DAY 7

Blake Lapthorn

File Note

New Kings Court, Tollgate, Chandler's Ford
Eastleigh, Hampshire SO53 3LG

DX: _155850 Eastleigh 7

Code A

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Client: Private

Matter: Gosport War Memorial -v- Gosport War Memorial Hospital

Matter No: 516130/000001/JCW/GOSPORT

Author: Gemma Bailey

Date: 26/03/2009

Units: 1

Attendance on Client

1 Units (Gemma Bailey) - Unknown - Gosport War Memorial

Day 7

Coroner – going to call Mr Ian Wilson first. Happy to take Neil Wilson's statement under r37 and if want to reserve position for future then can do.

PS – take advice on Neil Wilson.

(jury in)

IW

Coroner – heard about Robert Wilson. Want to go through own statement or say in own words?

IW – say in own words. Have some notes to help. Dad 74 years old, ex navy. Did 27 years in navy. Middle of 7 children. Wouldnt say close family, always fought and now spread across the world.

Coroner – NW in Bahrain.

IW – worked out get on better if don't see each other. Mum and Dad married for 32 years, lived in Fareham. NW probably favourite and IW Dad's least favourite. Would often get into trouble, took brother with him. NW went into army. Good relationship with father. Ran home like ship. After 32 years got divorced, mum instigated it, dad took it badly. IW more upset than others, spent lots of time with dad after navy. Was then bus driver so would go on trips with him. Got divorced early 80's. Dad moved to Sarisbury Green to lodgings with old polish man. Seemed happy. Alcoholic for whole of IW's life. Broad Scottish accent. Deaf in one ear due to something in war. Used to assume just selective hearing! Never got over mum, always hoped chance of getting back with her right until the end. Met someone else who was local barmaid. Easy relationship. She felt threatened by 7 kids. IW didn't like her, she didn't like IW. With her for quite a few years, married her but only told NW about

wedding. IW wouldn't have turned up at wedding. She looked after IW. Seemed to have nice life. Became his life – would go to club in morning, come home around 3pm, may then go back in evening.

Coroner – what did he drink?

IW – used to be beer but then rum and whisky. Major row with wife and then banned from house. Would see dad at club after that. Well known in club. That was life until 97 when admitted to hospital. Not 100% sure what admitted for other than had fall. Lots of tests done, lot to do with alcohol.

Coroner – liver damage referred to by PB

IW – cant remember how long in hospital but all went to visit bar IW's mum. When released from hospital was told to do something about drinking so went from rum to whisky. Not told in hospital in 97, wife said nothing to do with children. Made clear to her he was their dad and expected to be told if happened again. In 98 wife in Cornwall on holiday, dad just received compensation payout from navy for deafness (£20,000 or so). Wife would often disappear on weekends away. Meant always bottles of spirits around the house. In September 98 wife in cornwall, had been away 4-5 days. Whisky in morning, then club and then home for more drink. Didn't bother eating. So regular at club could set watch by him. One morning didn't turn up. Steward decided would go and make sure ok. Found him fallen over by side of bed, hadn't been able to get up. Had put on huge amount of weight in later years, not very fit. Centrally obese. Only exercise was to walk 200 yards to club and back. Ambulance called and went to QA. Presume hospital given wifes contact details. If wife had been at home would have probably been discharged, but because she was in cornwall he was kept in. He refused operation.

Coroner – RW refused surgery on admission and not until condition deteriorated that couldn't do operation.

IW – by time he said yes he had become too ill. Had been in around a week before IW told. Not sure who found out first between IW and NW. Went to club and steward let them know. Went to hospital was first to visit. Shocked when saw him, couldn't believe state and how he looked. If died then wouldn't have been surprised. Laid in bed, no energy, wouldn't do anything, no life in him, wouldn't talk, not eating or taking liquids. Worried about him. Phoned other family members to let them know how bad he was and spoke to nursing and medical staff. Spoke to doctor (cant remember name) asked if RW would die. Doctor said problems weren't in themselves life threatening. Had nasty fall and painful and serious fracture. Told now too ill to have operation. Other problems = alcohol related. Didn't know what problems were at the time. Doctor said none actually life threatening. Some elderly people give up will to live – suggested this may be case with RW. Didnt ring true with IW as dad fighter. When younger and lived at home parents had lots of ups and downs. RW always strict. Mum always said he would die a sad and lonely old man. That is what IW saw. He had been there for a week with no one. Wife not there nor ex wife.

Coroner – deeply affecting for you.

IW – gutted, heart broken. Devastated, took parents for granted. Over next week or so all went to see him. Mum also went in and saw him. Dad started responding. Took food and drink, much more alert and involved. Instead of being laid in bed would be sat on bed or sat in chair. Tried to keep arm fixed as still in pain with that. Over next 8-9 days improvement immense. Eating again and drinking, nurses knew getting better as arguing back and talking to them. Seemed to be getting back to himself. QA nursing staff and doctors very helpful. Always someone to talk to and happy to discuss. Thought responded as had family around him again, and had been on medication for liver and other problems. Now taking effect. QA very aware of friction between mums side of family and current wife. Made point of always telling both sides what was going on. Cant remember wife

being there very much. NW there all the time but had problems of his own – wife just had premature baby and also working. Social Services got involved. Wanted to move out of QA as didn't need to be there but wife refused to have him home as said she couldn't cope. Stressed RW as didn't want to go to nursing home as wife and step daughter both worked in nursing home and had told him many stories. At one stage mum volunteered to have him home and brothers help but decided not good decision. Then decided he was too well for nursing home. Questions over funding as had improved so much. Social services looking for care home/rest home primarily ex navy so he could go into comfortable environment. Suggest moved to St Christophers hospital in Fareham in meantime. As far as IW aware that was what would happen. On night before moved went to see him in QA. NW there. Then told going to GWMH instead as easier for people to get to it, but only easier for IW to get to. Difficult for wife to get there from Sarisbury Green. When left him he was sat up in bed was talking, eating, drinking, generally happy and content had to move to GWMH. One thing concerned about was travelling. Hated travelling and being driven by anyone else. On morning transferred not been able to confirm exact time but appear picked up from QA around 10am not by ambulance or paramedics but passenger transfer. Got to GWMH just before 2pm or just after. Went everywhere – to various different hospitals.

