progress in their careers.

Q We know that the War Memorial Hospital was not a teaching hospital, in the sense that doctors would not be trained there. Would nurses be trained there?
A No.
H

A Q What would you say about the morale or the nursing practices and treatment of patients that was evident at the Redclyffe Annex when you were there at the beginning of the 1990s?
A Shortly after I took over the unit problems did start to arise. I would say that the morale down there was very low. I had several complaints from members of staff on different issues relating to patient care.

B Q Were these complaints that affected other members of staff?
A Yes.

Q I wonder if you can help us with some examples, but without giving us names necessarily.
A Yes. Those complainants were nursing auxiliaries, untrained nurses. One complaint was that patients were being force-fed and basically not given the choice in what they did or
C did not do.

Q Yes.
A And that they were not always treated with the greatest of respect.

Q Right. We know that towards the end of the 1980s Sister Gillian Hamblin arrived at Redclyffe.
D A Yes.

Q She took over Redclyffe and, subsequently, after the reorganisation of the hospital, she became nursing sister on Dryad Ward.
A That is correct.

Q I think Dryad Ward and Daedalus Ward came into being at about 1993.
E A That is right.

Q Does that sound right?
A Yes.

Q I wonder if I could ask you about Sister Hamblin's arrival towards the end of the 1980s and whether that brought about any changes or whether there were any tensions after
F she arrived on Redclyffe.
A She initially came, if my memory serves me correctly, from St Christopher's Hospital, which was another long-stay unit, as the senior staff nurse to the then sister, shortly after which the sister went on long-term sickness; so she in fact ran the department.

Q She was acting up.
A Yes, for at least six months prior to her being made up as the sister of the unit.
G During that time she did introduce many improvements into the general nursing care that was being given to the patients.

Q Yes.
A And obviously seemed to have a great knowledge of elderly care and a great empathy with the patients.

H

Q Clearly you remained at the War Memorial Hospital for a number of years after Dryad Ward came into being.
A Yes.

Q You will have seen Sister Hamblin working at Gosport over a period of about eight years or so from when she arrived.
A Yes, it would have been about that.

Q Again, just looking as a totality at Sister Hamblin's care for patients, what would you say about her abilities and skills as a nurse?
A I never found any reason to criticise them at all, and I was always more than happy with her care that she gave to the patients.

Q If she was instituting changes when she was acting up as senior staff nurse and then once she was appointed sister on Redclyffe Annex, were those always welcomed by perhaps nurses who had been there for a longer period of time?
A No. Change was not always welcomed by all the staff.

Q I understand. We know that Dr Barton was appointed as the clinical assistant in 1988 and she started at the Redclyffe Annex and obviously provided care for patients on the two wards, Dryad and Daedalus, once those came into being in the 1990s.
A Yes.

Q What was the provision of medical care for patients before Dr Barton arrived as the clinical assistant?
A Before she came there would be a designated practice within the town that provided care for the elderly care patients, and it was very much on an ad hoc basis: if we had a problem, we called in a doctor, but if we did not have a problem, we did not see one.

Q Right.
A Other than on the consultant's round, which was once a week.

Q Yes. Once Dr Barton did arrive as the clinical assistant, how did things progress?
A We had daily visits from Dr Barton.

Q Was that a good thing?
A Very much so, yes.

Q The Panel has heard that Dr Barton would be in every weekday morning to see patients.
A Yes.

Q And, as required, later in the day.
A Yes.

Q Either to admit new patients.
A Yes.

Q Or to review patients or see relatives.
A Yes.

Q Perhaps it is obvious, but did that make things easier so far as caring for patients was concerned, and also speaking with relatives, compared with the provision that had been there before.
A Yes. She obviously was aware of the patients, as we were, and knew them and knew their problems and she would come and inquire, if the patient had a problem the previous day, as to how they had progressed or otherwise.

Q You have suggested that there was some resistance to changes brought in at the end of the 1980s/early1990s. Can you tell us when the use of syringe drivers was started, roughly, at the Redclyffe Annex?
A I think it was in 1991, at the time that we had the problem.

Q Had those been available for a long time or were they relatively recent, once they arrived at the War Memorial Hospital?
A They were relatively recent. If my memory serves me correctly, we had a patient on the female ward who was on a syringe driver at home and had to be admitted into the hospital. I believe it was the Macmillan Nurses who were looking after her at home. They reluctantly let her keep the syringe driver while she was an inpatient, rather than remove it from her. We found it very beneficial – the nurses liked it – and we decided we would try and get some for the hospital, so that this problem would not arise again; so that if we had patients brought in who had been on a syringe driver we would have some of our own.

Q We have been told that they were very expensive.
A Yes, they were quite expensive. If my memory serves me right, round about the region of £100 each, but I would not like to be quoted on that.

Q We have heard much greater figures put to us – more like £1,000.
A Not each. Not each.

Q Fair enough. How did the staff react or respond to the introduction of syringe drivers? Clearly some were in favour.
A Yes. We bought five for the hospital. They were on an "as need" basis throughout. I think what seemed to upset some nurses was the fact that you obviously put a whole day's dose within the syringe at one time, so the figures looked a lot larger than they were used to giving.

Q I understand. How did the day staff react to the use of syringe drivers?
A I would say on the whole they welcomed them.

Q We know that nurses come with different levels of experience and qualifications. We know that a sister or a matron would normally be a G grade nurse.
A Yes.

Q A senior staff nurse, just one rung below, would be an F grade.
A Yes.

Q There might be staff nurses as well, who would be an E grade.
A That is correct.

A Q Were there nurses below them?
A Not there, because one of the criteria for being an E grade nurse on grading, which was shortly before then, was that if you spent a certain amount of your time on duty in charge of the unit then you qualified for the E grade; so they all qualified under that criterion.

Q Right. What about the night staff? We will talk about one or two specific individuals soon, but would the night staff typically be at the same level of qualification and grading?
B A They were at the same grade, yes.

Q Does that mean that they had the same training or just that they had spent a time being in charge of the ward and therefore got bumped up a grade?
A It was irrelevant, to be honest, to how much training they had had; it was purely because when they were on nights they were there in charge.

C Q Right.
A There was normally just one trained nurse.

Q Does it follow from what you have said that you may have a nurse who has a grading to suggest she is able to be in charge but who does not have much training?
A At that time, yes.

D Q Can I ask about the night staff and any concerns that some members of night staff might have expressed about the use of syringe drivers?
A It was not just purely on syringe drivers; it was purely on the fact of giving diamorphine on a regular basis that they objected to, but it arose at the time of introducing a syringe driver because obviously you cannot help but give that over the 24-hour period.

Q I understand. From your position, did you have a role in dealing with any concerns
E that were expressed?
A Yes. When staff raised concerns over the use of diamorphine I spoke to them and we held a meeting so that everyone could express any views, fears, worries that they had.

Q We have some documentation – and the Panel have seen it over the last seven weeks; we may turn to it in a minute – but could I ask you, as an overview, what your view was as to where these concerns came from. You have told us that the day staff welcomed syringe
F drivers.
A Yes.

Q What was the view of the medical staff about the use of syringe drivers?
A No-one had raised any objections from the medical staff about the use of them.

Q What about the more qualified members of the nursing staff, the sisters, the senior
G staff nurses?
A Again they welcomed them for the patients that required constant analgesia.

Q What was your view of why it should be that some few members of night staff should be expressing concerns about them?
A One member particularly seemed to be under the impression that you should only ever give opiates on an "as need" basis; that is, you waited for the patient to be in pain and then
H you gave it. If they were not in pain, they did not get it. It arose because one of the patients

A we had was experiencing a lot of pain in the mornings. During the day she would be given her opiates regularly. But at the end of the day she would be comfortable and she would be asleep. Because she was asleep, the night staff would then not give her anything form ten o'clock until she woke in the morning, at which point she woke in pain and it would then take several doses before the day nurses could get the patient comfortable again.

Q Would the night staff have seen that patient in pain?
B A No, because she had been having opiates all day and she was pain-free by the time the night staff came. She would have a dose to settle her for the night while she was still pain-free, but going from ten o'clock until six or eight o'clock in the morning the pain would return.

Q Were there discussions between day staff and night staff, so far as you were aware, about that sort of situation and the desirability of allowing it to continue?
C A We started arranging meetings between the day and night staff because there did seem to be very much a divide between night and day staff at that time – it was evident – and these sorts of issues were talked about.

Q I am going to take you to the documentation. If you turn to your left, you should find folder 1. Would you open that folder, please, to tab 6. The first page is meaningless. It refers to something that does not follow, so people can put a line through that if they wish.
D Page 2, I hope, is a summary of a meeting held at the Redclyffe Annex in July 1991 at which you were present.
A Yes.

Q Would that be right?
A That is correct.
Q If we go to page 4, we see your initials in the bottom left-hand corner.
E A Yes.

Q Which might mean – tell me if I am right – that this is your note.
A That is correct.

Q Your summary of the meeting.
A Yes.
F

Q If we go back to the start of the document, this was:

"A meeting arranged for the trained staff at Redclyffe Annex following concern expressed by some staff at the prescribed treatment for 'Terminal Patients'."
A Yes.

G Q Those present are listed.
A Correct.

Q We see you as the first person there named.
A Yes.

Q We see various other names that the Panel have become very familiar with: Sister
H Hamblin, Staff Nurse Giffin.

A A Yes.

Q Staff Nurse Barrett.
A Yes.

Q Staff Nurse Anita Tubbritt.
A Yes.

B

Q And Enrolled Nurse Turnbull at the end.
A That is correct, yes.

Q Just remind us, is enrolled nurse at a lower level than a staff nurse.
A Yes.

C Q Was it then?
A It was then.

Q It reads:

"The main area for concern was the use of diamorphine on patients. All present appeared to accept its use for patients with severe pain, but the majority had some
D reservations that it was always used appropriately...

The following concerns were expressed and discussed:

1. Not all patients given diamorphine have pain.

2. No other forms of analgesia are considered."

E

I know the Panel have read this many times. I can read it again, but are you familiar with it?
A I am very familiar with it.

Q Sir, unless I am asked to, I will not go through it point by point. At the bottom of that page, after the ten numbered points, I think you indicate that you acknowledged that staff concern on this subject was emotive but important.
F A Yes.

Q You say that both Dr Logan and Dr Barton would consider staff views so long as they were based on proven facts rather than unqualified statements.
A Yes.

Q You pointed out that you were not an expert in this field and were therefore not
G qualified to condemn or condone the statements, but you did ask them to consider certain points. Again there are a number, which I will not go through, but could
I point you to number 6. Should that read:

"That treatment sometimes needed regularising as patients condition changed – were staff attributing" –

H rather than "contributing"?

A Yes.

Q "... attributing signs of patient deterioration to effects of drugs?
A Yes.

Q "Few patients remained aware until the moment of death."
B A That is correct.

Q Can I break off at that point and ask you to give us your experience of patients approaching death, patients in the days or hours before their death. Was that your experience, that few patients remained aware?
A Yes.

C Q What do you mean by that?
A Well, as their condition deteriorated, then obviously their awareness did as well.

Q By awareness, do you mean consciousness?
A Yes, responsiveness, if you like.

Q For that last sentence "Few patients remained aware until the moment of death", are
D you saying that dying patients may drift in and out of consciousness?
A Yes.

Q Does that cover patients who are on medical treatment and those who are not?
A Yes.

Q At the bottom of that page you say again,
E

> "It was evident that no one present had sufficient knowledge to answer these questions with authority; it was therefore decided that before any criticism was made.... we needed to be able to answer the following questions."

You list a number, one of which, the penultimate entry on the page, is:

F

> "Is it appropriate to give Diamorphine in fact due to other distressing symptoms other than pain."

Was that an issue with the concerns that were raised?
A Yes. On several occasions the statement was made to me that the patient was on diamorphine but they did not have cancer. There were certain members of staff who seemed to think that only cancer patients should be given diamorphine or palliative care in this
G manner.

MR JENKINS: I wonder, unless there is any objection, whether you would not mind identifying those members of staff. We have heard from a couple. We have heard a statement read from Sylvia Giffin.

MR KARK: Please do not lead.
H

A MR JENKINS: I was told not to lead, which is me asking questions suggesting the answer. If you want to see these individuals who were present again, you can turn back to the start of this document. One nurse, you told us, suggested that only those with cancer should have diamorphine?
A Yes. Certainly Staff Nurse Giffin was one of them. In fact, I think she was probably the strongest vocal-wise on that subject.

B Q I understand. If I take you through the documents that follow, I do not think you can deal with page 6 because that was not a meeting that you were involved in, or a visit.
A No.

Q But we see the names of several nurses there, including the one you have just given us. If we turn to page 11 – Sir, I turn to 11 because it is the same as page 10 and I have just put a line through one of them – this is a letter to you from a member of the Royal College of
C Nursing?
A Yes.

Q Referring to concerns that had been expressed by staff earlier that year and other discussions that had taken place. The letter reads in the second paragraph:

> "It had been understood that the concerns raised would be addressed and the RCN had
D anticipated that clear guidance/policy would be promulgated as a result of the very serious professional concerns Nursing Staff were expressing."

The letter reads on:

> "It is now a matter of serious concern that these complaints were not acted upon...."

E At the bottom of the paragraph the writer says,

> "We now expect a clear policy to be agreed as a matter of urgency."

If we go on, I do not think you can deal with page 13 because again it is not a piece of correspondence with which you had any involvement. If we go on to page 14, again correspondence with which you were not involved but it may be that you saw it. I do to
F know if you recall?
A I cannot remember seeing it at that time.

Q There is reference in, and it a letter dated December 1991, in the second paragraph which says:

> "I was contacted by a staff nurse who is currently employed on night duty in
G Redclyffe Annexe...."

and it sets out the concern. It then deals with correspondence with you in April 1991; it refers to a meeting that took place in July 1991 and says in the fourth paragraph:

> "Following the aforesaid meeting two study days on 'Pain Control' were arranged, as you will see from the minutes relating to the meeting...."

H

A It says,

> "These study days did temporarily alleviate the worries of the staff."

Would you have had any role in arranging study days for members of staff after concerns had initially been expressed?
A Yes, I contacted the nurse specialist in pain control who arranged and came to the unit B to give the staff the study days, and obviously gave them then the opportunity to ask any questions.

Q Are you able to help us with the identity of who came to give talks and assist the staff?
A I cannot honestly remember at that point in time. It was arranged through --- his name escapes me at the moment. C

Q Are you thinking of an individual or of a unit?
A He was a nurse within the elderly care.

Q We might come on to his name very soon. If we go over the page, there is reference at the top of the page:

D
> "After receiving this report Isobel responded by sending a 'memo' (copy enclosed) to the trained staff at Redclyffe."

I think we will see in a moment there is reference to the author of this letter in the second paragraph on page 15 saying,

> E "I have been told that it is only a small group of night staff who are 'making waves'...."

Page 16, this is a letter to staff Nurse Tubbritt from you, I think?
A Yes.

Q Thanking her for her letter to you telling you of the meeting that had taken place in October. You say: F

> "I am happy to discuss any areas of concern that staff may have, in fact I would welcome open discussion as I feel the only alternative is disruptive criticism which achieves nothing positive and leaves staff feeling frustrated."

A Yes.

Q Over the page, is this the memo that we saw referred to two pages ago? It is G distributed, as we see from the bottom, to every trained member of staff at Redclyffe Annex, the night sister, the two doctors and a Mr Hooper.
A Yes.

Q Can you remind us who Mr Hooper was?
A Mr Hooper was the --- I am just trying to think what role he would have had at that time. He was possibly the hospital manager, or he might have become the Gosport Care H Manager.

A

Q Was that Bill Hooper?
A Bill Hooper, that is right.

Q We have heard his name before. In your memo you say:

"It has been brought to my attention that some members of the staff still have
B concerns over the appropriateness of the prescribing of Diamorphine...."

A Yes.

Q Can I break off – "still have concerns" meaning after the training?
A Yes.

C Q "I have discussed this matter with Dr Logan and Dr Barton who like myself are concerned about these allegations. To establish if there is any justification to review practice we have agreed to look at all individual cases staff have or have had any concerns over and then meet with all staff to discuss findings.

I am therefore writing to all the trained staff asking for the names of any patients that they feel Diamorphine (or any other drug) has been prescribed inappropriately."

D

You say you would appreciate a reply from everyone, even if it is purely to state that they have no concerns.
A That is correct.

Q You say:

E "I am relying on y our full co-operational and hope on this occasion everyone will be open and honest over this issue..."

A Yes.

Q You say that you want to resolve this issue in a constructive and professional manner.
A Yes.

F

Q Was that right? Was that the approach that you were taking?
A Yes.

Q There is then a letter at page 18 in which I do not think you were involved and a letter at page 19, a copy of which I think you will have received. In which Mr Murray says:

G "As far as I am aware it is not the use of syringe drivers that is the cause of concern..."

A That is correct.

Q Then we go to page 21, please. This is the second memo from you, I think, in which you refer to the one that we have just read.
H A That is correct.

A

Q Again, it is a memo, as we see from the top on the right-hand side, to "All trained staff at Redclyffe" and the various other individuals to whom the first memo was sent.
A Correct.

Q You say:

B "Due to the lack of response to my memo of the 7th November Dr Logan will be unable to comment on specific cases. However we have arranged a meeting for all members of staff at Redclyffe who have concerns on the prescribing of Diamorphine on Tuesday 17th December at 2 p.m. to discuss the subject in general terms.

It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have so I hope everyone will take the
C opportunity to attend and help resolve this issue."

Can I just go back a bit? Were nurses at Redclyffe perhaps dealing with syringe drivers on the ward before they had ever had any training in their use?
A No. The company that supplied the syringe drivers actually sent a trained nurse to the unit and went to visit each department and showed them the use of the syringe driver.

D Q Graseby is the name that we have seen. Is that the company?
A That sounds familiar.

Q Do you know if the Graseby representative was able to see the night staff as well as the day staff?
A She visited each unit several times, so, yes, they would have had the opportunity.

E Q Can I take you to page 23, which I think is the note of the meeting in December 1991. Again, if we go to the last page, the third page of it, on page 25 I think we see your initials?
A That is correct.

Q Suggesting it was your note of the meeting?
A It was my note of the meeting, yes.

F Q Again, going back to page 23, do you see your note of who was present at the meeting?
A Yes.

Q I think everyone turned up. Would that be right?
A Yes.