Coroner- was a general bus.

IW – yes. Travelled with wife. Told him evening before IW wouldn't be visiting first day but would be in next day. Transferred on 14th, went to see him 15th. When arrived at GWMH on 15th late afternoon. Was horrified when went in. Had regressed and was worse than he was. Laid on bed, unable to move, could hardly speak, couldn't believe decline. Wife there so asked what happened. She said long transfer to get there, didn't travel well. She had been told seriously ill and would die. Sister told her that despite what told at QA. IW asked to see sister, told not available, asked to see doctor, told only comes in once a day. At that time emotions got better of IW and he kicked off. Told by nurse wasn't designated family member, wife was. Nurses and doctors would talk to her and it was down to her to pass information on. Pointed out she was an alcoholic and hated IW. Threatened with being ejected from hospital and being arrested. Kicked off again. Went home as didn't want to be arrested. Spoke to other family members. Believe one of sisters also spoken to and made a designated family member. NW unable to attend as daughter unwell. IW couldn't even get nurse to talk to him. Before left on 15th went to give dad a hug and he spoke last words – 'help me son they are killing me.' IW replied they are trying to do best for him, and left him. Went in next day and he was in a coma. Had syringe driver in by then – wanted to know what that was for but no one would tell IW. Wife didn't know either but thought it was pain killer. At QA dad anti drugs, refused paracetamol. Now at GWMH being given pain killers. NW phoned sister in LA and told her to come to UK. Sister arranged flights and NW picked her up, arrived on 17th. Cant remember what time she arrived but afternoon sometime. RW had been moved into small private room, nurses would come, wife there, step daughter there, other family members there and mum been to see him too. Each time nurses came to make him comfortable nurses would insist everyone left room. They would then be allowed back in. From 17th IW went home once sister turned up, left sisters there. Wife and step daughter there for a bit but then left. Got call late in evening around midnight saying he had died and should go in to see him. Went to GWMH brother there, NW there and sisters. Believe wife and step daughter also there. Stayed with RW for a while then left and went to IW's house. (IW, NW, LW, CW) talked about what to do now. Decided wouldn't do anything until met the following day. Knew didn't want wife to take control as she would exclude kids. Arranged

to get together following day but IW and TW never heard anything. Found out NW and other siblings collected death certificate, arranged funeral and arranged for him to be cremated. TW and IW kicked off.

Coroner- fair to say because of reaction at GWMH they pushed IW aside?

IW – no. Reason kicked off was because being excluded.

Coroner – excluded because not designated person and conflict between IW and wife.

IW – hospital not aware of conflict. When first arrived asked to see someone and told not designated person.

Coroner – PB confirmed RW ill but perhaps not in way we understood. Illness not evident before transfer?

IW – no. Been told by QA nothing life threatening right at beginning when looked really bad.

Coroner – anything else?

IW – no.

Coroner – any questions.

AJ – questions on behalf of Dr Barton. Clearly still working through own issues with father. Said black sheep?

IW – no.

Coroner- said probably least favourite.

AJ – don't want to put words in your mouth. Don't want to ask about family relationships. Number of people due to see father in GWMH – children, mother and wife and step daughter.

IW – yes but not all at once. All in at different times.

AJ – in addition to alcohol father was smoker. 80 a day?

IW – probably at one time yes. Heavy drinker and smoker.

AJ – not good at eating?

IW – said when living on own not good at eating. Would drink rather than eat. When wife there she would feed him and he would eat. As for smoking he gave up 16 years before he died.

AJ – medical records suggest wife said didn't really eat at home.

IW – cant contradict as wasn't there. Always had good appetite but pure laziness.

AJ – when arrived at QA real concern he hadn't been getting adequate nutrition.

IW – 5 days previous had had rum or whisky.

AJ – talking long term.

IW – not long term, not seen that in notes. Didn't eat perfect diet, ate what he liked.

AJ – know in October he was seen by psychiatrist. Whilst might have been bright when IW saw him but psychiatrist said saw no point in living.

IW – psychiatrist saw in first few days.

AJ – had been in hospital a few days. Seen 10 days before death. Psychiatrist suggested dementure and Alzheimer's.

IW – suggested but no proof

AJ – discussion about renal failure too.

IW – believe under control with medication at QA. Even Dr Black said that.

Coroner – PB said wasn't going to get better all could hope was to control it.

AJ – know view at GWMH was that heart not working effectively.

IW – don't know that as no one at GWMH talked to IW.

AJ – one of 10.

IW – heard so far nurses caring etc but they weren't. Otherwise would have found time to talk to us.

AJ – know ward with very little doctor input.

IW – yes. Terrible. Tried to see a doctor and couldn't.

AJ – saw father on syringe driver. Not put on this until 16th.

Coroner – first saw on 17th at GWMH?

AJ – syringe driver instituted on 16th after seeing psychiatrist. Psychiatrist noted possible heart attack.

IW – also know no assessment done when admitted to GWMH. Heard that from PB.

Coroner – will be one of issues to deal with. May not be documented but did it happen?

IW – surely if happened it should be documented.

Coroner – have open mind at present.

IW – don't think assessed.

AJ – can say what like but wasn't there. Doctor wrote ccm (possible heart attack), wrote him up for many drugs.

IW – want truth.

AJ – get it through evidence rather than speculation. Seen by psychiatrist who noted deterioration. After that put on syringe driver.

Coroner – what is notes say.

IW – have to assumed notes right.

AJ – know Dr Peters saw RW 2 days later. May not have spoken to doctors but they were there assessing and seeing father, changing prescriptions etc.

IW – changed it all

AJ – condition changed

IW – think due to drugs that condition changed. On 13th said got a lot better. Then on 14th goes immediately downhill, on 15th in coma, on 16th on syringe driver.

AJ – told us what said about transfer.

IW – would have been agitated after long transfer but don't think this killed him.

AJ – note says decline overnight, swelling in arms and legs, query deterioration of liver function and heart attack.

IW – had swelling at QA being dealt with by drugs.

AJ – further rapid deterioration. Not saying didn't happen?

IW – no but how much diamorphine.

AJ – suggested father said killing him. When?

IW – 15th.

AJ – told police that?

IW – yes. Well documented with police and GMC that missed so many things out of statement.

AJ – sign it?

IW – yes. But lots of controversy. Volunteered to go to police station to give statement.

Coroner – probably not relevant line of questioning. Doesn't go to syringe driver on 16th but says being killed on 15th.

AJ – doesn't say in statement about killing him.

IW – when police came to house had to sign it. Refused to do it under recorded conditions, wouldn't give IW tape either. Had to sign declaration to say that wasn't secretly recording the conversation. Then asked for copy

of statement which eventually received and omissions from it. Made it clear that not happy with statement as its not clear.

AJ – have statement.

IW – what said was 'help me they are killing me'. For 10 years wanted to put this to bed. Don't want to be here doing this. Would you like this to be done to you.

AJ – unwise for witnesses to ask questions.

PS – taken to facts and evidence. Be given bundle of medical records. Aware of father's renal problems?

IW – didn't know exactly what problems were but knew multiple problems, not just fracture to arm.

PS – just will hear from Dr Wilcock in due course. Wilcock concludes renal impairment at QA had resolved completely with appropriate therapy.

IW – under impression renal problem dealt with. Drugs at QA had desired effect.

PS – variety of notes now. Pg 18 – documents are records made at time. 8th Oct date of assessment by psychiatrist. Seen by OT, refusing to wash for second day. At risk of self injury, look for suitable home until recovered. Accord with memory at that time? Been at QA 10 days.

IW – yes. Said he had got better and too well to go to nursing home.

PS – bottom of page says seen by psychiatrist. Pg 19 – 08/10. Wife unable to visit, not heard from social services, trying to arrange discharge, didn't want him to go to home and RW didn't want to either. Said busy tomorrow too but would call social services. 09/10 – social worker will contact wife re placement. Continuing care may be only option. Pg 21 – 12/10 – 12.30 tried to put him forward for continual care bed as bartel score too high at 7. Social worker said bartel too low. Consider whether appropriate for rehab. 13/10 – reviewed, continues to require special care. 24 hour hospital care until healed. Seen by dietician, encourage supplementary drinks. Will follow up at St Christophers.

IW – yes under impression going there.

PS – pg 34 – nursing notes – 08/10, no problems communicating, eating well. Arm remains swollen, refused wash. Very chatty. Cooperative after initial reluctance. Hand remains red. Appetite variable, no complaints of nausea. Sat out for most of afternoon, paracetamol given as prescribed. 09/10 – 10am given shave. Declined further care, visitors all afternoon, chatty and appears well. 10/10 – good nights sleep. 11/10 – communicating well, as required codydromol, no extra analgesia overnight. Good diet taken, pain remains bad in left arm. Managed to shave himself. Transferring better, eating and drinking well. Overnight drinking well, appears comfortable, regular analgesia. 12/10 – good breakfast, pain. Night staff washed lower half. Arm hand and feet swollen. Restless overnight. 13/10 – weight gone up. Diet fair, good mood. For discharge to Dryad. No complaints of pain, passing urine independently. Peaceful night, no complaints of pain. Accord with memory of lead up to transfer?

IW – yes.

Dr Barton

Coroner – Dr Jane Barton.

JB – yes.

Coroner – not obliged to answer any questions if likely to compromise you in any future proceedings. Up to you. Presume taken advice on this. Tell me about job. Read statement.

JB – Forton medical practice, qualified 1972 in Oxford. Joined present practice in 1980. GP minimum full time commitment, 8 GP surgeries a week, home visits etc. In addition took sole clinical assistant post in 1988 at