G Q You detail the history, including a staff meeting on 11 July 1991, a second meeting on 20 August where Steve King, nurse manager, and Dr Logan spoke to the staff?
A Yes.

Q You spoke a few minutes ago about someone in nursing who had spoken to the staff. Was it Steve King you were thinking about?
A It was, yes.

H

A Q The aim of this meeting was to allay the staff's fears by explaining the reasons for prescribing.

"As no one challenged any statements at this meeting or raised any queries, it was assumed the problem had been resolved and no further action was planned."

A That is correct.

B Q You go on with 3:

"Staff were invited to give details of cases they had been concerned over."

That was the first of your two memos that we have looked at, the one in November?
A Yes.

C Q But no information was received. We see that in the second memo?
A Yes.

Q

"It was decided to talk to staff on the general issue of symptom control and all trained staff would be invited to attend."

D You talk about:

"The issue had put a great deal of stress on everyone, particularly the medical staff."

The Panel will have seen before what this paragraph says. Was that from your own observation that some people felt under stress as a result of these concerns being raised?
E A I found it rather confusing because, if you asked the staff if they were concerned that patients were being given two much diamorphine or it was in any way harming them, they would deny this. No, they did not have problems with that. It would just keep going back to the fact that it was patients who did not have cancer that it was being given to. It all seemed to be related to the fact that they were not sure that the type of patient that the diamorphine was given to was appropriate. There was no question at that time put to me that inappropriate amounts were being given.

F Q If we turn over the page to page 24, the second page of your memo, you have listed a number of bullet points in which you stated the problems as you saw it?
A Yes.

Q You invited staff to indicate if they did not agree with your interpretation?
A I would say that it was my interpretation of what problems they had, not what
G problems I had.

Q Can we deal with the first of those.

"We have an increasing number of patients requiring terminal care."

A Yes.

H

A Q Everyone agreed with that statement, we can see from the note after the five numbered points?
A Yes.

Q Can you expand on why it should be that there were an increasing number of patients requiring terminal care in 1991?
A Because of the ever increasing pressure on elderly care beds, the criteria for getting a
B place within what was then classed as long term care was being raised. This resulted in, whereas before patients were coming to us in a very stable albeit disabled state, we were now getting very ill patients coming into the terminal care that quite frequently were dying within a month of arriving in the unit.

Q So the mix of patients was changing?
A Yes.
C
Q That Redclyffe was dealing with?
A Yes. That type of patient required totally different care to a patient that came that you would anticipate would be staying there for a year or more, as had been the norm prior to this time.

Q The second numbered point I do not think I need deal with. The third point, again
D I do not think I need deal with. The fourth point is the particular concern, I think:

"What is questioned is the appropriateness of prescribing diamorphine for other symptoms or less obvious pain."

A Yes.

E Q Again, you have dealt with the fifth point that:

"No one was questioning the amounts of diamorphine or suggesting that the doses given were inappropriate."

A No.

F Q Is that your recollection?
A That was definitely my recollection.

Q We know that Dr Logan spoke to the staff at length. Is that your note of the points that he sought to make?
A Yes.

G Q Again, the Panel are very familiar with these. But, can we deal with several of them.

"(d) The aim of opiate usage was to produce comfort and tranquillity at the smallest necessary dose – an unreceptive patient is not the prime objective."

A Correct.

H Q

A "(g) The difficulty of accurately assessing levels of discomfort with patients who were not able to express themselves fully or who had multiple medical problems. The decision to prescribe for these patients had therefore to be made on professional judgment based on the knowledge of patients' condition to enable patient to be nursed comfortably."

A Yes.

B

Q "(h) It was not acceptable for patients who are deteriorating and require 2 hrly turning to have pain or distress during this process. They require analgesia even if they are content between those times."

A Yes.

C

Q I am going to break off and go on several pages to page 26. You will see that these are notes that the prosecution in this case have placed before the Panel, notes produced by Dr Logan. If you go on to page 27, you will see a typed note from Dr Logan in which he is the first person. When he talks of "I", he obviously means himself, Dr Logan.
A Yes.

D Q Also, we have a letter at page 29 written by Dr Logan which has been placed before the Panel the Panel may have seen but which we have not really been through. Since it is in front of the Panel and you are with us, can I ask you about that letter. It is dated July 1991 which was about the time of one of the meetings which had been arranged with the staff?
A Yes.

Q He writes:

E "Dear Steve",

You and I have referred to Steve King as a nursing manager of the hospital?
A That is correct.

Q

F "Thank you for agreeing to help regarding the use of opiates on poor prognosis longstay patients. Enclosed are the concerns which the staff hold. It seems to centre around the feeling that it is wrong to start subcutaneous diamorphine by pump for <u>any</u> patient who:

1. Has not tried 'lesser' analgesia first
2. Could take oral (or rectal) diamorphine
3. Does not have patient-voiced pain (even though they may be obviously restless and distressed)
4. Has not been discussed at full staff conference!"

G

A Yes.

Q Can we stop there. That is his view, as expressed in this letter, of what the concerns appeared to be. Does that reflect your own understanding of what the concerns were, that

H

A people were being given diamorphine subcutaneously when the patient has not said, "I am in pain"?
A That is correct.

Q You smiled when I read point number 4, "Has not been discussed at a full staff conference!"
A It was one of the suggestions made by Staff Nurse Giffin that we would have weekly
B meetings at which point it would be decided whether a patient should start or not on an opiate, which would mean, of course, you would leave the patient in pain for a week until she decided that she could go on it or not.

Q You laugh. Again, is that appropriate or consistent with the care of patients?
A No.

C Q Let us go on with page 30. Dr Logan writes:

"To me, the important points to make in answer to these questions would be.

1. Patients with distressing pain need adequate analgesia first – once pain is controlled reductions or changes in dosage can be made.

D 2. The subcutaneous route is more convenient for many patients and overcomes problems of vomiting back analgesics, variable absorption. The continuous infusion may allow lower total doses to be used."

A Yes.

Q

E "3. Opiates are analgesic but also euphoriant and thus psychologically beneficial for many patients. Many distressed, uncomfortable, frail, elderly are unable to report their discomfort.

4. Prompt treatment is the best."

He writes:

F

"If you do not agree on any of this, please give me a buzz. Otherwise I think a 15-20 minute chat from you regarding the relief of symptoms and where opiates come in would be just the ticket.

I will try and tee up this for 2 pm on 20 August 1991 – maps, grid references etc provided anticipating the meeting."

G

A Yes.

Q Back to the four numbered points on page 30, from your perspective, as the Patient Care Manager, were the points that Dr Logan, as a consultant, was making valid?
A Yes, they were.

H

A Q To the extent that some of the concerns expressed were along the lines of those set out on page 29, what did you consider to be the merit of the concerns that were being expressed?
A I always felt that to a certain degree the concerns raised were through a lack of knowledge or understanding on what was then classed to be the up to date thinking of pain control; ie to achieve a patient totally pain free on the lowest amount of opiates possible, was the prime example rather than give as and when needed, which often resulted in higher doses having to be given to get the patient pain free.

B Q Do nurses have their own responsibility to keep up to date?
A Yes.

Q The Panel will know very well that doctors, and indeed all professionals, including lawyers, have to ensure nowadays that they undergo continuous professional development?
A Yes.

C Q Do you know if nurses had similar obligations back at the time we are talking about, in the beginning of the 1990s?
A Not prior to 1998. When grading came in, this was the requirement that was brought in if my memory serves me correctly.

Q Let us come back to the note you made of the meeting. We left off at the bottom of
D page 24, which will take you to page 25. You just detailed the points Dr Logan had made and you say:

> "Following general discussion and answering of staff questions, Dr Logan stated he would be willing to speak to any member of staff who had concerns."

A Yes.

E Q It is apparent that there was then a discussion because you say:

> "Comments raised during discussion were..."

and you made a number of points?
A Yes.

F Q The first one is that:

> "All staff had a great respect for Dr Barton and did not question her professional judgment."

Is that right?
G A Yes.

Q When you say "all staff", was that everyone who turned up?
A That was correct.

Q It says:

H

"The night staff present did not feel that their opinions of patients condition were considered before prescribing of diamorphine."

A Yes.

Q Does that reflect what you have already told us as an example?
A Yes.

Q That night staff may not treat a patient if they appear to be comfortable?
A Yes. They still seemed to think they should have the say as to whether the patient required a dose at night.

Q Point (c) is obviously a concern expressed by the day staff:

"That patients were not always comfortable during the day."

Only the day staff would know that?
A That was referring back to what I was saying earlier that, yes, they were finding that patients were sometimes in pain in the morning because they had not had anything during the night.

Q There appeared to be a lack of communication causing some of the problem. Are you able to illustrate that – communication between whom, or a lack of it?
A There were definitely two separate teams within the unit at that time, the day staff and the night staff. Communicating skills were perhaps not very good on either side to be perfectly honest.

Q

"Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms."

A I think this, again, goes back to the fact that the type of patient we were having in the unit was changing, so yes, therefore, the number of patients who required this treatment was increasing. It was because the type of patient was changing and this is what they could not always seem to grasp.

Q We go on in your note to say that you would be happy to talk to staff and you spoke to the staff ---
A Yes.

Q --- after some had left, and you asked if staff felt there was any need for a policy relating to nursing practice dealing with the concerns that had been expressed to you in correspondence and you were told that nobody felt it was appropriate?
A I will say that we already went by the RCN drug policy which we were obliged to, as trained nurses, and the unit also had one so I could not see the point in producing another one because it would have to be identical to the ones we already had.

Q If we go back to page 27, we have looked at it noting that this is Dr Logan's note of that same meeting. Are you able to confirm, looking at the top of the second paragraph, that when invited to talk in general terms about the use of opiates on the long stay wards,

Dr Logan expressed the view that it was often very difficult to know what was best for the very frail, elderly patients who could not express their symptoms and that one could only do one's best in interpreting them. When there was any question that the patients had pain, they should be given the benefit of analgesia?
A Yes.

Q He talks about there being no useful middle range drugs between codeine, dihydrocodeine and diamorphine and there were useful psychological effects producing some psychological detachment and euphoria which can do much for the patient's tranquillity?
A A lot of these patients would not have been capable of taking tablets which narrowed down the choice.

Q We have seen some who could not swallow, we have seen some who refused to take oral medications?
A Yes.

Q It goes on, halfway down that paragraph, that:

> "...it was vital for us to make sure there not more simple reasons for the patient's pain or distress, such as a full bladder or faecal impaction that could be quite simply dealt with. Having established that and being content that the patient was distressed and probably in pain, then one should not hesitate to use opiate analgesia if necessary."

A Yes.

Q Nurse Giffin makes a point, and Dr Logan deals with it according to the body of his note. He said:

> "...it was not necessary for the patient who was tranquil and apparently asymptomatic. On occasions a patient would only become distressed when disturbed, for example when two-hourly turning was necessary. I explained that I felt in these circumstances the patient should have this pain dealt with, even if it was only transient and intermittent. I am not sure if she accepted this view or not."

He goes on to say:

> "... we were all agreed that when opiates were given there was no need for the patient to be rendered totally unconscious. Far from it, the aim was to keep the patient comfortable ..."

As we see from the end of the note,

> "The general concept that improved communications between day and night staff and between night staff and medical staff might help in the future was met with little apparent enthusiasm from Staff Nurse Giffin."

That is his comment. I do not know whether you agree with it.
A Verbally she was agreeing and had no objections, but her body language said differently.

A Q Can you tell us what happened after these meetings in 1991. Was there further training given to staff?
A Yes. We had an ongoing policy of training the staff and identifying training needs and sending them off. We also arranged meetings once a week between the day and the night staff – which I believe Dr Barton initially joined us in – to allow everyone to just discuss care that was being given within the unit generally, not specifically on this topic.

B Q We have heard of a consultant from the Countess Mountbatten, a hospice locally – Dr Bee Wee is the name we have heard being involved in giving further training, as one amongst others.
A The staff attended courses on terminal care outside of the hospital but I cannot remember ----

C Q It is nearly 20 years ago, Ms Evans. No-one would criticise you. Are you able to tell us whether people were brought in to give further education to nursing staff.
A Yes. Staff did attend the department specifically on the giving of opiates in terminal care, but also the staff went out of the unit to attend courses.

Q You retired in 1996.
A That is correct.

D Q Obviously nearly five years or so after these concerns had been raised and the meetings and training that we have talked about had taken place. From your perspective had the concerns been dealt with?
A Yes. And they certainly were not raised again from the December meeting until I left.

E Q We have heard from some members of staff who had been on additional training outside the hospital or had undertaken their own training as to whether their concerns continued at all. I do not need to ask you any more about that. Can I turn to Dr Logan. He was the consultant in geriatric care ----
A At that time.

Q -- at that time. It is clear from what we have seen that he has been expressing his own view about how his patients should be treated.
A Yes.

F Q From your understanding, was Dr Barton providing treatment in accordance with Dr Logan's wishes?
A Yes.

Q What can you tell us of Dr Barton's demeanour when dealing with the meeting or meetings that were held at that time? How did she deal with it?
G A As always, she was very approachable towards the staff. I felt that, considering – particularly after the second time it was raised – she was very restrained. I think if anyone showed signs of any anger, it was Dr Logan. It was certainly not Dr Barton.

Q If he was showing signs of anger, why might that have been, from what you could see?
A Because he had taken the trouble to come over and talk to the staff and arranged for
H Stephen King to come over and they had all stated that they were quite happy with the

A explanations given to them, and then they went to the RCN, rather than come back to us, because they had further concerns. At the end of the day, the nurses were questioning medical treatment – or they appeared to be.

Q You have told us already, and we have seen from the documentation, that by 1991 you had an increasing number of patients requiring terminal care. We have seen that from your document.

B A Yes.

Q Did that position stay the same or did things change after 1991 until you retired in 1996?

A I would say it was still getting progressively worse.

Q Can I get you to tell us what you mean by that.

C A Insofar as the patients that were coming over, I would have found it difficult to class as long-stay patients. They were very close to being acutely ill patients ---

Q What about ----

A -- or rehab.

Q I am sorry, I interrupted you and I may have distorted the sense of what you were

D saying. The state of the patients coming over were worse and worse.

A Yes.

Q So they were not really long-stay patients.

A No.

Q Or rehab patients, you said.

E A Sometimes. Not as often. There would be the occasional rehab patient.

Q Right. Again this is in the period leading up to your retirement in 1996.

A Yes.

Q Why were patients coming in in a worse condition than they had been coming in earlier years?

F A Because of the pressure on the acute beds.

Q Acute beds being other hospitals?

A Yes. In Portsmouth, which is 20 miles plus away from Gosport, they did not have any beds. They had to free a bed, so they would send us, if you like, the least acute patient over. But as the pressure increased on them it also increased on us, because the patients were coming to us at an earlier and earlier time in their treatment or it was the type of patients they

G could no longer do anything for which they were sending to us. On one occasion I remember a patient died within 24 hours of getting to the unit, not because of anything she was given, she received no treatment, but she was just so ill. One had to ask was the 20 mile journey contributing to her death rather than anything else.

Q I was going to ask. In your experience, transferring patients, was that always something that resulted in improvement in the patient's condition or typically did it remain

H the same?

A A No. It was not the ideal scenario, particularly as some of the patients we were getting at that time were not even local patients. They were not even Gosport patients. They were being sent away from relatives at a time when they needed their relatives the most. Certainly I did raise concern on that issue at various meetings at that time.

Q Raised concerns with whom?
A Again, to think back, it would have been at meetings I had with management.

B

Q Did you have the power to change anything?
A No. No. In fact, we would not, because we were at the mercy of what the elderly unit sent to us – in fact the beds were their beds. We just staffed them, if you like.

Q On a question of geography, Gosport is just across the water from Portsmouth.
A If you can swim.

C

Q Or if you can get the ferry.
A Yes.

Q It is a peninsula, effectively.
A Yes, it is.

D Q It is a long way round by road.
A That is correct. I believe it is 22 miles from one hospital and 25 miles from the other.

Q The precise distances probably do not matter.
A I used to claim mileage for it!

Q All right. It is clear from what you have told me that the transfer of patients did not
E always result in their condition improving.
A No. No.

Q One patient, you have said, died the same day.
A Within 24 hours, yes.

Q Did anything happen as a result of that? You have said you spoke to people but did
F not yourself have the power to change things.
A No. Nothing happened that I can remember.

Q Would it have been raised if patients who are unstable, who are acutely ill, are being transferred to Gosport?
A I am sorry?

G Q It is an issue that has arisen before in the hearing about acutely ill or unstable patients being transferred to Gosport.
A Yes.

Q If that had happened, a decision had been made that the patient should be transferred to Gosport, and it is felt on arrival that this patient really should not have been brought or that their deterioration after arrival is due to the transfer, would anyone have complained?

H

A I certainly did not complain directly to the elderly unit. I certainly mentioned it to my immediate boss in the hope that they did. I did not attend meetings or anything that met with the elderly services, so my only route was to go up through my management.

Q I understand. But if you had complained, what do you anticipate would have happened as a result, given the situation that you were dealing with?
A We would have just probably got the same answer we normally did, that they did not B have any option because of the pressure they were under.

Q I would like to ask you about Dr Barton herself and your opinion, as patient care manager, of her as a doctor.
A As a manager, I found her very good to work with. She was always willing to help in any way she could with any project that we had for the unit, whether it was on a professional level or anything to do with the patients or even down to the raising of funds for the unit. She C would help us with that. As a doctor, I found her to be very professional, very caring, very dedicated to the patients she was looking after, and, above all, very compassionate to them.

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

THE CHAIRMAN: Thank you, Mr Jenkins.

D Mrs Evans, we will take a break now. You will be taken somewhere where hopefully you can get some refreshment and recover yourself a little before we come back and ask Mr Kark to begin with his questions.

Please do not discuss the case during your break, and if you have subsequent breaks that remains true.

E (The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everyone.

Cross-examined by MR KARK

Q Mrs Evans, you retired, I think, in 1996.
F A That is correct.

Q You told us you were a matron at GWMH up until 1988.
A No, I was a ward sister until 1988.

Q Then what did you do after that?
A Then I took over the role – the title of matron was not given to me but it was the role G that the old matron would have had; that is, just nursing.

Q Until when? You then became ---
A Patient care manager. I think after about a year I was given the responsibility for the domestics and the catering staff.