GWMH. GWMH 48 long stay beds originally 3 sites. Resourced for long stay. 4 sessions a week – 1 allocated to partners to deal with. Then increased to 5 sessions, 1.5 to partners for out of hours. 3.5 sessions for JB. In addition to GP practices. By 98 working dryad and deidlus – 48 beds. Some for slow stream stroke but rest for continuing elderly care. Dr Lord – deidlus, Dr Tandy – Dryad. Considerable responsibilities elsewhere so time at GWMH limited. Dr Lord only there to conduct ward round every other Monday, would also be conducting out patients Thursday when would do further round for stroke patients. Dr Tandy didn't return until 99 as took annual leave and maternity leave. Dr Lord covered but given own position couldn't do ward round on dryad so for much of 98 had no effective consultant support for one ward as trust wouldn't cover it. At time of resignation in april 2000 were 2 consultants. Consultant there now not always available to conduct round. Would arrive around 7am, do ward round and conduct GP duties at 9am. Would return at lunch time, new patients normally arrived before lunch so would admit and write up charts and see families. Would sometimes return in evening as concerned to see families who worked. Concerned to make available even outside those hours so nursing staff would ring either at home or at surgery if medication to be increased, even if within prescribed amount. Nursing staff would inform immediately or shortly after. Level of dependency initially was low – analogy now to a nursing home. Over time dependency increased – patients admitted were profoundly dependent. Increase in care required for patients. Bed occupancy 80% but trust wanted to increase that so rose to 90% meaning 40 patients to be seen each day. No increase in staff and no support from social services. On day by day basis JB was only medical input. Responsible for day to day medical management of patients approaching end of their lives. Vast majority had undergone treatment elsewhere and were transferred for rehab or palliative care. Majority suffering dementure as well as organ failure. Tried to forge relationships with families but often strained due to unrealistic expectations of families in what could be provided by hospital. Relied on nurses trained and untrained. Tried to offer level of freedom from pain and symptoms. Difficult to offer. Believe established good working relationship with staff. Felt able to place significant measure of trust in nursing staff. Marginal increase in staff over years despite significant increase in workload. By 98 marked increase in dependency and numbers and limited consultant input. Demands on JB considerable given expected to provide in 3.5 sessions. Raised concerns but no one else able to do it. Felt unable to continue and resigned. Position then replaced by full time staff grade, may now be increased to 2 positions. Reflection of demands on JB. In addition consultant care increased to 10 sessions. In 98 tried to raise with trust management but felt obliged to remain and support colleagues and care for patients. Felt if left then would be letting down staff and patients, many of whom JB's own patients. Felt compelled to resign in 2000. In caring on day to day basis could make basic notes about all or see patients for longer and write brief notes. Medical records don't set out each and every review in full. Of necessity were sparse. Nurses had same problems. Similarly re prescribing adopted proactive prescribing to give nurses some freedom. If deteriorated such that required further drugs could be given. Adopted out of necessity but had trust and confidence in nurses who would be acting on this and nurses would liaise with JB anyway. Accept not necessary in normal hospital where consultant would be available there and then. May be of significance that prescriptions regularly reviewed by consultants when carrying out ward rounds. Never told this was inappropriate.

Coroner – looking generically. Arrive at 7.30, then surgery by 8.45-9am. During that time what do you do?

JB – arrived at dryad, liaised with sister or senior staff nurse who would be at end of report with night staff. Would walk through ward with her, see patients, ask relevant questions to patients and any problems nurses had.

Coroner- quick visit.

JB – didn't all require same level of attention if condition stable.

Coroner – if ward round done write what was necessary?

JB – yes.

Coroner – if admitted did you see them?

JB – generally didn't arrive until lunch time. Would come back to GWMH where would clerk them in. Full clerking. Prescription written by JB there based on notes which would arrive with patient.

Coroner – said occasions when notes didn't arrive with patients. What then?

JB – would ask nurses to contact ward where patient come from and get notes sent. Sometimes would arrive with medication and paperwork, sometimes one, sometimes neither. Would clerk them in at first available opportunity.

Coroner – condition of patients deteriorating over years, degree of dependency increasing, not type of patient unit set up to cope with. Bed blocking mentioned and pressure from Haslar and QA. Experience that?

JB – wasn't JB's problem. Problem for management. If told someone arriving would clerk them in. Not job to refuse to take them.

Coroner – trying to pick up on increased demands at that time.

JB – enormous pressure. Patients deserved to be clerked in on day of arrival.

Coroner – generic questions.

TL – Dr Barton not giving evidence relating to any represented families today, no questions.

JT – good relationship with nurses. Proactive prescription, nurses would liaise if making changes to prescriptions. Nurses appeared to be acting appropriately within authority.

JB – yes entirely.

PS – no questions.

Coroner – going to go to jury before AJ.

Jury – what timeframe to clerk a patient?

JB – 20-30 minutes. 5 new patients a week.

Jury – contractually obligated 3.5 sessions a week. When went back in afternoons/evenings was that part of contract?

JB – no, wanted to do it, needed to do it.

Jury – how long is a session?

JB – approximately 3 hours. Had an hour and a quarter every morning. Lunch visits and any family visits.

AJ – not a district hospital. Other doctors on site?

JB – no.

Coroner – whilst say not on site were they available?

JB – in theory could call someone if needed advice but wouldn't be on site.

AJ – equipment? Put patient on ECG machine?

JB – no ECG machine at time. No intravenous facilities or defibrillator.

AJ – if had had ECG trace anyone on site who could interpret it?

JB – no.

AJ – told us alternate weeks on ward round with Dr Lord. Gaps when they couldn't attend. What would ward round involve?

JB – walk round ward with notes and senior staff, discussing more fully each patient, progress, treatment progress and notes. 20 minutes with each patient.

AJ – one ward had 20 patients the other similar so long session.

JB – yes would take whole afternoon.

AJ – consultant would have clinical entries and would have drug chart. So far as medical records any concern ever expressed as to detail or adequacy?

JB – no.

AJ- heard of proactive prescribing either when patient didn't need strong opiates or prescribing when did need but at range where didn't need upper end. Consultant and nursing staff aware of that.

JB – yes.

AJ – sister joins said practice discussed and embarked upon to ensure patients could receive appropriate pain relief.