Q That would have been by 1990, would it, patient care manager?
H A Yes.

Q Then hospital manager followed from that.
A Yes.

Q That is obviously between 1990 and 1996. Can you tell us when?
A I think about 1993.

Q When you were dealing with the issues that arose in 1991, you would then be the patient care manager.
A That is correct.

Q As the patient care manager, can you help us with what medical role you would have?
A Purely just overseeing the nursing.

Q How do you do that? Do you mean in terms of rotas and the like?
A No, that would be the duty of the ward sister to do rotas.

Q Right. How often would you go round the wards?
A Redclyffe Annex, because it was away from the hospital, very much depended on what was happening within. Several times a week I would be doing that.

Q And the purpose of that would be what?
A Just to satisfy myself that things were all right down there and give them the opportunity to question me.

Q Them being the nurses.
A Yes.

Q Right. When we come to the issues that arose in 1991, you seem to have had a fairly pivotal role.
A Yes.

Q Who had the nurses gone to in the first instance? Was it to you?
A Yes. I am not aware that they went to anyone other than me.

Q If we turn page to page 2 in this document, this is the summary of the first meeting in July of 1991. Did you actually have this document typed up yourself?
A Yes.

Q We can see that it starts with the words

"A meeting was arranged for the trained staff at Redclyffe Annex following concern expressed by some staff at the prescribed treatment for 'terminal patients'."
A Yes.

Q Was it specifically in relation to patients who were dying that these concerns were raised?
A It was the treatment of patient that were dying at that time, yes.

Q We can see that there are I think it is 10 nurses who are named.

A A Yes.

Q Your understanding was that the majority of those nurses had some reservations. Yes?
A No. I would not say the majority.

Q I am sorry. Can we deal with the next paragraph:

B

"The main area for concern was the use of Diamorphine on patients, all present appeared to accept its use for patients with severe pain, but the majority had some reservations and it was always used appropriately at Redclyffe."

I took that to mean the majority of the nurses there.
A Certainly the way it is written.

C

Q I expect now it is rather difficult for you to remember precisely 18 years ago but it would appear from that, would it not, that the majority of those nurses who were present, who would include both night and day staff, had concerns?
A There were four nurses there that raised concerns of one form or another.

Q Who were they then?
D A Staff Nurse Giffin, Staff Nurse Rider, who was a relief nurse ---

Q She was a day nurse staff, was she not?
A Yes. She was not actually a member of the unit: Staff Nurse Tubritt and Enrolled Nurse Turnbull.

Q Tubritt and Turnbull were both nights, so who were the others who had concerns.
E Can you now remember?
A I cannot remember any of the others raising any concerns at all.

Q And the concerns were in relation to the use not of syringe drivers specifically but diamorphine?
A Yes. Staff Nurse Rider's concern was specifically on syringe drivers but the others were generally on diamorphine.

F

Q Did you regard your role as reassuring the nurses about their use, about the use of diamorphine and the use of syringe drivers?
A To satisfy myself and them, yes, that it was being used appropriately.

Q Had you in your own practice when you had been a sister, matron and nurse, used syringe drivers with opiates yourself?
G A Not actually syringe drivers as they were only just being introduced at that item.

Q When you made a statement to the police, you said this: In regard to the amount of diamorphine used, some of the staff were under the perception that patients were getting more. This was because they were used to giving the patients for example 10 mg of diamorphine orally every four hours. Yes?
A Yes.

H

Q However, now with the use of syringe drivers, they were getting 60 mg at once but this was fed to them over a 24-hour period by the driver at a constant level. This obviously equated to six doses of 10 mg over 24 hours. Some of the staff originally could not comprehend this. Was that the kernel of the problem so far as you were concerned?
A It certainly was if my memory serves me correctly with Staff Nurse Rider. That is why I said her concerns were specific.

Q I just want to make sure that I follow what you said in that statement. The nurses were used to giving patients 10 mg of oral morphine every four hours ---
A Can I say that the figure of 10 I plucked out of the air. It was not an example of ---

Q It does not matter if it is 10 or 5 or anything else.
A It was just that it was an easy number to multiply.

Q Even on my maths we get 60 mg over the day. Then you say, using those same figures as I understand it: Now with the use of syringe drivers they were getting 60 mg at once, but this was fed to them over a 24-hour period.
A Yes.

Q Was that your understanding, that when you convert from oral to a syringe driver, you would be giving the same dose as it were, but over a longer period?
A If you were changing from oral to injection, no, you would normally reduce it from giving them 10 mg by injection.

Q Sorry, just repeat that, will you – from giving them 10 mg by injection you would do what?
A Normally if you are changing a patient over from oral to injection, then the dose is quite often adjusted because it has a different effect on the patient.

Q Quite. Can you remember now by how much it should be adjusted?
A No, off the top of my head.

Q At the end of all of these discussions, and we will look at them in a little more detail in a moment, although the gentleman, Keith Murray, the branch convenor who had been representing the nurses, had wanted a written policy drawn up, no such policy was drawn up, was it?
A It was not within my power to draw up – a policy on drugs.

Q But your view was that policies that you had in place already, by which I mean presumably the palliative care handbook and the like, were sufficient?
A We had the RCN.

Q The RCN what?
A The Royal College of Nursing leaflet on drugs, and we had a unit policy on drugs, if my memory serves me correctly.

Q Do you remember *this* coming into force, and I am holding up for the purpose of the note the Palliative Care Handbook? Do you ever remember that document?

A A I cannot remember that one specifically but we had literature from when nurses had been to study days and sessions on palliative care and they had brought back literature from Countess Mountbatten and various places.

Q You also had no doubt, even in those days, the BNF?
A Yes, but that was for the use of the doctor not for prescribing. The nurses would refer to it if they had any doubts on the dosage.

B

Q Because the BNF would provide, as you said primarily to the doctors who are prescribing, a fairly good guideline for the prescription of drugs.
A Correct.

Q And in general terms you would expect that to be followed?
A Yes.

C

Q If we come back to this letter at page 2, paragraph 5, one of the concerns was that "The use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients needs." Is that referring to titration?
A Sorry? We are referring to ---

Q Titration of doses.
D A They were concerned that once it was set for the day it could not be adjusted until the following day.

Q Was it you understanding that before a syringe driver should be started, there should be at least a good idea of what the patient needed to control their pain from the previous doses of oral morphine?
A Yes. More often than not a patient would go from injection to the syringe driver
E rather than oral. Normally, if they were able to take oral medication, they would continue to do so.

Q One of the purposes of using an injection obviously is to relieve pain?
A Yes.

Q It is also to find out what level of pain relief the patient requires?
F A Yes.

Q Before a syringe driver is started?
A Yes.

Q Do not agree with me if you have any doubt about that. Do you have any doubt?
A I cannot remember an example where the patient was started off, in my experience,
G straight on to a syringe driver, put it that way.

Q I have called it titration and perhaps that is not her right word, but the idea, the principle, was that you should try to identify what the patient's required level of opiates was before you start them on a syringe driver, for instance. That would not be a novel idea to you, would it?
A No, not really, but you would normally give them initially a larger dose in any case.

H

A Q A bolus, you try and give a bolus dose?
A Yes.

Q I understand.
A It is quite often a little bit of trial and error; i.e. you give them a certain dose if ---

Q That would mean presumably that doses can go up, as they say, as well as down?
B A That is correct.

Q You referred to the November meeting. As I understood it, what you were saying was that Dr Logan who attended on --- I am sorry, I think it was in fact in December. Dr Logan who had attended was slightly more irate, as it were, than Dr Barton herself. Is that right?
A When he was talking to me, he was the only one that expressed slight irritation, should I put it.

C

Q If we go to page 15 of this bundle, and it is the letter that you were asked about from Mr Murray to Chris West, it is not to you and I do not think you were copied in on it but you are asked to comment on it. If you look at the second paragraph down, Mr Murray writes:

> "I feel the staff have acted professionally and with remarkable restraint considering that it is fair to say that since highlighting their concerns there has been a certain
D amount of ostracization."

Is that right as far as you understood it, that there was at this time quite a difficult atmosphere in this hospital?
A I was not aware oaf any ostracization. As I say, I was aware that there certainly was a certain amount of antagonism between day and night staff but it was a problem that we were addressing during that time, and nobody had raised any issues.

E

Q No, but of course it would make it difficult, I expect you understand, or it might make it difficult for nurses to speak out at a meeting, particularly when there are two doctors present. Did you understand that or not?
A At the first meeting it was just myself and the nursing staff; there were no doctors present.

F Q But if we go to page 23, and it is the meeting of 17 December, you were there as Patient Care Manager?
A Yes.

Q Dr Logan was there as the consultant geriatrician?
A Yes.

G Q Dr Barton as there as the clinical assistant and then there was Sister Hamblin and there were various nurses.
A Yes.

Q Did you consider at any stage whether it might be difficult for any of those nurses to speak out at such a meeting?

H

A I could not see why. I had actually worked with all of these, done shifts with them, during this time between the two meetings, so they had plenty of opportunity to talk to me on a one-to-one basis had they wanted to and they did not.

Q You see, you describe Dr Barton as being very restrained, Dr Logan as quite angry?
A Not with the staff.

B Q With whom?
A When I raised the subject with him, he showed some irritation because like myself he had been very open and patient with them at the beginning. The staff had appeared to be appeased; they all said that they were happy with the explanations given them, they were happy with the care they were providing. Then, without any warning to any of us, I get a letter from the RCN saying that they are taking out a grievance against us because we are ignoring their complaints.

C Q That took you by surprise?
A It did, yes.

Q And you said this, and again this is possibly my rather poor note of it: At the end of the day the nurses were questioning medical treatment.
A Yes.

D Q Can we take it you did not approve of that?
A No. I would support any nurse raising any concern over any issue but they seemed to think that it was a problem that I could solve, that I could snap my fingers or say to the doctors what they should or should not prescribe. They were asking me to do something that was not within my control. They seemed to fail to recognise that what they were saying was implying that the doctors were prescribing inappropriate drugs. When you said that to them it E was shock horror – oh, no, we are not. So it was very difficult for myself to really know what they were expecting us to do or what they wanted from us.

Q That would be one of their functions, though, would it not? If they thought that inappropriate drugs were in fact being issued, they would be under a duty to raise that, would they not?
A They would. In fact, as a trained nurse, I would refuse to give inappropriate drugs.

F Q I also just want to examine briefly with you this issue between the night staff and the day staff. What you said, as I understood it, was that the day staff would have an understanding of the patient's needs because they would be turning them and the like; the night staff would see them when they were asleep. Then the patient might wake up in the morning in pain because they had not received anything overnight.
A Yes.

G Q And so there was this disparity between what the day staff were seeing and what the night staff were seeing. Is that right?
A That appeared to be the case, yes.

Q That could not be in relation to patients on syringe drivers, could it?
A No.

H

Q This is in relation to patients who have been given either oral morphine or four-hourly intramuscular doses?
A Yes, they were prescribed this on a regular basis.

Q What was the suggestion – that the night staff should wake the patient up during the night to give them an oral dose?
A No.

Q How was it going to work?
A It is very difficult when you are going back. I cannot remember specific patients that they talked about but obviously if a patient is awake, then you would give it. If not, it would be given in the morning at the prescribed time.

Q By the day staff?
A By the night staff.

Q By the night staff as they were going off shift?
A Yes.

Q That is not the syringe driver issue, is it?
A No, the syringe driver would have been an ongoing thing. I can say at this point we only had one syringe driver within the unit, and it was not in constant use all the time.

Q Later on, as you told us, you had five?
A No, no. We had five in the hospital, one of which was given to Redclyffe annex.

Q We know that changed ultimately, by the time you left in 1996?
A As far as I was aware, there were still only the five within the hospital.

Q You told us about Nurse Giffin verbally agreeing, but her body language said not. We all understand what you mean by that. Was that in relation to this meeting in December?
A Through both actually.

Q So it certainly appeared from her body language, if not at least verbally, that she remained concerned?
A That she did not accept our views, yes.

Q Was anything done about that?
A Not really. She concurred and did what we asked of her.

Q Finally, the result of all of this, essentially, was that, first, there was no written policy but you expect, presumably, the National Guidelines and the Local Guidelines to be followed?
A Yes.

Q Secondly, the nurses received further training in relation to the use of opiates and syringe drivers?
A Yes.

Q Dr Barton did not receive any further training, did she?

A A That, I honestly do not know. I cannot remember.

MR KARK: Thank you.

Re-examined by MR JENKINS

B MR JENKINS: Can I come back to a further couple of points arising out of that. You were taken back to your statement with the police in which you were dealing with the idea of a patient being given a quantity of medication something every four hours and the nursing staff then giving a much larger quantity, six times or so of that quantity, over 24 hours?
A Yes.

Q You told us you know about conversion, although having retired in 1996, you do not
C recall the fractions of the conversion rate?
A No.

Q Was that part of the concern, that nurses were being asked to give a much higher dose via syringe driver than they had ever given before?
A They were perceiving it as a higher dose because you are normally giving a patient – I cannot remember what doses patients were on at that specific time – say, it was 10 mg, it
D does not seem as much when you ask them to get hold of a syringe and draw up 60 mgs in one go – when you get them to stop and say you would be giving that to the patient over 24 every four hours.

Q You mentioned the RCN leaflet on drugs. You said there was also a unit policy on drugs and you were asked about the concept of the nurse stepping in and declining to give medication if they thought it was inappropriate to do so. Can you tell us whether the RCN
E leaflet or the unit policy on drugs would have referred to that concept of a nurse as the patient's advocate?
A It is the UKCC leaflet.

Q It was then, but it has moved on. It is something different now?
A I think the last page specifically states that a nurse has a responsibility not to give anything that she feels will harm a patient, so yes, it is no defence to give something to a
F patient and say, "That is what the doctor wrote up", if you are aware that it would harm them.

Q The last point I want to ask you about is a document we have looked at before. It is page 2, which is probably open in front of you – page 2 of tab 6. You were asked about point 5 on that page, that this is a concern which was expressed and discussed, a suggestion that:

> "The use of the syringe driver on commencing diamorphine prohibits trained staff
G from adjusting the dose to suit the patient's needs."

We have heard on a number of occasions during the last seven weeks of cases where the contents of a syringe driver were discarded and a different dose was instituted?
A It can be, yes.

Q What comment do you make about that concern?
H

A It was just a comment that was made and I felt it important to put all comments made by all the staff in this so that we could address all the concerns. I did not want them to come back. That was just something that they saw as a problem, but you rightly say you can discontinue and start off a different dose.

Q Are they right to think that would be a problem, that you cannot adjust the dose?
A No.

B

MR JENKINS: Thank you very much. You may be asked more questions by the Panel.

Questioned by THE PANEL

THE CHAIRMAN: This is the time for the Panel to ask questions of you if they have any, and I will turn now to see if there are any questions. Mr William Payne is a lay member of
C the Panel.

MR PAYNE: A couple of questions with regard to the whole episode, the whole investigation or inquiry. Why did it become your role to do the investigation or inquiry, why was your input required?
A As the immediate in-line manager, they were raising their concerns with me, which was the right channel for them to go.

D

Q They also must have raised their concerns with their trade union, their union, the Royal College of Nursing?
A They did at a later date.

Q Is that because they were not satisfied with the way the inquiry was going?
A I believe that was the explanation they gave to the RCN.

E

Q On page 10 you received a copy of a letter that you received from Mr Steve Barnes. It is you, is it not?
A Yes.

Q On paragraph 2 it says:

F

> "This office was aware of the concerns that had been expressed by staff earlier this year and other discussions that had taken place with yourself as the Manager. It had been understood that the concerns raised would be addressed and the RCN had anticipated that the guidance/policy..."

You have told us that it was not your position to write the guideline or a policy?
A No.

G

Q Whose was it?
A As a nurse you cannot override the policies that are laid down by the nursing body, i.e. what was then the UKCC. It would be, I think I am right in saying and someone will correct me, illegal to do so as a nurse.

Q I accept that as the role of the nurse, but surely Mr Barnes, as the officer for Wessex,
H would have known that, would he not?

A A I would have thought so, yes. I must admit that, following these two letters which came out of the blue to me from Mr Barnes, I did write and explain that everything I had done prior to the meeting, and they seemed to be quite happy with that.

Q To carry on from there, it says:

"... as a result of the very serious professional concerns Nursing Staff were
B expressing.

It is now a matter of serious concern that these complaints were not acted upon in a way that had been anticipated."

That is quite a serious letter concerning its concerns?
A Yes.
C

Q Afterwards you took to having another meeting with the nursing staff and with the doctors?
A Yes.

Q All in one room together?
A Yes.
D

Q Am I right in thinking that you had been down that road once before and, obviously, it had not quenched their fears?
A The first time I saw the nursing staff on my own, and then as a training exercise Dr Logan came over and saw them. On the second time I felt it was important that everybody should meet. As I had not received any information from the staff from the first meeting until I got this letter the RCN, I had no idea what their concerns were or what the
E problems were.

Q Do you think that once you had received that, this should have been something that went much higher than your pay grade, for want of a better explanation?
A They also wrote to Chris West who was the chief executive so, obviously, they were aware of what was happening and were overseeing.

F Q There was no input from that gentleman at all?
A No.

Q None whatsoever?
A Not to my knowledge.

Q If you are in a situation where you have some people complaining and some people
G trying to answer the complaint, but the complaints are about the people who are trying to answer those complaints, would it not have been prudent – and we are all talking with hindsight – to actually get an opinion from someone else outside of the whole unit?
A They had a nurse specialist in pain relief, I think her name was Linda Foster if my memory serves me correctly, who came over and talked to staff on this issue, so, yes, they had input and they were nothing to do with the unit whatsoever.

H Q That was an input from a nursing staff grade?

A A Yes, to answer nurses' queries.

Q It was not an input from someone on an equal to, say, Dr Logan, perhaps from another hospital?
A No, but these nurses were working with specialists for pain control and were very aware of the correct drugs and doses to be given.

B Q You talk about individual cases. It says, in your memorandum on page 17, that, "Dr Logan and Dr Barton are prepared to discuss..." – paragraph 2 – "...individual cases staff have". I do not think anyone came back, did they?
A No. After the first meeting Dr Logan had talked about, in general, the prescribing of drugs, who one would prescribe it for, for what reasons, how much etc.

Q Sorry, would you say that again, I missed what you said?
C A I said, Dr Logan, after the first meeting, spoke to the staff and went into detail as to what type of patients or for what reasons it would be, in his opinion, appropriate to prescribe opiates. Also, there was in existence at that time a sliding scale of pain relief that the doctors and nurses could refer to. All that was discussed, but after that they went to the RCN. They obviously still had concerns, so Dr Logan said what he wanted to do was to explain to staff fully why Patient X was given "y", for what reason, but they would not give us this. They would not tell us which patients they had concerns over or why they had concerns over a
D particular patient so we were not able to answer their concerns individually. Do you understand what I am trying to say?

Q Yes, I do understand?
A I felt they were trying to get us to solve the problem blind folded, ie they would not really tell us what the real issue was that they were raising the concerns over.

E Q You have no idea why that was?
A I have. Knowing the individuals concerned I have perhaps some conception of why, but that would only be my own personal view and that would not be based on fact.

Q No one said anything to you official?
A No.

F MR PAYNE: Thank you.

THE CHAIRMAN: Dr Roger Smith is a medical member of the Panel.

DR SMITH: At some point you described how it was that syringe drivers came to be introduced.
A Yes.
G

Q A patient came in with their own syringe driver. Can you remember who instituted the use of syringe drivers, whether that was Dr Logan or whether it was Dr Barton?
A It was myself.

Q You started it?

H

A A Yes. On request from staff on what was then the female ward. We regularly had terminal patients in who the Macmillan nurses were looking after at home but suddenly would require hospital admission.

Q Can I go back to something Mr Kark explored with you and I think, in a way, Mr Payne did too. It is how nurses deal with problems with doctors, or with what doctors do in general. I wonder if you could help me understand how a nurse thinks, when confronted B with the doctor in the room, about her position as a nurse when there is a doctor there, the relative position?
A I would say most nurses look at themselves as the patient advocate for the doctor and the treatment they are receiving. As a nurse you are with a patient 24 hours a day and, possibly, are more able to assess the patient's condition, ie whether a patient is improving or otherwise, than the doctor who is on a five minute visit. I think the doctors rely quite heavily on the nurse's assessment of that patient as to what treatment they require, particularly when C you are talking of pain. You are with the patient 24 hours a day, or one of your colleagues are and you see how much pain the patient suffers. The doctor might come in the morning and in that five minutes the patient is pain free, but half an hour later the patient might be writhing in agony.

Q At the bedside it would not be difficult, to use the words, broadly challenge a doctor and say why.
D A Yes.

Q But when it comes to a meeting, everybody marches into a meeting, the door is closed and there is an issue. As Mr Payne says, you have two sides of an argument there, and you have nurses, a consultant and a general practitioner?
A It was a very informal meeting. The doctors concerned were very approachable. I do not think anybody would feel threatened by Dr Logan or by Dr Barton who were the only two E medical people there.

Q On a formal issue might they feel intimidated by a consultant being present, a consultant being, if you like, the opposite side of ---
A Not in the circumstances of that meeting, no, I would not accept that. There was nothing threatening about the meeting. If you like, I was voicing their concerns for them and I was not saying, "Nurse X said 'Y'." I was saying, "The nurses are raising", so they could F not have – and, certainly, the individuals concerned were not, I think, the type of nurses to be intimidated.

Q This might sound impertinent and I hope it is not: do you think that your view of what happened then was because you were no longer a nurse but a manager?
A No.

G Q Were you still being a nurse? I think you said something about doing shifts.
A Yes. I used to try to work in at least one department one day a week, just to keep my hand in and, if you like ----

Q Keep your feet on the ground.
A -- build up a rapport with the staff. Otherwise, you were just someone in the distance.

H

A Q Okay. On this question of why night nurses might see things differently from day nurses, and why night nurses, I think you said, would not see the patient in the morning when they had their pain – or that was the suggestion – can you refresh my memory about the exact sequence of what happens in an elderly care ward. The night staff see the patients wake, do they not?
A Yes, normally. They are there until eight o'clock in the morning.

B Q What functions would they carry out with patients before they go off duty?
A They would normally give the patients drink. The vast majority of the patients would require changing. Those that did not would need to be toileted. None of the patients were able to get to the toilet on their own. And medication.

Q Some significant activities on the part of the patients.
A Yes.

C

DR SMITH: That is all I wanted to ask you. Thank you.

THE CHAIRMAN: Thank you, doctor. Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Going back to a point where you were trying to establish the basis of the complaints raised by the nursing staff and you were talking about them not wanting to say
D that it was the level of drugs due, the prescription by the doctor, did you get to the bottom of why they did not see this around the prescribing levels?
A I am sorry.

Q You were saying that some of the complaints were about the amount of diamorphine that was being prescribed for individual patients.
A Yes.

E

Q But then I understood you to say that, when you were trying to understand the basis of their complaints, they did not want to level a complaint against the doctors. They did not see it as a doctor problem.
A No. They -----

Q But they are the people who were doing the prescribing.
F A Yes.

Q Did you get to the bottom of that?
A They were adamant that they had no complaints about the amount of diamorphine being prescribed. It always came back to the fact that they did not always see the type of patient being prescribed the diamorphine.

G Q So it did come back to prescribing really.
A It came back to the prescribing, yes.

Q To clinical decisions.
A Yes.

Q What do you think was going on that the nurses could not put those two facts
H together?

A I honestly could not explain it at the time and I cannot now. Other than, yes, we were, in line with guidelines, we were trying to get the nurses ... If it was recognised that a patient needed to go on these strong drugs then we were preferring that they had it on a regular basis, so that we could try to control the levels they had better.

Q Yes.
A Rather than, as had been the practice in the past, you just gave a single injection and then you waited for the patient to be in pain again and then gave them another one – injection or tablet or whatever. Some seemed to have a resistance around that issue. They could not see why. I think the whole thing was very complicated, because there were lots of different things going on at the same time, because they were getting a different type of patient in as well.

Q To me, you are raising questions around clinical judgments.
A That is correct, yes.

Q Around the treatment of the patients.
A Yes.

Q But the nursing staff could not articulate it in that way or would not articulate it in that way.
A No. On more than one occasion, it always came back to the fact that they have not got cancer. There was always the inference there from some of the members of the staff that if they did not have cancer they should not be given opiates.

Q Going back to questions that my colleagues have already questioned, my understanding of hospitals is that there is quite a hierarchical position between the different tiers, between different doctor tiers and nursing tiers. Tell me about that hierarchical position.
A We were a very small hospital – what was classed as a GP hospital. Certainly from when I started in 1961 until I left, the hierarchy thing had merged slightly in any case, but it was almost non-existent within the small hospital. We were a very friendly unit. I do not think the fact that staff felt intimidated in any shape or form was really an issue on any front.

Q Yet, on the other hand, you say that Dr Logan became irritated when the nurses raised questions again. That tends to suggest that there is a hierarchy there.
A No, it was more a frustration, I think, than anything. Certainly that is how I felt.

Q Right.
A Because you were trying to solve a problem without really knowing what the problem was.

Q Yes. Yet there was something, in a way, that was stopping the nurses being able to communicate that problem, so as you could understand it fully.
A Possibly.

Q Would you say that?
A Yes, I would accept that perhaps it was a failure on my part to fully understand them, but I do not know what else I could have done.

A Q Okay. What we cannot grasp then is really the basis for that, what was behind that. That is what we are having difficulty grasping.
A What their fears were based on, then, no. Other than, as I say – but it is only supposition on my part – saying that.

MRS MANSELL: Thank you.

B THE CHAIRMAN: Thank you, Mrs Mansell.

Ms Joy Julien is a lay member of the Panel.

MS JULIEN: I just want to clarify where you fitted in in the process regarding the complaint. You may have answered it and I may have missed it. At the point where the nurses took their complaint to the Royal College of Nursing, were you out of the picture by then or did it come
C back to you? I was not quite clear.
A After the initial meetings and the staff training, I was not aware there was a problem until I got a letter from the RCN stating staff grievances.

Q It was raised then. Did the RCN take it up specifically?
A Because the RCN obviously wrote to me saying the staff had concerns, I then went back to the staff.
D

Q Did the RCN fall out of the whole picture then, as it left you?
A They were quite satisfied with the response I gave them as to what I had done in relation to staff complaints.

Q When you mentioned a grievance, was that what you were talking about, the RCN?
A The RCN, yes.
E

Q So there was no outstanding grievance after that.
A No, no. It never reached that

Q Okay. You also mentioned the unit having a policy. Did you mean as a result of these issues from this meeting, or was that something that pre-existed?
A It pre-existed.
F

Q Did it address the issues?
A There were five small hospitals within the unit that were similar to ours, in so far as we did not have a resident doctor on call. This sometimes creates problems in relation to prescribing and giving drugs, so we felt it was necessary as a unit to have a policy which covered those issues that were not covered in the UKCC policy that we were bound to; that is, we had a policy on which drugs a nurse could give without a doctor prescribing – such
G things as Panadol if a patient had a headache – not relating to opiates, obviously.

Q Okay.
A That is the type of thing that was in our own unit.

Q As a result of this complaint and these meetings, was the policy amended?
A No, because there was nothing that was not already covered in the existing policy that
H would have changed the situation.

A

Q Should those nurses not have been aware of that?
A You cannot write a nursing policy stating what a doctor can prescribe for certain patients. It is not a nursing role. They were looking for me to include medical policies, if you like, within the nursing policy – which is not feasible. It just cannot be done.

Q This was just a nursing policy.
B A Yes. I do not know honestly where they got the bit from saying that a policy was going to be made from.

Q As far as you know, was there ever a policy that addressed these issues?
A No, the policies that were already in existent were sufficient.

Q Then, as a result of the discussions and meetings, as far as you know there was no
C further policy development.
A Not in relation to the giving of the drugs, no.

THE CHAIRMAN: Finally, it is me. I am a lay member. You have told us that you started out as a nurse and you ended as a manager.
A Yes.

D Q I take it that you would be in a perfect position to understand the extent of the chasm, be it big or small, that might exist between the two sides or two parties.
A Yes.

Q You have also told us today that in dealing with this or trying to solve this problem – a problem which you did not really know what it was but which you knew you had to solve – staff intimidation was not an issue.
E A No, in my opinion not.

Q Yet when you wrote your memo on 5 December 1991 on page 21 of tab 6, you said,

"It is not our intention to make this meeting in any way threatening to staff."

A Yes.
F

Q Would that indicate that at that time you recognised that some staff might have that concern?
A Well, the fact that they had gone straight to the RCN and not come back to me made me wonder if they felt in any way intimidated or threatened, but no other reason did I have for concerns that they felt so.

G Q In your meeting of 11 July 1991, you had had very specific issues and concerns raised, and you have very helpfully listed all of those. You are, I am sure, aware that similar concerns were raised again some six to eight years later.
A Only what I have read in the press.

Q It appears that the problem that you were seeking to understand and try to solve at that stage is one that apparently came back at a later stage. I would like to understand from you if
H you felt that there were any external circumstances that might have been leading to this

general disquiet among the nurses in 1991. You have told us that there was concern where the heavier medications, the opiates, were concerned. Am I right or not to get the impression that around this time there was a general up-scaling towards heavier medications in general hospital practice? Or have I misunderstood that

A No, I do not think so. Certainly we were looking at the way we were giving it. There were guidelines coming out from places such as Countess Mountbatten and others on prescribing and how it should be given, and we were doing our best to follow those guidelines.

Q You mentioned just now that at that time in 1991 the nurses were getting a different type of patient in.

A Yes.

Q I take it that you are referring to the less acute of the acute patients and those who were going to be more difficult for a variety of reasons to manage.

A Yes.

Q So that that problem was already manifesting itself in 1991.

A Yes.

Q Do you see any connection between that problem manifesting itself with more of those sorts of patients coming through onto the ward and the consequent increase on pressure on the nursing staff? Do you see any connection between that and their concern, which you had difficulty in really pinning down but which seemed to be about the prescribing of opiates and the care of those patients?

A Only in so far as obviously the higher number of patients you had in who required terminal care, then the higher the proportion/the number of patients you are going to have within a unit who require opiates. Whereas it had been a fairly rare event for a patient in that unit to be given diamorphine, it was becoming a more common thing because of the type of patient they were looking after.

Q Perhaps that is really the issue I am struggling to understand. Is it simply because there were more patients who were requiring opiates, or rather that the patients for whom opiates were seen as appropriate widened?

A Mainly the first. Possibly .....

Q Possibly the second also?

A Yes, as people's awareness, if you like, became ....

Q Would that explain concerns such as number 6:

"That too high a degree of unresponsiveness from patients was sought at times?"

A Again these points I will stress, were just comments that they made.

Q Yes.

A It was not the general opinion of that. As a nurse, I would say the last thing you would want to do is to increase the unresponsiveness of the patient because you are just making harder work for yourself. It is much easier to look after a patient who can wash, feed, dress themselves, than one you have to do all those things for. Obviously the higher the

A degree of responsiveness you can leave a patient in, but at the same time have them pain free, then that would be your aim.

Q Would that be equally true of a very demanding patient who was constantly crying out and requiring a great deal of nursing time, where you have a one-on-one system, where a nurse has to sit with the patient for a period of time to calm them?
A Well, I do not think for that type of patient, if their only problem was disruptiveness, B then I would think you would be looking at sedatives rather than opiates, but if the patient had multiple problems in amongst those problems with that, then, yes, it might be that that patient was given.

Q We have been told that the general profile was that it was multiple difficulties that tended to be presenting themselves rather than one individual one.
A Yes.
C

Q Similarly, you had the concern you noted also, number 4, that a patient's death is sometimes hastened unnecessarily. Is that again something that you would ascribe to the first issue or would that also perhaps be connected with the second issue, the fact that there was now increasing pressure on the wards, one, to receive inappropriate patients, but it appeared to be, from the descriptions we had had, an endless requirement. The acute wards were constantly seeking to move on. We have heard the phrase dumping patients on your wards.
D A I think that comment – and again, it is very difficult for me in my mind having to go back so many years – was made in relation to patients being given opiates on a regular basis rather than a PRN basis or on an as-needs basis, that there may be an ulterior motive, but I would hasten to say there was never any proof to that.

THE CHAIRMAN: I was just trying to understand what you clearly had been trying to understand, what the real problem was. I am most grateful for your assistance in that regard.
E We have a little bit more for you. Mrs Mansell would like to come back swiftly.

MRS MANSELL: I am sorry about this. We were trying to get to grips earlier with the prescribing and whether it was actually about the different patients and the prescribing for those different patients. As the Chairman was asking you questions, it did seem to me: was it the diagnosis that someone was now into terminal care and so that the diamorphine was being given as part of the dying process?
F A No, I am not suggesting that every patient once they were labelled as terminal was given diamorphine. The one case I can remember, and it is actually in here, was a patient that became very distressed every time she was turned or had to have treatment, and this was on a two-hourly basis. In my book to put a patient through agony every two hours when it can be alleviated is not on but some of the staff did not feel that that type of thing was enough of an excuse for a patient to be given an opiate.

G Q We probably cannot go further than that.
A I find it difficult sometimes to express myself.

THE CHAIRMAN: Don't we all? Now we are at the stage where the barristers have the opportunity to ask any questions which have arisen out of the questions asked by the Panel.

H

Further cross-examined by MR KARK

Q I do not have very many questions. In light of the fact that the nurses did in fact end up going to the RCN and that apparently was a surprise to you, do you think you may have misunderstood the level of their concern?
A It might sound arrogant, but, no, I do not. In fact, the RCN representative said to me in private that he could not understand what the problem was either.

Q This is the same RCN representative who spoke about making a grievance?
A Yes. He had not realised the full extent of what I had done in answer to their complaints the first time.

Q So, despite everything that you had done, the nurses had still gone to the RCN?
A Yes.

Q When you received this letter saying it is now a matter of serious concern that these complaints were not acted upon in the way that had been anticipated and they now expect a clear policy to be agreed as a matter of urgency, that came as a shock to you?
A Yes. I had no knowledge of the policy that they were expecting.

Q But you did not take it any higher than yourself, as it were?
A I obviously took the letter to my manager. What he did with it, you would have to ask him.

Q We do not see his input here, do we?
A No.

Q You were asked by Ms Julien about the policy that the nurses were working to. Again, I just want to understand what it was. Was this a nursing booklet?
A Guidelines issued by the UKCC.

Q And the guidelines covered what?
A They covered the administration of drugs by nurses.

Q You also spoke about the guidance given by the Countess Mountbatten House but you do not know this book?
A I cannot remember that specific book. I can remember we used to have a sheet with a sliding scale. I am not syiang I have not seen that; I just do not remember it.

Q The sliding scale we have all heard about; that is the sliding scale of analgesia.
A Yes.

Q Was it your understanding that that was used?
A Yes. It is not always appropriate for patients but where it was appropriate, then, yes.

Q You were asked by Mr Payne about whether anybody from outside, as it were, had come in to review your practice and policies. You mentioned a nurse specialist who came in.
A Yes.

Q It was never thought appropriate that a palliative care consultant should come in and review the practices either of Dr Barton or Dr Logan?
A No. The nurses continually said that they did not have a problem with the amounts that were being prescribed. Dr Logan was aware that I would have left that to him.

Q I just wanted finally to ask you this. You said that on a number of occasions and I understand that, but how does that square up with the complaint that patients' deaths are sometimes being hastened unnecessarily?
A That was a comment made by one nurse and that was one of her fears; i.e. the route being given.

Q That must relate to over-dosing, must it not?
A Not necessarily so, no.

Q How else would it be?
A I think I am right in saying --- Again, you are asking me and I am no expert but I think you will find that with anyone, particularly in a very ill condition who is regularly on opiates, you do run the risk of possibly shortening their life slightly. It is a choice between allowing them to be in pain for six days or to be pain-free for five and a half type of scenario.

Q The suggestion here is not simply that they were being hastened, and that would be a consequence of the double effect, but that they were being hastened unnecessarily.
A Yes, but I personally did not have any concerns on that issue.

Further re-examined by MR JENKINS

Q You introduced syringe drivers to the Redclyffe Annex?
A Yes.

Q And elsewhere in the Gosport War Memorial Hospital. You told us why you did so and you related it to the fact that there were other patients being treated by Macmillan Nurses or cared for by Macmillan Nurses?
A Yes, and in fact they wanted to take their syringe driver off the patient but we did not have one to replace it with, so they allowed us to keep it for that patient, and we endeavoured to get some for the hospital.