JB - yes

AJ – doctor attending at weekend either ward?

JB – varied, one or two of partners would pop in and check if anything needed doing but if they weren't on duty then nothing done.

Coroner – under impression JB's practice contracted to provide out of hours care.

JB – their understanding of providing OOH care was to attend if asked.

AJ – if called they would attend to see specific patient for specific reason. Weren't at hospital except for few hours each weekday. Where did information on patients come from?

JB – from nursing staff.

AJ – PB said nursing staff key.

JB – agree

Coroner – getting snapshot when see patients but nursing staff seeing them all time.

JB – yes totally reliant on nursing staff.

AJ – any involvement of pharmacist or pharmacy?

JB – weekly visit from pharmacist who would check prescriptions and refill pharmacy on site. Would check each ward and make sure everything in order.

AJ – any concerns expressed re prescribing?

JB – none.

AJ – reason for resignation?

JB – serious bed crisis in acute trust sector and received letter suggesting beds were under utilised and should put more patients in to relieve bed crisis. Felt aggrieved because of existing workload compared to other community hospitals. Then further letter saying to try harder.

Coroner – said 90% occupancy. Indication of increased demand. Trust looking for more.

AJ – fair to give JB letters.

JB – first one from director of medicine for elderly people 16/02/2000 – bed crisis at QA continues. Routine operations cancelled now. Try to utilise all beds as efficiently as possible, some under utilising of elderly care beds. Propose use empty beds for post acute elderly care.

AJ – post acute?

JB – less stable medically than continuing care patients.

Coroner – Mrs Barrett referred to patients being transferred too soon.

JB – wrote back 22/02/2000 – disappointed and concerned. Less than month after letter find being asked to take higher risk category patient. Patients have right to expect appropriate care to be provided. No consultant cover for one ward and other consultant cannot be expected to provide further care. Cannot do job to safe and acceptable standard. Staff subjected to ever increasing pressures causing stress and sickness. Question under utilisation when handling 40% of elderly patients.

Coroner -2000. Just after period we are looking at.

AJ – how long had pressure been building up?

JB – 2-3 years.

Pittock

JB – 83 years of age, depression since 50's. Residential home and in patient at other hospital. Treatment for severe depression. By September had taken to bed and not eating or drinking properly. Admitted to Mulberry. Lost weight, and appeared frailer and anxious. Admitted to mulberry for assessment. Admitted under care of Dr Banks. Mulberry = long stay elderly psychiatric ward. Treated with lithium and other drugs. Discharged from GWMH 24/10/95. Dr Bayly said scored 8/10 on mental health score. Referred to frail physical condition but mood improved, to be followed up as day patient. Readmitted 13/12/95. Nursing staff found difficult to manage. Deteriorated rapidly and had chest infection. Bed bound expressing wish to die. Dr Lord assessed 04/01, happy to admit to long stay bed. Noted suffered from chronic depression. Recent chest infection now completely dependent. Ulceration, eating little. Needed high protein drinks. Happy to arrange transfer to Dryad. Wife aware. Believe Dr Lord felt unlikely to get better. Admitted to dryad 05/01. JB undertook assessment, now no real recollection of him but admission note says inability, depression, broken sacrum, sores, catheterised, transfers with hoist, may help to feed himself. Would have seen him each weekday and reviewed condition. Didn't make note but assume condition unchanged.

Coroner – if significant change would note that?

JB – would attempt to. On 08/01 increasing anxiety. 09/01 – small amount of diet, generalised pain. Prescribed arthotec for pain in hands. Prescription dated previous day – don't know why. 09/01 – increased anxiety and agitation, note may need to increase opiates. Change of medication to be considered following day with Dr Tandy. 10/01 Dr Tandy noted dementure, for TLC. Indicated agreed with Dr Lord, felt not appropriate for rehab. Had discussion with wife who agreed in view of poor condition not appropriate. Prescription chart shows oromorph for relief of pain anxiety and distress 2.5mls 4 hourly, 6am, 10am, 2pm and 6pm. Prescription written for diamorphine and hyoceine and medazolam. Concern oromorph may be insufficient. Hamblin recorded to occupy long stay bed. All that could be given was palliative care. Anticipate seen next day but no entry. Increase oromorph available by adding evening dose to see him through night. Also further prescription for diamorphine, hyoceine and medazolam (last 2 higher doses). Anticipate saw him on Friday but then away over weekend. Would have reviewed on Monday. Believe may have been told deteriorated over weekend. Did not have opportunity to make note but nursing note indicates saw him. Syringe driver commenced that morning. Previous medication insufficient in relieving condition. Transferred in poorly condition. Considered in terminal decline. Concerned to ensure did not suffer further. Tried to judge medication to ensure appropriate levels. Syringe driver had to take account of lithium etc had been given and he would have had some tolerance to drugs. 16/01 – condition remained poor, some agitation. Appear medication previous day relieved some but not all pain. Tolerant to medication given. In view of agitation added further drug to syringe driver. Didn't make

clinical note but nursing notes mention visit. Daughter aware of condition. Saw 17/01 – from nursing notes tense and agitated so increased medication. Further prescription for diamorphine. Other drugs increased too. Reviewed early afternoon again – medication revised at that stage. Deteriorated further that evening, said by Hamblin to be aware of when attended. Increase in medication not caused excessive sedation. 18/01 – further deterioration. Analgesia continues, difficulty managing symptoms. Believe agitation returned. Increased drugs to control this, gave anti-psychotic drug too. Appeared comfortable between attention. Marked deterioration later that day. In process of dying. Breathing intermittent. Appears GP partner available over weekend. 20/01 partner consulted, increased anti psychotic drug and discontinued another. Assume he was advised of condition and did not consider regime inappropriate. Then saw him next day following verbal advice. Noted more settled, quiet breathing. Not distressed. Did not disagree with overall medication. JB then saw again on 22/01 but no note. 23/01 – nurses said poorly condition remained unchanged, peaceful. Not necessary to alter prescription. Deteriorated overnight and died.