Q Clearly this was a relatively new development, the use of syringe drivers?
A Yes.

Q Certainly new to Gosport when you introduced it?
A It was new to Gosport and, as I say, there were a lot of people who advocated that it was the easiest and most economical way of giving the diamorphine.

Q The doctors and the senior nursing staff did not have any difficulties with it, indeed supported it is what you told us.
A Yes.

Q You have been asked questions along the lines of: the nurses expressed concerns and the Chairman used the idea that there was general disquiet amongst nurses. Did that reflect what was happening? You said there were four, and you identified them for us.

A A The four?

Q You said there were four nurses and we looked the second page; you identified them for us by name.
A Yes.

Q If we stay at page 2, the following concerns were expressed and discussed, and there
B are 10 points. Can you help us: were all four expressing those concerns?
A Not all 10 concerns. The 10 concerns were raised by all the staff generally.

Q If one person raised one concern, that would be written down?
A Yes. I tried to include everything. I did not want anything left out because I felt if we were going to go into the issue, then it was no good resolving one issue and then the following week going back and having to resolve another.
C

Q Again, just to understand the nature of the complaint, you were told, in correspondence with the RCN representative, that it was not the use of syringe drivers that was the cause of concern? That is page 19.
A By that time, no, but the initial concern was related to syringe drivers and then once we got into questioning staff, then all these other issues came. Obviously by the time they went to the RCN, they were quite happy with the syringe drivers but still had concerns.
D

Q So it was not the use of syringe drivers that was still a problem later on?
A No.

Q And you have told us again and again the amounts of diamorphine that were being given to patients; no one was questioning those – page 24, point number 5. You said on that page "What is questioned is the appropriateness of prescribing diamorphine for other
E symptoms or less obvious pain."
A Yes.

Q What we have heard from you is that there was one nurse who had a view about cancer and treating patients with diamorphine?
A There were several of them that mentioned that. I think I am correct in saying Nurse Turnbull and Nurse Giffen certainly raised the issue that ---
F

Q We have seen Dr Logan's letter right at the end of that tab talking about one of the concerns that appeared to be that there should be a full staff conference before anyone could be prescribed subcutaneous analgesia .
A I would say if you could wait that long, then the patient would not need it.

Q I understand but does that reflect the sort of concerns that were being raise – we
G should all be discussing it?
A Yes.

Q Dr Logan also deals on the same page, page 29, with the suggestion that it would be wrong to start subcutaneous diamorphine where there had not been a patient-voiced concern about pain?
A Yes.
H

Q Even though a patient may be distressed regularly?
A I find it very difficult the fact that you could have nurses that had worked in a long-stay, elderly care unit that did not recognise that sometimes within the elderly patients have pain but are not able to verbally express that.

Q You have told us of a patient being in agony every two hours if they were treated.
A Yes, but at other times quite a lot of these patients are very confused and they are unable to verbally put it to you but you recognise it by signs; the patient gets very agitated and fidgety. Each patient is different. You get to know the patient. You get to realise that they are in some discomfort, or at least distress.

MR JENKINS: You were asked questions from members of the Panel and others about what lay behind these concerns, given that the precise nature of the concerns was not clear to you and you said that knowing the individuals concerned you would have an idea what lay behind it. I am entitled to ask you what you mean by that.

MR KARK: Is that not speculative? You are not inviting the witness to speculate?

THE CHAIRMAN: That must be right, must it not, Mr Jenkins?

MR JENKINS: The question of what weight the Panel gives to the answer is a matter for them, but I think I am entitled to ask the question. I am prompted by one senior to me. The Panel have been asking that sort of question and I am keen that we grasp the nettle, as it were.

THE CHAIRMAN: I think that is a fair point. What is sauce for the goose should be for the gander.

MR JENKINS: I will ask the question again. You said "knowing the individuals concerned I would have an idea what lay behind their concerns". You also said they were not the type to be intimidated of the people you have named.
A Yes. I have got to say that the worst culprit had to be Staff Nurse Giffin, who was a very vocal lady and seemed to be of the opinion that if she was not trained to do anything in 1961, then she should not be expected to do it now. Any change she was resistant to and if she did not think it warranted change, then it should not be changed.

Q And yet there were changes by the nature of necessity in the patients?
A Yes, and she would go along with it, but she would let you know that she did not approve.

Q Do you want to say anything about the others?
A Enrolled Nurse Turnbull was a very caring nurse who was easily swayed and worked a lot with Staff Nurse Giffin, so I think once doubts were put into her mind, she rightfully wanted them answered.

Q Lynn Barratt has told us that she does not remember being at any meetings. She accepts that she was because she has seen the documentation but she cannot say now that she had any concerns then, so I do not need to ask you about Lynn Barratt.
A She never raised any concerns but did not always help the situation with the barrier between the night and the day staff. She was not always terribly diplomatic with what she should say.

Q I understand. What about Anita Tubritt?
A Anita Tubritt in my view was a good nurse, had the patient's interests at heart, but over this particular issue I was a little disappointed, because I thought that we built up quite a good rapport, that she felt she could not come to me when she felt she had further concerns. I could not fault her as a nurse. Saying that, as she worked on night duty, I did not have a great deal to do with her.

Q Concerns were raised initially. We have heard that Steve King was involved. You told us Linda Foster was involved and she was independent of the hospital.
A Yes.

Q A nursing care specialist?
A Yes. I cannot remember whether she was a Macmillan Nurse or not but she certainly was involved within the terminal care and pain relief.

Q Steve King was on the nursing side. Did he have a specialty at all?
A He was branching out into being a tutor and as a nursing officer had been for many years within the elderly service and was very highly trained. If you like, you could say he was the specialist within elderly care.

Q Notwithstanding that training or that talking to nurses, these complaints re-surfaced?
A Yes.

Q We have seen the letter from the RCN, at page 10. You have told us what Gerrie Whitney told you confidentially. You told us you wrote back.
A Not Gerrie Whitney.

Q Keith Murray?
A Keith Murray.

Q You have another letter, you told us, in which these complaints resurfaced. You told us you wrote back, I think you said a long letter?
A If my memory serves me correctly, and I do not have it on record, Staff Nurse Tubritt wrote me a little note and just said that she had been to Gerrie Whitney to discuss this issue with her, and that was my response to that note.

Q You wrote back to the RCN?
A I wrote back to the RCN, gave them a minute of the meeting, which they already had in any case, but then went through the training sessions that I had arranged and the meeting that they had with Dr Logan and the fact that we had staff meetings etc.

Q You told us that you thought that was an end of it when you wrote back?
A Yes.

Q You answered a question from Ms Julien saying that it was not a grievance, it was not taken that far?
A No, it did not come to the grievance.

Q So far as policy was concerned, we know from page 25 of this bundle, from your note, that at the meeting in December 1991 you asked staff if they felt there was any need for a policy relating to nursing practice and no one thought it was appropriate?
A That is correct.

Q Was there further training organised after this meeting?
A Not specifically ongoing from this but, yes, we had a regular programme of identifying as part of staff appraisal, staff training needs and arranging the appropriate training.

MR JENKINS: Thank you very much.

THE CHAIRMAN: That concludes your testimony. We are most grateful to you for coming and assisting us. When a Panel has, as this one does, from such a great distance in time enquire into circumstances and events, it really assists us enormously when witnesses such as yourself are prepared to come forward in person and share your memory and understanding with us. We are most grateful for that and you leave with our thanks. You are now free to go.

(The witness withdrew)

MR JENKINS: You will want to take a break as a Panel?

THE CHAIRMAN: Your perspicacity never ceases to amaze me, I was just contemplating the amount.

MR JENKINS: I was rising because I knew you were going to deal with that. I have two witnesses to call. One is Barbara Robinson and the nurse, Patricia Wilkins, who deals with a couple of patients. I was not proposing to take her at great length through the treatment she gives the patients, Lavender and Stevens, B and L, but I know she has to finish today. She is not available tomorrow and I was proposing to call them in that order, Barbara Robinson first and then Patricia Wilkins. It may be that the Panel would find favour in having a slightly abridged lunch period today.

THE CHAIRMAN: You are not making yourself as popular as Mr Kark did on Friday! We will try and accommodate you. Let us say we will come back at half past two.

(Luncheon adjournment)

Barton32e1ln

2.30

THE CHAIRMAN: Yes, Mr Jenkins.

MR JENKINS: Sir, I am going to call Barbara Robinson, please. The Panel will recall her name and if they look at D4 they will see a document she had a hand in writing.

BARBARA FRANCES ROBINSON, Sworn
Examined by MR JENKINS

Q (After introductions by the Chairman) What is your full name?
A Barbara Frances Robinson.

Q I think it is Mrs Robinson.
A Mrs Robinson.

Q I think you qualified a long time ago as a nurse?
A I did, in 1967.

Q I think you then qualified as a district nurse in 1971.
A That is correct.

Q You then worked in various settings in nursing until your retirement in 2004?
A That is correct, yes.

Q I think you worked as a district nurse with the practice where Dr Barton was a GP in the 1980s, between 1982 and 1987.
A That is correct.

Q I think you were subsequently appointed to the position of Services Manager for the Community Hospitals and Elderly Mental Services in Fareham and Gosport?
A That is correct.

Q From 1996 to 2000 you were responsible for nursing, administrative and catering staff at the Gosport War Memorial Hospital?
A I was, yes, as part of my larger role.

Q The last witness we heard from, Isabel Evans, was responsible for nursing and other matters at the Gosport War Memorial Hospital, was she your immediate predecessor?
A She was, yes, but it was a different role that I took over.

Q But she was responsible for nursing, as were you once you took over your position at Gosport?
A That is right, yes.

Q I think after 2000 you went to the Queen Alexandra Hospital as chief nurse for older people's services?
A That is right, it was elderly medicine at Queen Alexandra's and St Mary's and elderly mental health services at St James' Hospital in Portsmouth.

Q Can I come back to the time when you were a district nurse.
A Yes.

Q And working for patients for whom Dr Barton was their GP?
A Yes.

A Q Would you have had a fair exchange of information and contact with the GPs whose patients you were looking after?
A Yes. It was an excellent GP practice and we met every day at coffee time to discuss patients with the doctors, and at other times during the day if we needed to.

Q What sort of patient group would you be dealing with as a district nurse in the 1980s?
A Certainly terminal care, leg ulcers, any post-surgical wounds that needed dressing.

B

Q As a district nurse would you be seeing some patients in their homes?
A Every patient in their home.

Q What about patients who might be treated on a GP ward in a hospital? We have heard of Sultan Ward at the Gosport War Memorial Hospital, you would not be there?
A No, no, the district nurse's role was purely in people's homes.

C

Q So it was community based?
A Community based, yes.

Q The War Memorial for GP beds would have had their own resident staff?
A That is correct.

D Q So you would be dealing with patients who had leg ulcers and other conditions which needed to be treated at home, including patients who might be approaching the end of their lives?
A Yes.

Q How did you find the care that Dr Barton was providing for that class of patients?
A Dr Barton's care was excellent. She really cared about the patients. She cared about
E the carers. She always had time to listen, discuss treatment regimes. She always had time for the district nurses and Dr Barton always treated the patients in a way that would give them the best quality of life until they died.

Q You have been in nursing for 40 years or so …
A That is right.

F Q You will have seen many, many doctors ---
A Certainly, yes.

Q --- over that period of time?
A Yes, I have.

Q What proportion of those doctors would you say were excellent? I am inviting you to
G put Dr Barton on a scale?
A Maybe 75 per cent.

Q You said she would listen to nursing staff as well.
A Yes. I mean, Dr Barton always made time. If you went and knocked on her surgery door during surgery she would always see you after the patient she had with her had gone. She always made time.

H

A Q Would you be able to say the same of all the doctors that you have worked with?
A No.

Q When you moved to the Gosport War Memorial Hospital, what we know is that patients were being treated with Dr Barton as the clinical assistant, in two wards, Dryad and Daedalus ward.
A That is right, yes.

B Q You were based at the hospital.
A I was based there, yes.

Q How much contact would you have had over the course of a working week with Dr Barton or the nurse managers, sister or nurse manager, on those two wards?
A I would see the wards most days. Every day I was in the hospital I would always
C walk round the wards. I did not see Dr Barton a huge amount, but if I needed to see Dr Barton I always knew where to find her and what time of day to find her.

Q I understand. What would you say of the level of medical care that was being provided via Dr Barton to those patients on Dryad and Daedalus Ward?
A It seemed to be very good, and I would know that from the sisters, the nursing staff, so if they had been unhappy with the medical care then they would have certainly
D complained.

Q Would it follow that you would have had regular discussions with the nurse managers on both those wards?
A Yes.

Q Would you have had discussions with the nursing staff as well?
E A Quite often, yes. I was a person who walked the wards.

Q We know that there might be a sister, say Sister Hamblin, on Dryad Ward, but on occasions when she was not on shift there might be another senior staff nurse who would be in charge of the ward.
A That is right, yes.

F Q Would you have regular feed back from that individual over time?
A I would, yes. If the sister was off duty, yes.

Q Again, what would you say about Dr Barton's care of the patients as far as you were able to judge it, both from your own observations and the feedback that you were getting?
A I had no reason ever to be worried about the care that was being given to the patients, as far as I could see it was excellent and relatives were pleased. I would often talk to
G relatives about the care because in those days it was the beginning of real quality and trying to get patient and relative feedback, and that was always good.

Q If you were talking to relatives what would you be talking to them about? Would you be discussing clinical matters concerning the patient they were a relative of?
A I would be asking them if they were satisfied with the care that their relative was being given at the time, and that could be anything. That could be the food, but nobody ever
H complained about Dr Barton's care to me.

Q As time went on, whilst you were at the Gosport War Memorial Hospital, again between 1996 and 2000, what can you tell us about the type of patient that was being admitted to Dryad and Daedalus Ward?
A It was the beginning of a time of change really because more and more patients were going into nursing homes more quickly – iller patients were going into nursing homes so that the Gosport War Memorial beds could be cleared for iller patients from the acute unit to come to Gosport War Memorial so care was changing and patients had very complex needs and the number of those patients during that period increased from the days maybe where it was more convalescent, but a slower pace.

Q The acute wards, are we talking about the two surgical units locally?
A No, I am talking about the Department of Elderly Medicine at QA and may be some of the medical wards at QA and Haslar Hospital medical wards.

Q So patients were frailer than they had been at an earlier time?
A Definitely.

Q And their medical needs were more complex?
A They were. They were definitely multi-pathology. They had a lot of needs. In the end, most of the patients on the wards needed feeding, it was very time-consuming.

Q Was there any change to the resources that the wards had over this period of time, change dealing with the nursing complement and the number of nurses that were there or the skills of the nurses or the medical complement?
A There were a few more nurses employed for the stroke unit, which started on Daedalus Ward at that time, otherwise there were not any more nursing staff. There were certainly no more medical staff. There was no more help for Dr Barton during that time, except the two consultants did start visiting weekly rather than fortnightly. At first one used to visit one week and then the other the other week.

Q What would you say about the workload for the nursing staff and also for Dr Barton as time went on?
A As time went on the nurses were more and more stretched because of the complex needs of the patients, and also we had to start sending them to the QA to the acute elderly medicine wards to try and give them more training in more acute needs of patients, so that was time-consuming in itself.

Q Can I just go over that: you would send nurses over to the Queen Alexandra Hospital so that they could get more training?
A Yes. It was a bit of a deal because QA at the time were really stretched. They were imploding. They had so few staff on their wards in elderly medicine, but from Gosport we, for maybe a period of a month or so, we would send somebody over to help them out but also at the same time to gain more acute skills to bring back to Gosport War Memorial Hospital.

Q So the nursing staff were stretched over this time?
A They were, yes, yes.

Q What about Dr Barton?

A A Well Dr Barton was also more stretched because of the frailer patients, more people inevitably were dying; they had more complex needs so ward rounds would take longer and the through-put of patients, the number of new patients being admitted was ever increasing, so, yes, Dr Barton's workload increased hugely I would say.

Q How was she coping with that?
A As far as I know extremely well, probably by doing more hours. I am not sure how
B many more hours but, I mean, she never let us down, she always attended, every morning, returned later in the day if needed. There was never any suggestion that she was not actually covering her workload but it must have been at her expense.

Q Can I ask about transferring iller patients to the War Memorial: when patients came in what sort of reasons were given to the relatives (or the patients) as to why they were coming?
A We did have a problem because more and more relatives were being told they were
C coming to Gosport for rehabilitation. I think this sometimes was to appease the carers who did not maybe want them to move and when they arrived at Gosport they were quite clearly were not for rehabilitation, they were very ill people who were in end-stage illness.

Q Would you pause there? You said the relatives were being told this.
A Yes.

D Q Who was telling them that?
A The managers, particularly from Haslar. Haslar Hospital was a particular problem.

Q The Panel has heard evidence to the effect that there were real difficulties at other hospital concerning beds ...
A Yes.

E Q The availability of beds and the scope for those hospitals to keep doing routine or emergency operations.
A Yes.

Q Are you able to tell us why it was that patients were coming to you when the relatives (perhaps the patient) had been told something that was not actually right?
A When we spoke to the managers it really was because they had to clear the beds
F because of the next lot of people who needed acute beds because there was a shortage of acute accommodation, acute beds. They had to keep the through-put going and ... Yes.

Q How did patients who were frail and perhaps being transferred early, how did they respond to being transferred out of an acute unit into the War Memorial Hospital?
A I can only tell you from what the ward managers reported back to me because I did not necessarily see them arrive. The ward managers were concerned that the patients were
G really quite worn out when they arrived and, because of their frail condition, a journey did not do them any good at all.

Q We have heard that a patient should be stable when they are transferred from one unit to another. What would you say about the stability of patients who were being transferred to Gosport during the time with which we are concerned?
A I do not think I can really comment on that.
H

A Q You told us that you contacted others in relation to ---
A I spoke to the managers of Haslar and the managers at Queen Alexandra's.

Q What prompted you to speak to them?
A The ward managers from Gosport had come to me and said how worried they were about the expectations of relatives. This was causing real problems on the wards where relatives were getting quite cross with ward staff because their relative was not having the B rehabilitation and not getting better and their expectations were not being upheld.

Q The response from the Haslar, or the units that you were speaking to, was that they had to transfer the patients out?
A Yes, they had no option.