Coroner – one of problems = death not optional. Difficulty in looking at palliative care. JB and those at GWMH had to deal with that. Look at para 21 – proactively wrote up prescription. PB said considerably higher than would have started. Necessary for Pittock?

JB – yes necessary. Hands on that led to believe this.

Coroner – PB clear didn't have patient in front of him. Start on that level?

JB – for someone new to opiates routinely consider 20mg diamorphine, but felt Mr Pittock had previous psychotic medication in system still so wouldn't respond to 20mg. Proved by his response to medication.

Coroner – diamorphine would cope with agitation and anxiety. PB clear drug of choice here, not just for pain relief.

JB – had to have help from anti psychotic drug too. Wouldn't have just increased diamorphine. Just increasing diamorphine would have relieved symptoms but administrative difficulties. End result would be the same. Changed balance of drugs as appropriate way of treating symptoms.

Coroner – change of cocktail not just routine increase. Each review considering from base level.

No questions

Lavender

JB – aged 83, transferred on 22/02/96 under Dr Lord. Diabetes for over 40 years, registered blind since 88. Lived alone since death of husband. Fell down stairs 2 weeks before and admitted to Haslar. Not seen any of Haslar notes. Dr Tandy examined, said likely brain stem stroke led to fall. Weakness in both hands, could stand with assistance. Long standing stress incontinence and anaemia. Agreed to take to GWMH for rehab ASAP. Recorded ulcers on both legs. Given considerable passing of time no real recollection but assessment reads fall at home, laceration to head, incontinence, insulin dependence, help to feed and dress, query if suitable for rest home. Profoundly dependent on assistance. Prognosis not good but hope may be able to rehabilitate her. Prescribed various drugs for heart failure, diabetes, anaemia, asthma preventer. In view of pain experiencing on admission also prescribed dihydrocodine. Would have reviewed following day – 23/02 – catheterised last night. Possible UTI – antibiotics prescribed on precautionary basis. Nursing notes say platelet level low – JB informed and to review. Records saw her next day, pain not controlled. Prescribed morphine twice a day. Did not normally see at weekends may have been on duty previous night and concerned to attend her if in pain. In consequence of morphine comfortable night but deteriorated and in more pain. Would have reviewed again on Monday. Believe sore bottom, concerned have Pegasus mattress. Probably made aware

son wanted to see her and would have returned. Saw son that afternoon – no recollection but anticipate understandably concerned. Anticipate appetite poor, pain and skin deteriorating. Often the case that major fall can have serious effect leading to death. May have indicated mother dying. Would have discussed options for pain relief and probably explained necessary to use syringe driver. May have mentioned this may hasten death. Believe son concerned mother to have adequate pain relief. 26/02 – not so well over weekend, family seen and aware. Following discussion with son wrote up proactive prescription. Diamorphine 80-160, hyoceine 40-80, medazolan 400-600 micrograms. 26-28/02 required no insulin in morning suggesting poor nutritional intake. Would have seen 29/02 and 01/03 but no note. Deteriorating at this point. Wouldn't then see her until 04/03. Suffering pain again. Increased morphine to 30mg twice a day. Would have reviewed following morning, pain still uncontrolled. Poor night and distressed. Not eating or drinking. Necessary to set up syringe driver. Diamorphine and medazolan at lowest range. Consider doses appropriate given pain uncontrolled. Further increase necessary. Likely to be dying. 05/03 – deteriorated over last few days. Let family know. Son contacted by phone. Medication appears successful. Reviewed again – 06/03 further deterioration. Happy for nursing staff to confirm death. Now comfortable and stable. She died during evening on 06/03.

Coroner – heard PB opinion re high cord injury. Surprise you?

JB – yes.

Coroner – weak in everything?

JB – Dr Tandy is expert in stroke. Said Lavender suffered brain stem stroke, assumed could be generalised weakness, no reason to query it, wouldn't have altered management of this.

Coroner – presume appropriate examination undertaken on admission to Haslar.

JB – don't know as didn't have notes for Haslar.

Coroner – admitted with Bartel of 4. Highly dependent. Doesn't improve. Significant deterioration. Seem to be adjusting medication to cope with pain. Sores would cause great pain. Would take view that prescription appropriate.

JB – yes. Nursing staff administered as and when required.

Coroner – contact JB before increasing doses?

JB – if available yes. If not would contact after but would be within range written up.

Jury – if haslar had picked up broken neck would she have stayed there?

JB – cant answer.

Coroner – PB said nothing could have done. Surgery or protracted bed rest. Prognosis no different. Wouldn't have stayed in Haslar as would have needed long term bed.

AJ – who would have seen Lavender after fall? If taken by ambulance?

JB – SHO in A & E. Then transferred to medical bed.

AJ – have to be admitted to medical bed? Is a doctor before medical bed who assesses her. Expect paramedics to assess?

JB – yes.

AJ – Surgeon Taylor expect some investigation to see what problems are.

JB – yes.

AJ – PB mentioned xray. One ordered but not seen. Physio mentioned. Expect them to be able to form a view?

JB – alarmed if had been standing patient with potential fracture.

AJ – PB only one who didn't see patient. Professor Tandy saw her and said brain stem stroke. Mr Lavender – first witness, recollection was several conversations with JB. Sound right?

JB – yes.

AJ – more conversations than recorded?

JB – possible.

AJ – records saying about getting rid of cat. JB mentioned this too.

JB – caused concern for nursing staff as to whether a nurse would adopt cat.

AJ – notes query suitable rest home if home found for cat. JB believed mother going to die.

JB – perhaps not exactly in those words but yes.

AJ – duty to be honest with relatives?

JB – yes.

AJ – asked by others for copies of letters. Coroner may also want a copy.

Coroner – yes. Farthing and Turnbull tomorrow. Need to be away at reasonable hour tomorrow.

Mrs Service

JB – Helena Service 99, 1981 partial gastrectomy, malignant stomach ulcer which then appeared benign. Heart problems too – right sided stroke, left sided paralysis. Made good recovery, sent home. 1987 – rib fractures following fall at home. No signs of cardiac failure but chest xray confirmed enlarged heart. Following request from GP seen by Dr Lord on 09/01/95. Increasingly short of breath over previous 2 weeks despite increase in medication. Suspected may need ace inhibitor. Indicate in heart failure. Assessment on 10/01. Dr Lord observed irregular pulse, murmur, diuretics increased to 80mg frusimide daily. Didn't start ace inhibitor immediately as needed to ensure renal function normal first. Renal function established to be normal. Breathless on exertion, mobility limited. 17/01/95 arranging for admission to QA for ace inhibitor. Discharged 25/01/95. Admitted in 96, pain to wrist having hit them against wall. Gout. May 97 deteriorated and home unable to cope with needs. 12/05/97 recorded GP visited and diagnosed as being in heart failure. Very poorly, admission to QA. UTI infection recently, responded to antibiotics but now confused and disorientated. Evidence of left ventricular failure. Chest xray showed patch consolidation consistent with pneumonia. Treated aggressively. Not for 555 (resuscitation). Improved a little over following days. Contacted nursing home who said must be able to transfer with 1 person before could go back. Social services may be needed. Floppy left hand. Rest home declined to take her back as unable to weight bear and left sided weakness. Seen on 29/05/97 by locum, noted further episode of left ventricular failure but noted better. To be transferred to GWMH. Then remained at QA waiting for bed at GWMH. Immediate transfer not possible probably due to high occupancy at GWMH. Nursing records note short of breath on exertion. No signs of confusion but demanding overnight, shouting constantly. Transferred 03/06.

AJ – date jury have is 99. It should be 97.

JB – recorded as 99, confusion and heart problems. Medication included asprin and other drugs. Expectation transferred to transfer lounge until possible to bring to GWMH.

Coroner – transfer lounge?

JB – room where they wait. Stressful experience for elderly lady in heart failure. 03/06 – recent admission 17/05/97. Confusion, RTI infection, diabetes, gout, came from rest home. Needs palliative care if necessary, happy to confirm death. Now no longer able to mobilise and confused. Heart struggling to cope. Very unwell, believed probably dying and might die shortly. Multiple system failure, dehydrated due to powerful diuretics

which were needed to treat heart failure. At time of assessment consider more appropriate for care at QA but transfer back there not appropriate. Would have deteriorated on way to GWMH and would have deteriorated further on way back. Her bed at QA likely to have been allocated already to someone else. Had to do best to care for her. Concerned in cardiac failure – 5-10mg diamorphine to be given intra muscularly, asprin and others. Also prepared prescription for diamorphine 20-100mg, hyoceine – 200-800 micrograms, and medazolan 200-800mg. If condition deteriorated then diamorphine would assist in relieving pain. Diamorphine and medazolan would relieve distress and hyoceine available to dry chest secretions. Bartel assessment = 0, totally dependent. Recorded buttocks red and sore with broken skin. Overnight failed to settle, restless and agitated. 20mg medazolan given by syringe driver. Nurse would normally contact JB but for diamorphine. Anticipate nursing staff properly administered medazolan without further reference to JB. Condition deteriorated overnight, remained restless, driver recharged 20mg diamorphine, 40mg medazolan. Nephew informed. Not made entry for this. Anticipate restlessness due to cardiac failure. Now terminally ill, heart failure, distressed. Continued to deteriorate died 3.45am 15/06/97. Diamorphine and medazolan prescribed and administered solely with relieving distress and diamorphine treating heart failure too.

Coroner – transfer in general terms. HS 99. Too often deal with deaths resulting from transfer. Disorientates them, leaves them vulnerable. Concerned prospect of transferring her back to QA. Would have been terminal?

JB – possibly not have survived journey.

Coroner – part of decision making process. Say now dying. None of her conditions reversible? Easing path.

JB – no not reversible. Palliative care.

Coroner – any questions?

PS – draw distinction between assessment on HS's arrival and subsequently when say notes of what happened not made. Give proper assessment on transfer. What see in statement represents a paradigm of that?

JB – what is paradigm? Assessments would have been with nursing staff. Nothing in statement which isn't in nursing notes.

PS – para 20. Not seen records but set out transfer, condition and examination details. Entitled to take that as representative of what would normally be done when transferred?

JB – yes.

Jury – timeframe for proper assessment after transfer?

JB – 20-30 minutes.

Jury – but only had 1hour for ward round?

JB – would be done over lunch time. Other assessments done in morning.