Q Was Dryad Ward or Daedalus Ward set up to provide rehabilitation?
C A Daedalus Ward at that time had just started to have some rehabilitation beds and some stroke unit beds. Dryad Ward was not for rehabilitation, that was a continuing care ward.

Q It follows that if patients or their relatives were being told that the patient was being transferred for rehabilitation, that was not going to be provided on Dryad Ward at least?
A No. They did their best if that was possible, but usually they were not medically in a fit state to be rehabilitated.
D

Q Did that cause difficulties with relatives or patients themselves discovering that what they thought was going to happen, or should happen, was not going to happen?
A It was causing difficulties and I was called to the ward on one occasion to meet a relative who was very angry that his mother, who he thought had come from Haslar for rehabilitation, in actual fact was in severe pain and was deteriorating quite rapidly and had been put on medication and the relative was quite angry about it.
E

Q I think you wrote a memorandum that we have. I am going to ask you to look at a copy. I think you know it well. It is a document we have marked D4, if we look at that document, I think you are the author of this memorandum?
A I am, yes.

Q You say:
F

"Learning points and the ..."

then you give a name "Complaint".
A Yes.

Q The name is the surname of the son?
G A That is correct.

Q His mother was the patient?
A Yes.

Q Had a different surname?
A She did, and I cannot recall it.
H

Q Her initials, I think, were ES?
A I cannot remember her name.

Q It is not one of the patients with which – it is EP, I beg your pardon?
A "Purnell" it might have been.

Q Yes. That is my fault entirely, but this is not one of the twelve patients with which this Panel is concerned, but the son, and again you name him, complained?
A He did, yes.

Q Is this the person who you say was angry?
A He was extremely angry.

Q The reason for his anger was what?
A Because his mother was not being rehabilitated and she was deteriorating and that she had started having diamorphine.

Q Was this a case where it had been suggested at an earlier time that his mother could undergo rehabilitation?
A It was, it was from Haslar Hospital, yes.

Q It is apparent from your memorandum that you considered the complaint?
A We did, yes.

Q In your consideration of the complaint, was the view taken that this lady realistically could have been rehabilitated?
A No, it was not the view. She could not be rehabilitated.

Q But he had been told that she was going to receive treatment for rehabilitation?
A By Haslar Hospital, but when she got to Gosport War Memorial she was told by Ian Reid, the Medical Director who covered there, that his mother was dying.

Q He did not react well to it, plainly?
A No, she was in severe pain and she was adamant he did not want her to have pain killers, but she was in severe pain and needed pain relief.

Q Before I come to how this complaint was dealt with, that is one case where you dealt with a complaint and you were involved in dealing with it?
A Yes.

Q From your understanding, was that an issue that was repeated in other cases where relatives had been led to understand that a course of rehabilitation could be provided, that Gosport would get them back on their feet in a couple of weeks, that sort of thing?
A Yes. A complaint was put in later from somebody else which is part of this.

Q How were the staff able to deal with relatives who may have been given unrealistic expectations?
A It was extremely hard on the staff because they were the in between people and relatives would get angry with them when it was entirely not their fault at all. They did try very hard. Sister Hamblin was marvellous at talking to relatives and trying to explain things

A to them in the best possible way. She is/was then a very, very caring ward manager who is very hands-on with nursing care.

Q Let us come back to this particular case. Coming back to the document we have marked D4, you are writing to Max Millett, who I think was the Chief Executive at the time?
A He was, yes, of the Trust.

B Q Had you undertaken some investigation and asked for a Dr Turner to look at the concerns about this case?
A That is right, yes.

Q You have detailed a number of points arising, it would seem, from Dr Turner's letter?
A We had a meeting and Dr Turner wrote afterwards, yes.

C Q You deal at point 3(d) with "Good practice in writing up medication".
A That is right.

Q You say:

"It is an agreed protocol that Jane Barton, Clinical Assistant, writes up diamorphine for a syringe driver with doses ranging between 20 and 200 mgs a day. The nurses
D are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient."

A That is correct.

E Q What you told us is that, with this patient, diamorphine had been prescribed and administered?
A Yes.

Q Was the prescribing and administration of diamorphine part of the issue that Dr Turner was asked to look at?
A It was, yes.
F

Q Can you tell us why you say, "It is an agreed protocol that Dr Barton writes up doses ranging between 20 and 200 mgs a day"?
A I was confirming to Max Millett, the Chief Executive, that this was indeed the case.

Q Would it be fair to say that Dr Turner had raised an issue that that would not be usual?
A I cannot honestly remember if he did or did not. I believe he just asked what the
G protocol was.

Q Where did you get the information to say that it was an agreed protocol that Dr Barton should write up diamorphine?
A From Dr Ian Reid and it was confirmed by the ward managers.

Q The ward managers we know about were Sister Hamblin on Dryad, and in the year
H 2000 it was Philip Beed on Daedalus Ward?

A A That is right.

Q You spoke to both of them.
A Yes.

Q Dr Ian Reid was one of the consultants and also the Clinical Director?
A He was the Medical Director for the Trust.

B

Q We know that there was another consultant, Anthea Lord, who was dealing with patients on one of the wards at that time. Did you speak to her as well?
A I cannot remember. I probably did – I could not say for sure I did or I did not – but I used to meet with the consultants together about every three months and we would raise things like that.

C Q The rest of that paragraph and the information in it:

> "The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient."

D Where did you get that information from?
A From the wards, yes.

Q When you were investigating that issue, was there any suggestion that nurses had not been following such an agreed protocol?
A No, there was no suggestion.

E Q From your position as someone investigating that, how did it seem – that that practice was being followed, that it was working or that there were problems with it?
A It seemed to work very well because, apart from the few hours Dr Barton was in the hospital, there was no doctor in that hospital all day and when another doctor, a deputising doctor, might be called out, say in the night, they did not always come very quickly because they would think, "This is a hospital", and would put it as low priority for visiting, so there was a misunderstanding with the deputising service. We had to keep reminding them that
F there was no resident medical officer in the hospital.

Q Staying with that bottom paragraph, you say:

> "Ian may wish to raise this at the Medicine and Prescribing Committee."

Which Ian was that?
G A That was Dr Ian Reid, the Medical Director.

Q Who were the Medicine and Prescribing Committee?
A It was a Trust group and it was the Medical Director of Portsmouth Hospitals, Dr Ian Reid, senior consultant, geriatricians, senior pharmacists. There was a group of people who agreed protocols for medication across the two Trusts.

H

A Q When you were dealing with this issue and the practice of prescribing in that way, did you have more than 30 years' experience of nursing – I think you qualified in 1967?
A Yes.

Q Had much of your nursing been dealing with elderly patients?
A A good deal of it, yes, probably the majority.

B Q Would you have had many years of experience in prescribing and administration of medicine to elderly patients and palliative care situations?
A Yes.

Q Did you consider that you were in a position to understand the issues that were being raised by this?
A Certainly

C Q Had you had specific training in palliative care and syringe drivers?
A Yes. During my time when I was a district nurse with Dr Barton at the Crossways Practice, I went for a two-week residential course at the hospice in Midhurst looking at pain control and various palliative care treatments. I practice as a district nurse using those treatments.

D Q I understand. Would you have been very familiar with syringe drivers?
A Before I left being a district nurse they had just come in, and so I did use them quite a bit. I looked after two terminally ill people at home, one being my mother and one being an aunt, and they both had syringe drivers, so I became very used to them.

MR JENKINS: Again, in investigating this concern and knowing of the agreed protocol, what was your view as to whether there were any reason concerns about the use of
E diamorphine on these wards?

MR KARK: I am sorry, I just want to understand where this is going. Is this witness being treated as an expert witness and being asked to give her opinion on the appropriateness of this prescription? It sounds very much as if she is. I do not, with respect, think this Committee can be asked that sort of question. She is a nurse and a very experienced nurse but I do raise the propriety of treating her as an expert witness on prescribing, which she seems to be asked
F about.

MR JENKINS: Mr Kark throughout the case has asked a lot of the nurses, and indeed Dr Reid, one of the doctors whom he has called, about the appropriateness of care that was given to various patients. He has asked that question of the care that was provided by that individual and he has also asked them to comment on the care that might have been provided by others. The Panel have very frequently throughout the case asked witnesses – usually
G prosecution witnesses, but very regularly – "What would you think of this?" and "What would you think of that?" together with, "What comment do you now make about the care that you yourself provided to that patient?" I am not treating this witness as an expert witness, but it would be unrealistic to think that her experience is of no value when she comes to give evidence. If she were to be called as an expert witness, she would be wholly independent. She is not. She has been involved in this case in a role at the War Memorial Hospital. I am sure I am entitled to ask her whether at that time she had concerns. She had
H the picture of someone in a management position. She was investigating concerns that were

A then being raised. For it to be said that she is not allowed to express a view is being wholly unrealistic, I would suggest. It comes back to sauce and goose and gander, I think.

THE CHAIRMAN: Indeed I am very conscious of the sauce, and I think it is absolutely right, Mr Kark, that numerous nursing witnesses have been asked about their views about prescribing. Indeed, one of the central issues has been the duty of a nurse to challenge prescribing if they felt that it was incorrect.

B

MR KARK: That is right. This witness was not acting in that capacity in relation to any of these patients we are dealing with. That is the difficulty. She is being asked in a general way. As I have understood it, the witness was led with the question: Did you have considerable experience of syringe drivers? and her answer was: Well, yes, I had particular personal experience of two. That does not provide, with respect, the expertise that may be thought necessary. I understand this has been a topic that has been dealt with with nurses, but

C nurses who were dealing with our patients.

THE CHAIRMAN: Yes, I understand the distinction, but I think that the Panel is capable of giving such weight to the evidence of the witness in terms of her expertise or lack of it. But the fact remains that she was a nurse at the time that syringe drivers were in use, and, indeed, for what it may or may not be worth, she has direct personal experience herself of their use.

D MR KARK: You obviously want to hear it. I will not try to stop you further from hearing it, but I may address you about the weight of the answers you are about to receive.

THE CHAIRMAN: Yes. I look forward to hearing from you on weight. It is not that I think we particularly wish to hear it or otherwise, but Mr Jenkins clearly wishes us to hear it and provided we are appropriately addressed on the weight to attach, I do not think that any great harm will come if we do hear it.

E

LEGAL ASSESSOR: May I add something.

THE CHAIRMAN: Yes, indeed.

LEGAL ASSESSOR: I do not advise against the course which the Panel wishes to take, but, given that it seems to be accepted that this lady is not somebody who, as it were, is actively

F concerned in the administration or anything like that of syringe drivers, it would be my advice to the Panel that if she is to be asked this kind of question it needs to be very firmly established, first, what personal knowledge she has of what went on. It is not going to be sufficient to ask in a general sense whether she approved of procedures. The Panel will need to know exactly what her involvement was and whether she received any complaints and so on. Also, if it were to be her view that her procedures were acceptable, the Panel needs to know by what criteria she is coming to that kind of judgment.

G

THE CHAIRMAN: Mr Jenkins, you have heard that put very clearly by our Legal Assessor. Please ensure that you do "perspectivise" this for us appropriately and we will hear in due course from Mr Kark on the weight to attach.

MR JENKINS: Thank you.

H (To the witness): Coming back to training, you had been on a two-week course in Midhurst.

A A Yes.

Q That was roughly when?
A 1985.

Q Had you had any other training on palliative care or syringe drivers?
A Odd days, and the hospices came and trained us on how to use syringe drivers before
B we started using them.

Q Anything in the 1990s or anything whilst you were at Gosport?
A No.

Q All right. But you have been involved in the field, if I might put it that way, of elderly medicine.
C A Yes.

Q And palliative care.
A Yes.

Q For many years. You were dealing with a specific complaint.
A Yes.
D

Q And we have the son's surname and you have given us the patient's name. You will have looked into what happened in that case.
A That is right, yes.

Q We have been told that a pharmacist used to go round to the wards.
A That is correct. A pharmacist used to go in, I do not know if it was two or three times
E a week, and she was extremely thorough. She would be like a dog with a bone, so if there was anything she was not quite happy with ever, she would see the ward sisters or see myself and tell us about it. I never had any complaints from the pharmacist about the amount of diamorphine that was being prescribed.

Q The name we have is Jean ----
A Jean Dalton.
F

Q Jean Dalton.
A That is right.

Q At the time you were making this memorandum, would you have known all about Jean Dalton's role?
A Yes.
G

Q And the visits that she made to the wards?
A Yes. Yes.

Q Over what period of time, if you are able to tell us, was Jean Dalton making visits to the wards?
A Certainly during the time from 1996 to 2000 that I was there.
H

A Q So at least three years ----
A Yes.

Q -- by the time this memorandum was written.
A Yes.

Q Would you have known throughout that time that there were no concerns expressed
B by her about what she was seeing on the wards?
A Yes, definitely. She would have definitely come to me or written to me if there had been a problem.

Q What, so far as you understood, was she looking at when she was on the wards?
A She looked at the diagnosis of the patient and she would compare that with the treatment they were being given. She would look to see that things were written up
C correctly on the prescription chart. She would cross-reference the controlled drugs: what had been given, how many were left in the cupboard, had they been written up correctly in the controlled book. She was very, very thorough in cross-referencing controlled drugs.

Q What about if there was any possibility of drug interactions.
A She would look at that as well. That was part of her role.

D Q If there had been inappropriate prescribing for a patient's condition, would you have expected her to be aware of it?
A Most certainly. That was her role.

MR KARK: This is all leading. I have warned Mr Jenkins that I would raise my voice eventually and it really is quite important that this sort of evidence is not just led and the witness is allowed to give her answers freely.

E

LEGAL ASSESSOR: It is perhaps doing a disservice to Dr Barton sometimes for leading questions to be asked, because it is a matter entirely for the Panel to decide what weight it gives to the evidence and if the question being put to a witness by Mr Jenkins contains the seeds of a reply then it may be that the Panel will give that reply less weight than it otherwise would – and the Panel may take the view that that is not being fair to Dr Barton.

F MR JENKINS: I am reproached, but I will keep going, if I may.

THE CHAIRMAN: As long as it is not in the same vein. I think that the reproach must stand. First of all, it was you who reminded Mr Kark of the rules of leading early on in this case, and, secondly, there has been considerable discussion about the value to the Panel of hearing leading questions. What we are interested in is what is the view of the witness. When they are merely agreeing with something that is said, it may very well have less weight
G than when we hear their own words expressing their own view. As the Legal Assessor has pointed out, at the end of the day, if we do not get that, it is your own client who will be prejudiced, and we need to make sure that that does not happen.

MR JENKINS: Sir, I remember very well when you made observations. I accepted the reproach. If I have worded it to suggest I did not accept it, then I apologise.

H THE CHAIRMAN: Thank you very much.

MR JENKINS (To the witness): Was there anything else that the pharmacist would have picked up and notified you about beyond what you have mentioned?
A I cannot think of anything else.

Q Who did the pharmacist report to, if she had any concerns?
A She would report to the consultants or Dr Barton or to the ward manager, depending on what it was that she had found.

Q What would you have known about the sort of conditions that patients were being admitted to the wards for, Dryad and Daedalus?
A I would know the criteria of the patients that we should accept. I would not necessarily have known individual patients.

Q No. I think you had no role in the clinical treatment of patients.
A No, I did not.

Q When you came to look at this particular case and looked at the agreed protocol for Dr Barton to write up a syringe driver in an anticipatory way, what would you have known about other patients who might have been written up in a similar way? Would you have known of conditions of patients?
A I would know of conditions of patients, but I would not necessarily have looked at conditions of patients myself and then say to the staff: "And how are they being treated?"

Q I understand. We know that there were patients, some of whom had quite severe bed sores.
A Yes, they did.

Q Do you know if any of those were treated and prescribed in this sort of way?
A I do not know of individual patients who were, but it did sometimes happen. If bed sores were very deep and very painful, that would be the sort of medication that they might be prescribed.

Q Right. When you have said that it was an agreed protocol that patients could be written up with a range of doses for diamorphine in a syringe driver.
A Yes.

Q What sort of patients did you understand were being prescribed for in that way?
A The terminally ill. Patients who were receiving palliative care or patients with end-stage illness.

Q Using the experience that you had which you have talked about, did you have a view as to whether it was appropriate or inappropriate to prescribe in that way in that situation, only one doctor there for a relatively short period of every day, using a syringe driver and diamorphine?
A I thought it was a very reasonable thing to do for patients, to give them a good quality of care and to be as pain free as possible.

A Q Thank you. You have raised the matter with Dr Ian Reid and the idea that he should raise the fact of the agreed protocol with the Medicine and Prescribing Committee. Were concerns being expressed by any medical staff about that agreed protocol?
A No, they were not, it was just the fact that having had a complaint I always felt it was wise then, if a particular issue had been raised, to make sure that what you are doing is the correct thing to do.

B Q Staying with the memorandum, there is reference above what we have been looking at before to nursing care plans. You say,

> "This has been picked up as part of the Clinical Governance Action Plan for Community Hospitals."

You refer to a workshop for clinical managers and clinical practice development facilitators.
C You say,

> "This action plan was evaluated on 20 October 1999 and showed that work with Nursing Care Plans has taken place across all areas in the community hospitals."

That is a bit opaque for us. I wonder if you can tell us why you were writing to the Chief Executive about nursing care plans in the context of this complain.
D A Because, if I remember correctly, this was one of Mr Wilson's complaints. The first thing he did every day when he came to the ward was read the nursing notes, and he put in as part of his complaint that the nursing care plans were not always clear and had not been written up properly. So as that was part of his complaint.

Q You have told us that nursing staff became more busy and more stretched.
A Yes.
E

Q Over the time that you were at Gosport.
A They did, yes.

Q In what ways, if at all, did that increased workload reflect itself if we were to look at the paperwork?
A Unfortunately it is the paperwork that always ... Well, not necessarily unfortunately,
F but paperwork does tend to get behind or not done at all because the patients and their care had to come first. But what we were trying to teach the nurses is that it is really important to write up the treatments they have had, so it is continuity of care, and it could be detrimental to patients' care if care plans were not continually being written up properly.

Q I am going to ask you about one other aspect of this bundle of material. Do you have D2 in front of you or do you just have the page marked D4? (D2 handed to witness) We
G have heard, and the Panel have it as D1, that a senior staff nurse Shirley Hallman made a complaint. She complained about harassment by Gill Hamblin and she said that she was receiving similar overtures from Dr Barton. I take that from her letter of complaint, which the Panel have as D1. It appears from document D2 that there was a meeting held between various individuals. You will see that from the top of the page. If you go to the fourth paragraph down in the body of the letter, you will see reference to you. I am not terribly interested in the complaint itself from Shirley Hallman and I do not know that you have seen
H this document before.

A A I have seen it briefly.

Q If we look two-thirds of the way down the page, we see that Shirley Hallman had applied for a G grade post at Queen Alexandra's Hospital.
A Yes.

Q It is said in the bottom paragraph that she was interviewed for the G grade post but
B was not successful. She received interview feedback from Barbara Robinson who had previously always been very supportive but Shirley Hallman was surprised at some of the content. She was told that she had a reputation for having an attitude problem and that Dr Barton found her challenging to work with. I raise that because the Panel have to consider what Shirley Hallman said. They have this document in front of them and they will already have read this. I just want your take on this. I raise it in case there is any objection to this question being asked.
C A From me or from somebody else?

MR KARK: I am afraid it is always from the lawyers. If this witness had any direct involvement herself in this meeting or was asked to comment shortly afterwards, then she can comment but if she knows nothing about this meeting or this note, I would have thought it is difficult for her to comment.

D MR JENKINS: I raise it because there is a comment attributed to this witness, Barbara Robinson, that Shirley Hallman had an attitude problem and that she was challenging to work with. I think it is an issue that the Panel have to grapple with, Shirley Hallman, and the evidence that she has given. I have previously been told in relation to another potential witness that it is a settled issue in a particular respect but the Panel have already read this and it seems to me fair that the Panel should allow itself to receive further information about Shirley Hallman. I raise it for your consideration.
E

THE CHAIRMAN: Is your question designed to elicit information as to what was said during the meeting or is it merely to deal with the attribution that is stated in the final paragraph on the page in that Barbara Robinson is, within that paragraph, we are told saying particular things to Shirley.

MR JENKINS: I do not think Mrs Robinson was at the meeting. She was not involved in
F this.
A I interviewed Shirley Hallman for the post and I gave her feedback afterwards. I did say to her ---

Q Pause for a moment. Can I just ask: would you have had a view about whether she was easy to work with and if yes or no why that was?
A Shirley Hall was quite ---
G

Q I am not asking you to answer the question because it may be that an objection is maintained. Would you have had a view about whether Shirley Hallman was easy or not to work with?
A Yes.

Q You would. Did you ever express that view to Shirley Hallman?
H

A A I did in the debriefing after the interview. May I say that I did not say anything about Dr Barton, though.

Q That may be so. What other experience would you have had outside Gosport of Shirley Hallman and what she was like as a nurse or what she was like for people to work alongside? Do not give us a view. Just deal with: did you know of her working in other situations?

B A She took up a post at Jubilee House, which is part of the Elderly Medicine Department at Portsmouth.

Q After you left Gosport in 2000, you went to the Queen Alexandra Hospital.
A Yes.

Q With elderly medicine?

C A Yes.

Q And did Jubilee House fall under your remit then?
A It did, yes.

Q Would you have had a managerial role dealing with Shirley Hallman when she was at Jubilee House?

D A I had a managerial role for the sister --- No, I did not even directly have it for that. My Deputy managed the sister at Jubilee House.

MR JENKINS: Before I ask any questions about your view of Shirley Hallman, because objection may be maintained ---

MR KARK: I just wonder how much of this I suspect character assassination is going to help

E the Panel. If we can hear from one witness about what they think about another witness, we are going to be here for a never-ending process.

THE CHAIRMAN: I have to say, in the light of the reference to determination and the matter of settled issue, it is a very narrow area but I had hoped that it was clear within the determination that the Panel were indicating that it had had clear evidence from elsewhere that the individual concerned had raised specific concerns. Whether they were raised at a

F subsequent letter with a nursing support officer does not actually impact on that at all. In answer to Mr Kark's question as to therefore what value it will be to the Panel if this is put, I imagine the answer is "negligible". I would also perhaps observe, Mr Jenkins, to use a phrase that you employed a few days ago: you have shown us the bag. We have your point and perhaps not a great deal is going to be served by labouring that point.

MR JENKINS: The Betty Woodland point is a discrete one and that is rather separate, and

G I had not invited you to review your ruling at all. We have obviously adhered to it. So far as asking one witness to comment on what they think of another, that has happened throughout this case. Mr Kark is engaged on it on a regular basis. He has invited people to give an indication as to what they thought of other nursing staff, of what they thought of the qualities of Sister Hamblin as one. Why it should be said now that it cannot happen in relation to one particular witness when it has happened in relation to others has not been explained to you. As to the third matter that you raise, I may have shown you the bag but you have not heard

H

A the evidence. You may say "we think we know what the evidence would be" but it is a matter for the Panel to decide whether they properly should hear the evidence or not.

THE CHAIRMAN: There was a point within that which was that if we rightly predict what the evidence is going to be, the question is whether it is really going to be of any assistance to us, which was the point raised by Mr Kark. I cannot see that it would be, but if you feel that it is something you really wish us to hear, then by all means elicit the information.

B

MR JENKINS: Then I will. Was Shirley Hallman someone who did have a reputation of having an attitude problem?
A Yes, she was. She was always very critical of people and this was not popular with the nurses she worked with. She was always criticising Sister Hamblin and when she went to Jubilee House, she criticised the ward manager there and also took out a complaint about a night nurse, which was fully investigated and nothing was found.

C

Cross-examined by MR KARK

Q Can you go back to the document you were looking at, D4. I want to understand from you, please, who you say agreed to such a protocol?
A It was an agreement with Dr Ian Reid and Dr Althea Lord and Jane Barton as an agreed practice within the hospital.

D

Q But do you have a recollection of that because Dr Lord told us this: I have not quite registered that the dose range was that wide and I am not too sure why that was. I knew we were writing up. For me the fact that it was written up in advance is sometimes necessary but with hindsight maybe the 20 to 200 was probably too wide a dose range. That was her evidence before this Panel. Do you say that Dr Lord agreed to that protocol at the time?
A As I said before when I was actually asked, I asked Dr Reid and Dr Barton but I was not sure if I had asked Dr Lord or not.

E

Q Dr Reid told us as far as he was concerned, he was not aware of this.
A I find that very surprising.

Q But you have a recollection, do you, of speaking to him?
A Most certainly, yes, and, as I said in my memo, Dr Reid should take that to the Medicines and Prescribing Group to clarify that that was still all right for that hospital.

F

Q When you talk about a protocol in medical or nursing terms, what do you mean?
A I mean an agreement in this case of dosage.

Q Which people are meant to follow is the meaning of protocol, is it not? It is not merely guidance but a protocol; it is something medical staff are meant to follow. Is that right?

G

A Yes.

Q Do you mean that? In this case it was a protocol that Jane Barton would write up diamorphine doses between 20 and 200. That was her normal protocol, was it?
A I do not know if that was her normal protocol.

H

A Q What does this mean? It is an agreed protocol. Agreed with whom and in what circumstances?
A It was agreed with Dr Reid, Dr Barton and Jane Dalton, the pharmacist, who was very well aware, as she looked at these treatment prescription charts two or three times a week, that this was the practice.

Q Was this the practice in relation to those who were on a terminal care path?
B A Yes, that is right.

Q So if we see a prescription following this protocol between 20 and 200 mg, we can take it that that patient is on a terminal care path, as far as you are concerned?
A Usually, yes; it could have been somebody who was in very severe pain from a very deep wound but, yes, generally if I saw that, I would think it was for a terminally ill patient.

C Q You told us about the pharmacist who you said would be like a dog with a bone and she had no complaints that you became aware of?
A No.

Q And she reviewed the prescriptions regularly, did she?
A Yes.

D Q Would you like to take up one of the bundles to your left, patient bundle A, the very first one we have, just by way of example. Please turn to page 200. You are used to prescriptions. Look at that prescription for our first patient for diamorphine and for hyoscine and for midazolam.
A Yes.

Q Do you see that it has no date on it?
E A (Pause) Yes.

Q Sorry?
A No, there is not a date.

Q Is that a lawful prescription, in your view?
A It should be dated.
F

Q Is that a lawful prescription, in your view?
A Not without a date.

Q Is that the sort of prescription that this pharmacist who is like a dog with a bone should have picked up?
A She should have done, yes.
G

Q Can you remember her picking up any prescriptions of Dr Barton?
A No. I would not have necessarily been the one she came to.

Q Ms Dalton, had she signed up to this 20 to 200 protocol?
A As far as I was aware.

H

Q If you had seen the administration of drugs, not just the prescription but the administration of drugs four, six or eight times outside the recommended guidelines in the BNF, is that something that you think you might have picked up on?
A I would not personally, no.

Q It is something you would think the pharmacist ought to pick up on?
A Yes.

Re-examined by MR JENKINS

Q Was the pharmacist seeing anything in addition to the drugs sheets? Were they seeing records for the patients?
A She was looking at the patients' records because they look at the diagnosis of the patient and also at the controlled drug book.

Q Of course. Staying with page 200, is there a box for the date to be put in on the diamorphine prescription?
A No, there is not.

Q I think if you turn over the page, you see a prescription for diamorphine which does bear a date in the relevant box?
A Yes.

Questioned by THE PANEL

THE CHAIRMAN: This is the time for questions from the Panel, if there are to be any. My colleagues do not have any questions for you. I have a little and I am a lay member of the Panel. You said just a few moments ago to Mr Kark that if the pharmacist had picked up any discrepancies or concerns she would not necessarily have brought them to you?
A No.

Q But a few minutes before, if my note is approximately correct, you said something along the lines of: she would have come to or written to me if she had seen a problem.
A If she had had a problem she had not been able to resolve by seeing the clinical staff. It might be a problem of getting drugs to the hospital. It would be more of a management type problem than a clinical problem.

Q My note simply was if she had seen a problem, but my notes are notoriously inaccurate, so I will wait to see precisely what the transcript says on that front. So far as the document D4 is concerned, Mr Kark has already asked you a little about that. You have indicated that the person whom you first consulted and who told you about this protocol, if I recollect correctly, was Dr Reid.
A Who first told me about it?

Q Who first told you about this protocol? I think that is what you said earlier in evidence today.
A After the complaint, I then asked Dr Reid and Dr Barton what the protocol was for the prescribing of diamorphine.

Q This is important then. After the compliant, you spoke to Dr Reid and Dr Barton?

A A Yes.

Q Did you speak to them together or separately?
A Separately I think.

Q And you are sure that you spoke to both Dr Barton and Dr Reid?
A Yes.

B

Q And they told you what exactly?
A They told me that it was their agreed protocol that Dr Barton could write up 20 to 200 mg of diamorphine on a gradually increased scale according to the patient's need.

Q Is there any possibility that you are mistaken on this recollection?
A No, I do not believe so.

C

Q I am not a medic, but my understanding of a protocol is that it is, by definition, agreed because it is an agreement so, technically, there would be no such thing as an agreed protocol, but a protocol is normally in writing, is it or not?
A Normally, yes.

Q Were you then shown a document headed "Protocol"?
D A No, I was not.

Q You were simply told about it?
A Yes.

Q Two particularly important elements you say were within that protocol: one, that Dr Barton was within the agreement able to write up in this manner; and, two, specific doses
E were mentioned. Mr Kark has already told you that when we heard evidence from Dr Reid, he denied all knowledge of such a protocol. In fact, when I asked him again later in Panel questions about the agreed protocol, he said, "I was not aware of any protocol". I then went on to ask him about the issue of the dosage range and he says that he was not aware of that and, indeed, he told us that it was only when it was pointed out to him some years later, that he was even aware of there having been such doses. He said, I put to him, "You had no recollection of ever having seen doses of that large a range?", and he replied, "Yes, that is
F correct"?
A Dr Reid was doing a ward round every week, so I do not understand why he would not have seen that written up.

Q We have had his evidence, we have had your evidence. You are clear that you are not mistaken. It cannot be a simple matter of mis-reference?
A I am very clear because I would not have written to our Chief Executive without
G finding out my facts first.

THE CHAIRMAN: You cannot be clearer than that. I am grateful for that, thank you. That concludes questions from the Panel. We now go back to ask the barristers if they have questions arising out of the questions from the Panel. Mr Kark?

MR KARK: No, thank you.

H

THE CHAIRMAN: Mr Jenkins?

Further re-examined Mr Jenkins

MR JENKINS: Just one arising out of that. You are talking about Ian Reid in that document?
A Yes.

Q He is the Medical Director at the time?
A Yes.

Q You are writing a memo to the Chief Executive of the hospital?
A Yes – of the Trust, Portsmouth Health Care Trust as it was then.

MR JENKINS: Thank you.

THE CHAIRMAN: Thank you. That concludes your testimony. We are most grateful to you for coming to assist us today. It is only by hearing live evidence from witnesses such as yourself that this Panel can begin to put together in a forensic manner some understanding of what happened all that time ago. We are most grateful to you for your assistance. You are now free to go.

(The witness withdrew)

THE CHAIRMAN: I know you are anxious to move on to your next witness. Shall we take a break now and then launch into that?

MR JENKINS: Shall I tell you what I am proposing. I have told you that she was a nurse on Daedalus Ward. Her name is Patricia Wilkins. She deals with two patients, Elsie Lavender and Jean Stevens. I was not proposing to ask her anything about her treatment of those patients. I was going to confine myself to general patients. I am told that she could be back first thing Friday morning. I do not know how long questions may be from others. I will be about 15 minutes. Mr Kark does not believe me, I see the eyebrows go very high, but I hope to be about 15 minutes. I raise it now because the Panel will know whether they are still interested in general issues, I suspect they will be.

THE CHAIRMAN: We are always interested in general issues. Whether there will be any that arise from this witness only time will tell. We will take a break now for 15 minutes, returning at ten past four and see where we get to.

(The Panel adjourned for a short time)

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: Patricia Wilkins. I am told this witness could be back Friday morning if matters do not conclude.

PATRICIA ELIZABETH WILKINS, Sworn

(Following introductions by the Chairman)

A

Examined by MR JENKINS

Q Would you give us your full name, please?
A Patricia Elizabeth Wilkins.

Q I think it is Mrs Wilkins?
A It is.

B

Q You are a nurse?
A I am, yes.

Q When did you qualify in nursing?
A I did my training in the navy in 1969 as an enrolled nurse. I then went on to do my conversion course to RGN in 1991, I think it was.

C

Q Did you work at the War Memorial Hospital in the 1980s in Gosport?
A Yes, I did.

Q Were you working at the Redclyffe annex?
A Yes, I worked at the Redclyffe annex. That was for long stay patients. We had eleven patients at that time.

D

Q We know that in about 1993 the hospital was reorganised and that two new wards were created, one was Dryad Ward and one was Daedalus Ward.
A That is correct.

Q I think you moved to one of those?
A I did, I moved to Daedalus Ward.

E

Q I think you stayed on Daedalus Ward for a number of years?
A For ten years.

Q Daedalus was brought into being in 1993, so you would have been there ---
A I was, yes.

F

Q --- from 1996 to 1999 and the years each side of that?
A That is right.

Q I think when you first went to Daedalus Ward you were a staff nurse and later you were appointed as senior staff nurse?
A That is correct.

G

Q Are you able to tell us roughly when you became a senior staff nurse?
A I think it was 1998.

Q That is an F-grade, just one below the rank of Sister or Ward Manager?
A That is right.

H

Q I am going to ask you about patients that you will have dealt with over that period of time, first, when you were at the Redclyffe annex and on Daedalus Ward, towards the end of the 1990s?
A Yes. The patients actually at Redclyffe, and I also worked on the male ward, they were the continuing care patients. They are the type of patients that you would actually find in residential homes, but of course because long stay – we stopped doing long stay patients, we then came up to Daedalus Ward where we had slow stream stroke rehab patients and we also had continuing care patients.

Q Where those the same or were they different, and if they different in what way?
A They were different. The continuing care patients were always in a stable condition and they were sending over the slow stream stroke patients who were acutely unwell, so there was an awful lot of difference in them.

Q Did it mean that nurses had to be more heavily involved?
A Certainly. You would find the nurses would probably have to do everything for the patients, certainly their care, sort of feeding them, washing them, dressing them. They were really very dependent upon the nursing staff.

Q We know all about Barthel scores here because we have been dealing with it for weeks. If it is helpful for you to describe patients as having a particular Barthel score, feel free to do so.
A The Barthel in the majority of patients were zero, I would have to say, very few actually got more than about 5 or 6, so a Barthel of 20 is going to be somebody who is going to be totally independent, so they were very dependent.

Q As time went on, did it stay the same or did things change?
A I think the patients that we were getting over actually were more acutely unwell. They had a lot of underlying medical conditions as well as the stroke, they had a lot more underlying medical problems that needed a lot more care.

Q Where were the patients coming from?
A Mainly from Haslar Hospital and QA Hospital.

Q Why were you getting patients that were more acutely unwell?
A I think there was a pressure on the beds at the other hospitals to move the patients to us.

Q Why were they not staying where they were?
A Because they were being told to relatives that they were going to Daedalus Ward for rehabilitation and that they would be up and walking around, which was not the case.

Q Were you able to get people up and walking around on Daedalus?
A No, very, very few did.

Q We know that Daedalus dealt with stroke patients amongst others?
A Yes.

Q Do the very frail and unwell patients include some stroke patients or were they separate?

A A No, we had some – I think the majority of the patients we had that did come over were the stroke patients.

Q Patients or their relatives were being told that the patient was being transferred for rehabilitation?
A For rehabilitation, yes.

B Q What would your comment be on some or many of the cases that were being referred over in that way?
A One patient's relative said to me that, "We were told that she was coming here to be rehabilitated", and that we were going to get her up and walking. This patient was totally dependent, so it was very easy to see that we were not going to be able to get this patient rehabilitated. Looking at the past medical history on some of the patients, they were not very mobile before they had actually had their strokes, so it was an uphill struggle. The patients' C relatives had this preconceived idea what we were going to be able to do for them, so we were also, with this as well, with the patient's relatives, we had to try and balance what we were trying to do really.

Q Would you have conversations with relatives?
A Yes, we would.

D Q About what could realistically be achieved?
A Yes, and also the physiotherapists did as well. It was like goal setting really where you would be able to say the goal set would be to get the patient to sit up on their own and then go from there. I think there was a lot of pressure on patients themselves by relatives to say, "What have you done, how many times have you seen the physiotherapist today?" and their idea of rehabilitation, I think, is that the physio would be seeing them most of the day and they would be doing physio, but they were very frail so it was very difficult, really, to do E physio with them.