AJ – in morning on weekday go round both wards with nursing staff, review all patients need to know something about. Might be half an hour on one ward and then do other ward. If patient admitted would go back at lunch to clerk them in. Would take 20-30 minutes. Just dealing with one patient at a time

JB – hope so

AJ – but may be other patients to check if condition changed. When clerking patients would have patient, records (if available) to give indication of previous problems. If consultant had agreed to transfer would have letter from consultant stating why patient being accepted. Background information. What would you do to examine?

JB – basic examination.

AJ – asked re HS. Bases clear?

JB – no fluid on lungs. Listening to heart with stethoscope.

AJ – assessment continued like that for 3 years?

JB – yes.

Ruby Lake

JB – admitted 18/08/98. Previously admitted to Haslar on 05/08/98 via A & E after falling at home. Fractured left necofemur. Diagnosed as suffering mild hypertension. Arthritis and gout. Chest xray showed large heart, leg ulceration and soft tissue calcification. 09/93 admitted to QA with chest pain – left ventricular failure. Discharged 09/93, seen by Dr Lord. Done well since discharge. 04/11/93 – clinic. Reasonably well but elevated blood pressure. 08/97 referred by GP to Dr Barrett. Noted terrible ulcers on legs. In due course condition improved. Likely to be further ulceration in future. 03/98 referred with further difficulties associated with osteoarthritis. Joint pains affecting shoulder for 20 years. Continued to trouble her. Main complaint lower left lumber pain. 27/04/98 marked degenerative changes in lower lumber joints. 06/98 admitted to GWMH with infected leg ulcers. Not clear when discharged but 05/08 admitted to Haslar having fallen. Operation performed on fractured necofemur. Given 2.5mg diamorphine IV for pain relief. Developed chest pain after op, shortness of breath, vomiting and diarrhoea. 12/08 – much improved but developing sacral bed sores. Post operative recovery slow and periods of confusion but alert and well. Dehydrated but improving. Dr Lord suggested potassium supplement and hydrated orally and stools sent for culture and sensitivity. Difficult to know how much would improve but would go to continuing care bed next week. Recognised she may not recover and anticipate given underlying condition she may die. Dr Lord noted appetite poor, eating and drinking small amounts. Happy to arrange transfer to GWMH, uncertain whether would be improvement. Frail and unwell. Bartel score of 9. Admitted GWMH 18/08/98. JB admitted her but cannot recall anything about her. Notes continuing care required, transfers with 2 people, bartel 6, gentle rehabilitation. Happy for staff to confirm death. Bartel assessment likely to be assessed by others but shows need for assistance. Hoped rehab could take place but aware in frail condition. Conscious wouldn't recover hence note happy to confirm death. Trauma of fracture and op. Had heart failure and stress of hospital transfer at age 84. Note designed to ensure staff aware not necessarily to call doctor to certify death if occurred out of hours. Oromorph prescribed for pain relief in view of recent fracture and op and for ulcers. 10mg 2.5-5mls 4 hourly. 5mg oromorph given 2.15pm. seemed to have settled and fairly well. Slept well from 10pm-midnight but woke up distressed and anxious. 10ml oromoph given 12.15, little effect, remained distressed. Temazopam also available but not used. Might have made heart failure worse. By now experiencing further heart failure. 19/08 would have reviewed. Believe had meeting at 12.30pm so would have seen patients before then. Not made note – assume no opportunity. Concerned condition deteriorated in view of transfer and difficulties overnight. Appropriate relief required for hip and anxiety. Prescribed diamorphine 20-200mg, hyoceine 200-800, medazolan 20-80mg. Intend starting lower dose. 19/08 complained of chest pains, no worse on exertion. Pulse 96, grey round mouth. 10mg oromorph given. Nursing record also shows doctor notified, expect informed of her condition and content oromorph given but no recollection of events. No ECG given at hospital, difficult to prove heart attack. Oromorph not successful to relieve pain. Syringe driver commences 20mg diamorphine, 20mg medazolan. Don't know if informed of this but given still suffering with pain giving these was appropriate. By now received oromorph which was not sufficient. Comfortable night. Settled well. Drowsy but rousable next morning. Driver recharged next morning, added 400micrograms of hyoceine. Family informed of condition. Would have

reviewed but not noted in records. Continued to deteriorate. Distressed when turned. Pain relief not entirely successful in relieving distress. Recharged again – 60mg, 60mg and 800mg following day. Would have reviewed again not sure if before or after increase. Possible not informed at that point but would have arrived shortly after. Condition continued to deteriorate. Care continued. Died 6.25pm. drugs prescribed with intention of relieving pain, distress associated with heart failure.

DM – clarify went from 20mg diamorphine – 60mg but record shows nurse Turbritt drew 40mg. Is in nurse Turbritt's statement but not in nursing notes.

AJ – 394 – 395.

DM – says 60 not 40.

AJ – PB mentions in pg 13 of his report. 20mg, then 20mg, then discarded and 40mg given, then 60mg given.

Coroner – make sense?

DM – records show 5mg oromorph given at 2.15. was that day she arrived?

JB – yes 2.15pm on afternoon of arrival.

DM – after assessed her?

JB – yes. Very restless and uncomfortable after transfer.

DM – day after transfer chest pains, no ECG available, consideration given for further transfer?

JB – don't think she would have survived.

Jury – when unfit for transfer, was hospital transferred from ever asked why transferred?

JB – should have done.

Coroner – times when conditions demanded transfer back to QA or Haslar?

JB – would have been a few. If well enough. If well enough wouldnt have been at GWMH.

PS – concerned as just heard Dr Barton say end of line. Need to be clear on issue. Ever transfer patient back?

JB – cant remember but sure it did happen but not many.

Coroner – 10am tomorrow start Farthing then Wilson. May do r37 tomorrow.