Q What were the resources for physiotherapy on Daedalus Ward?
A I think the physiotherapist would perhaps spend a couple of hours if that.

Q With each patient or on the ward?
A No, no, on the ward. It may not be as much as that, I honestly cannot remember.
F
Q A couple of hours, was that over the week, each day or what?
A I think it really depends actually on the staffing levels of the physios.

Q If a patient needed help with moving, perhaps getting up and walking or recovering after a stroke, who would be doing that. Would it be the nurses or the physiotherapist or whom?
G A The physiotherapist would assess them, the handling side of things to make sure that we were able to carry on that treatment as well so, initially, the physios would assess the patient and then they would hand that over to us so we were obviously making sure that we were handling the patient correctly as well.

Q But with those patients where the relatives had been told they are coming for rehabilitation, and that was not realistic, would it be nursing staff saying to the relatives that H that is not realistic or would someone else have those conversations?

A A We would have the conversations with the relatives. The relatives would ask for a progress report on their relatives and we would often ask Dr Barton to speak to them, we would speak to them and also the physiotherapists would speak to them and see them as well.

Q If you were involved either in having that conversation with relatives or witnessing someone else having such a conversation with the relatives to tell them that rehabilitation was not very likely, what would you say about how easy those conversations were to have?

B A Again, I think they have had these preconceived ideas from the other hospitals that we were going to be able to do it and of course we are the ones that are having to say realistically we are not going to be able to rehabilitate them, so there were some relatives who were not happy with that. It was a real uphill struggle.

Q When you were saying in any given case that rehabilitation was unrealistic was anything said about the health of the patient or the general health or what the prognosis might

C be?

A I think a lot of the time, yes, we did. We would ask Dr Barton to talk to the relatives about the prognosis and also the consultants would also see relatives as well, so the consultants would be there.

Q If a given patient was not likely to be rehabilitated, what was the reason for that?

A The reasons that they would not be rehabilitated?

D

Q Yes.

A Because they were just too poorly and also they had had a very dense stroke so we were not going to be able to do it.

Q Can I ask about this changing workload. If frailer and more ill patients were being transferred to you, were the management providing more nursing staff to deal with patients in

E that condition as time went on?

A No.

Q What about more physiotherapy?

A No, not at all.

Q We know that Dr Barton was the clinical assistant on Daedalus Ward during the

F 1990s. Was there any other medical input?

A Just a geriatrician who used to come round once a week but there was no other medical input at all.

Q How were the nursing staff coping with the increased workload?

A It was very difficult because if somebody went off sick then we very rarely got cover for that, so it was a struggle. I have to say it was very hard work.

G

Q How was Dr Barton coping so far as you could tell?

A Because of the condition of the patients we were having to phone Dr Barton throughout the day for some advice and she would come back. In the morning Dr Barton would come round and do a ward round. If we had any concerns then we would actually phone and speak to Dr Barton, she would come back at lunchtime to review that patient and also to see relatives or to clerk in patients in the afternoon.

H

A Q I am going to lead on the next bit and if there is any objection I am sure I will be told. Dr Barton would attend Daedalus Ward in the morning.
A Yes.

Q There would be a discussion about all the patients on the ward.
A Yes.

B Q If there were concerns about particular patients Dr Barton would go and see those patients.
A Yes.

Q Would she see other patients as well?
A Yes, we would go round the ward and see all of them but those that we were a bit concerned about had priority.

C Q If there were investigations or tests or results in respect of given patients are you able to tell us when Dr Barton would see those?
A In the morning. If we wanted anything writing up like bloods or antibiotics, anything that we needed, then Dr Barton would write that up in the morning and tests again would be seen from the previous day on the next morning.

D Q You have told us that if it was needed you could get hold of Dr Barton during the day.
A Yes.

Q We know that she was a general practitioner. Would you also have access not just to the surgery number when you could phone her during the day but to any other phone number for her?
A Yes, Dr Barton left us her home phone number so that we could contact her at
E weekends if we had any concerns about the patients. It was obviously something that we did not abuse but if we had any problems then we would contact her at home.

Q You will have seen Dr Barton over a number of years, both on Redclyffe and also Daedalus Ward.
A Yes.

F Q How did you find her as a doctor?
A I found her to be a very dedicated, committed and caring doctor whose care of patients was paramount.

Q What would you say on the question of how busy she was when she was there?
A There were 24 patients to review and there were tests to be seen. We asked her to write up any medications that we might have needed like antibiotics. Yes, she was a busy
G doctor.

Q We know that when Dr Barton attended in the morning there would be a discussion about each of the patients on the ward.
A Yes.

Q We know that if concerns were raised about a patient during the day it would be
H nursing staff that would contact Dr Barton and ask her to deal with it in some way.

A A Yes.

Q What would you say about how approachable Dr Barton was?
A Very approachable. She was always more than happy to give us advice and to come in and see the patients that we had asked her to see. She was very, very approachable.

Q If you had concerns about a particular patient and whether what was being provided
B for them was appropriate or not, would you have felt able to raise those with her?
A Certainly, yes.

Q How would Dr Barton know how any given patient was getting on with the treatment that was being provided for them?
A We would discuss it with her on perhaps the next day that she came into the ward.

C Q Would you be there for handover in the morning?
A Yes.

Q Would handover involve the night staff giving information about each patient?
A Yes, they would give a report on each patient, how they had been through the night, if there had been any concerns with them.

D Q We know that Dr Barton would also be doing a ward round on Dryad Ward as well and that she saw one ward after the other. Was Daedalus the second ward that she saw or the first one?
A As far as I can remember I think Daedalus was the second ward that she came to.

Q When she arrived in the morning had handover already taken place?
A Yes, it had.
E
Q Or would she be there when it was taking place?
A To the best of my knowledge it was almost always over by the time Dr Barton came.

Q Who would go through the patients with Dr Barton?
A It was the nurse in charge that particular day.

F Q We know that Sister Sheila Joines was sister on Daedalus for many years.
A Yes, she was.

Q After that time the ward manager was Philip Beed.
A Yes, that is right.

Q If those were the nurse in charge of the ward would Dr Barton go through patients
G with them in the morning?
A Yes.

Q When you were senior staff nurse you were second in command to Philip.
A Yes.

Q Would there be occasions when you would go round the ward with Dr Barton when
H Philip was not there?

A A That is right.

Q You have told us about unrealistic expectations that there may have been in some cases. Did you see Dr Barton dealing with patients or dealing with relatives in cases of that type?
A Could you repeat that, please?

B Q In cases where patients were transferred, perhaps where unrealistic expectations for what could be provided or achieved were present, did you see Dr Barton dealing with the relatives or with the patients in that type of case?
A Dr Barton would actually come and clerk the patient in. She would also see relatives as well and explain to them the diagnosis and prognosis.

Q Would you be present for some of those discussions with relatives?
C A Yes, most definitely.

Q What would you say of Dr Barton's approach and manner in dealing with relatives?
A Dr Barton was very kind to them. She actually told them the prognosis of the patient and was very, very kind and went through the process of what they would like to be done.

Q From the way in which I framed the question these may be patients where the
D relatives had an expectation which was not likely to be realised. Does it follow that Dr Barton may sometimes be giving them uncomfortable information?
A Yes, but it was honest opinions and truth really. When the patients were in the other hospitals, certainly the relatives had been given expected outcomes really.

Q You have said that when patients were admitted Dr Barton would clerk them in.
A Yes.
E

Q Would you have been present when that was done?
A Yes, I would have been.

Q What happened when Dr Barton clerked in a patient?
A It was an examination of the chest normally and also then wrote down in the medical notes what was actually wrong with the patient, past medical history as far as I can recollect.
F

Q Would a nursing assessment by that stage have been undertaken of the patient or would that follow at a later stage?
A If a patient came in at lunchtime and Dr Barton happened to come in at the same time the nursing assessment would probably be taken after.

Q You have been in nursing for many years, I think?
G A Yes.

Q You will have seen many doctors clerking in patients in this setting and in others?
A Mostly this setting.

Q How would you compare Dr Barton's examination and clerking in of a patient compared with that of other doctors that you may have seen?
H A Fine. I had no problems or concerns about it.

Q We know that Dr Barton made notes following an admission of a patient.
A Yes.

Q We know that Dr Barton made notes when she was clerking in a patient and you have told us that you will have seen other doctors clerking in patients in the past. What would you say about the volume of notes that were made by the doctor?
A Dr Barton wrote quite precise notes and also we actually had a handover, so what was gleaned as well from the examination as well as what was written in the notes is what we would actually handover to the staff as well, so we had precise notes and a verbal handover that we used to give to the staff.

Q We know that on occasions there might be a prescription written up for a syringe driver.
A Yes.

Q We have called that anticipatory prescribing with a prescription being written up for diamorphine on a syringe driver at a time when the patient did not need to have that at that time. What was your understanding of why that might occur if it did?
A Looking at the past medical history of a patient and that they were perhaps on analgesia it meant that if a patient became unable to take medication orally that we could start a syringe driver at a time when it was relevant for the patient to have it without waiting for ages for a doctor to come in and to write up a driver.

Q Without waiting for ages for a doctor to come in and write them up?
A Yes. Certainly in my experience this has happened at weekends when it is an out of hours service doctor and they are based in Cosham, which is quite a way from Gosport hospitals and it seems that because we are a hospital we do not necessarily take priority for a doctor to come out so it could be hours before a doctor comes to see a patient.

Q If that were to happen that a prescription would be written out in that form and in advance of it being required, who else would have been aware of it?
A All the nursing staff would have been aware.

Q You say all the nursing staff. Does that include Sister Joines or the ward manager, Philip Beed?
A Yes, because it was actually written up on the drug chart that was kept for each patient.

Q What about the consultants?
A Presumably they looked at the chart.

Q Were you there for a ward round if one took place?
A I cannot remember, I am afraid.

Q You have made an inference but people will bear that in mind. So far as actually administering medication is concerned, would you have been involved in that as well?
A At times, yes.

Q We know that your signature appears in respect of a couple of the patients that the Panel are concerned with. I am not going to take you to those now – others may wish to do so – but can I ask you if you had had concerns about medication for a patient would you have raised any concern about that?
A Yes, I would have done. I would have challenged it.

Q As a nurse what would be your duty, if any, in relation to medication if you thought it was inappropriately suggested for a patient?
A I would challenge it and ask why because it may not be for the benefit of the patient.

Q You know that this is a case that concerns medication provided for patients.
A Yes.

Q Did you have any concerns about care given to patients on Daedalus Ward during the period that we are concerned with?
A No, not at all.

MR JENKINS: Thank you.

Cross-examined by MR KARK

Q On that last issue that you were being asked about that you would challenge medication if you thought it was wrong, did you actually ever do that?
A No.

Q What would be your reference point? What would you be checking the prescription against?
A It depends on each patient, does it not, because they are all individuals, so it would be very difficult for me to comment on anything on that at the moment because (a) I am not sure what patient you are saying ---

Q No, but if you are simply looking at a prescription, sometimes the notes were not perhaps as good as they should be, what would you be checking the prescription against, would you look at the BNF would you look at the Wessex Protocol?
A We would actually be looking at what they had before. I mean, if they have had something orally, oral medication and then you would ...

Q You would what?
A The oral medication and then they would go on to the driver.

Q Do you know what the guidance was about the transfer from oral to the driver?
A I cannot remember it I am afraid.

Q You cannot remember it?
A No.

Q So far as clerking in is concerned, you told us a bit about that: my note is – your voice is quite soft and I want to make sure I got the right word, did you say she made concise or precise notes?
A Concise.

Q Sorry?
A Concise notes.

Q Did you feel that the clerkings in that you saw were rushed?
A No, not at all.

Q I mean, Dr Barton had appropriate time, so far as you were concerned, to do a proper clerking in?
A Well, again, Dr Barton would come in at the lunchtime after surgery to clerk patients, and sometimes again in the afternoon.

Q Yes, but you did not feel any of these clerkings in were particularly rushed?
A No.

Q So far as the type of patients that you were getting in, would it be fair to put it like this, sometimes, particularly, what, in the latter half of the 1990s you were getting patients who had been given an over-optimistic prognosis, is that fair?
A Definitely, yes.

Q That obviously does not apply to all the patients: as you have said yourself, all the patients were individual but some had over-optimistic prognoses, yes?
A Uh-huh.

Q And on occasion you would have to let the relatives down ---
A Yes.

Q --- and, indeed, the patient down, yes?
A Yes.

Q It is important in those circumstances, I presume, to make a careful assessment of the patient, yes?
A Yes.

Q Because sometimes when the patient first arrives with you they may have been knocked back a little by the journey, is that fair?
A Yes, uh-huh.

Q So a proper and full assessment of that patient would be particularly important?
A Yes.

Q And a note of such an assessment would be important?
A Uh-huh, but this is actually ... We are talking about patients that had actually been on the ward for days, I would say perhaps a week, but relatives were still thinking that they were here for rehabilitation so, you know, they were not sort of admitted one day, assessed, and then we were sort of telling relatives that, you know, the prognosis was not going to be any good.

Q So some were, in your view, not really able to be rehabilitated.
A No.

Q But you did have some physio and rehabilitation services?
A Yes.

Q Did you say you had a physio spending a couple of three hours on the ward?
A No, it may be sort of like perhaps an hour and half on the ward really, realistically.

Q Per day?
A Yes, per day.

Q And this was on Daedalus Ward?
A Yes.

Q Which was supposedly the rehabilitation ward?
A Yes.

Q Presumably the physio would not have to deal with every patient on the ward because some patients plainly would not be fit for physio at all?
A No.

Q And some of these elderly patients would be doing very small amounts of exercise, such as turning their neck or lifting their arm, that sort of thing?
A Possibly or sort of trying to get the trunk control because some people that do have strokes they lose control of their trunks so it is basically perhaps the first step would be to sit the patient up and getting the sitting position sorted out first of all before you would actually go on to do anything else.

Q Also, presumably, to demonstrate on occasion to nurses how to get a particular type of patient out of bed and that sort of thing?
A Yes. With a patient with a Barthel of zero we would have hoisted them out of bed. We would not have actually got them to stand or anything.

Q I understand that. Finally this, in relation to the anticipatory prescribing, you obviously became quite used to that, did you not?
A Yes, uh-huh.

Q That was something that was done on a regular basis by Dr Barton?
A Yes.

Q I think you said it was particular relevant at weekends.
A I certainly think that was when we had the problems trying to get anybody in to see patients, if they had not been written up for any medication at all.

Q Would that mean that at weekends you as nurses could start those patients on a syringe driver without reference to a doctor?
A No, these are patients who have not been written up for any analgesia, that we ---

Q I understand that, I am sorry, but when you have a patient who has been written up for one of these anticipatory prescriptions, come the weekend if you the nurses take the view that

A that patient, for whatever reason, needs a syringe driver can you institute that of your own volition?
A Yes, if the patients were unable to swallow any medication and their condition had deteriorated and they were in a lot of pain we would start the driver on the lower dose of the analgesia.

Q You would not necessarily need to go back to the doctor at the time?
B A No.

MR KARK: Thank you.

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: I have no re-examination, thank you.

C

THE CHAIRMAN: We now come to the point when members of the Panel, if they have any questions of you, have the opportunity to put them. (None)

Questioned by THE PANEL

D THE CHAIRMAN: Again it appears the only potential question is going to come from myself: I am a lay member, and it is a very brief point, and you will correct me immediately if my note is wrong but I think you were telling us that in relation to dealings with relatives, you were telling us how kind to the relatives Dr Barton would be; she told them what the prognosis was and went through the process of what they would like to be done.
A Sorry, I should have been a bit more clear on that really. It was basically, certainly if they were on medication for any pain relief, because the majority of them were on some sort of Oramorph or something, and then it would be really the next stage to that, on how we
E would actually be able to administer pain relief to them, and I on many occasions have actually gone through a syringe driver with the relatives and actually shown them what they are and they have been really happy with that, that the pain relief would be given via a driver so that they would have pain relief 24 hours a day instead of intramuscular injections which they used to give prior to the syringe drivers, which are very painful, and obviously you get your lows and troughs with an intramuscular injection but with a syringe driver it was 24 hours pain relief. As I say, the relatives were more than happy with that. They did not
F actually say that they did not want it or they were unhappy with that at all.

Q But in terms specifically of your experience of seeing and hearing the way in which Dr Barton dealt with those relatives, on a scale of one to 10, say, how receptive would you say she was to the views of the relatives on matters of the trade-off, say, between amount of pain and amount of consciousness, if you heard such a thing?
A Could you repeat that again?

G

Q Yes. We have heard a lot about there being a trade-off between the amount of sedation that you receive and the extent to which you will be alert and the extent to which you will be pain-free: did you hear of any occasions when patient's relatives, who had a particular view one way or the other about the trade-off, whether there should be more alertness or more pain treatment, and if so how receptive was the doctor to the views of those relatives?

H

A I think most of the relatives just wanted their loved ones kept comfortable, pain-free, so I cannot honestly recall them asking about that really, about whether or not they would be more conscious or pain-free. As I say, the majority of relatives wanted their loved ones kept comfortable.

Q So in general terms, in terms of responsiveness to the concerns of the relatives how open was the doctor to taking on board the wishes and desires of the relatives?

B A Dr Barton was very sensitive to that and obviously took on board what the relatives were saying; and hopefully that that was the case – that they wanted them either kept pain free, which was what most of the relatives wanted for them.

THE CHAIRMAN: That was all I had. The very final bit is that I have to ask the barristers whether they have any questions arising out of those. Mr Kark.

C MR KARK: No, sir.

THE CHAIRMAN: Mr Jenkins.

MR JENKINS: No, sir.

D THE CHAIRMAN: Then that completes your testimony. Thank you very much indeed for coming. It follows that you will not need to come back on Friday. We are most grateful to you for your assistance. We do rely on the help of parties such as yourself to help us in our inquiries and you leave with our thanks.

THE WITNESS: Thank you very much.

(The witness withdrew)

E

THE CHAIRMAN: We will be starting at 11.30 tomorrow. If there is nothing else we will adjourn now and meet again at 11.30 tomorrow. Thank you very much, ladies and gentlemen.

(The Panel adjourned until Tuesday 28 July 2009 at 11.30 a.m.)

F

G

H