Dr Barton

DAY 28

A the question of Shirley Hallman and Betty Woodland. I am not going to go over that again, but I want to make one thing clear with you, please. We understood from your evidence that there had been conversation between you and Nurse Hallman in relation to palliative care – and I am not going to go over it all – and her concerns that she had expressed to you.
A Yes.

Q In relation to the complaint that Shirley Hallman made about you and Sister Hamblin,
B the complaint of harassment, did her complaint against you – and I am stressing the complaint – ever have anything to do with syringe drivers or their use?
A I was not aware that at the time of the complaint she was concerned about our use of the syringe drivers.

Q Does it follow that her complaint did not involve anything to do with syringe drivers?
A As far as I was aware at the time of the complaint, she was concerned about her role
C and the way she was being treated in the ward hierarchy, but there was no mention of syringe drivers at that time.

Q Thank you. That is all I wanted to ask you about that. Perhaps we can move on, please, to Patient G, Arthur Cunningham.
A I have a problem with Patient G, in that I do not seem to have an up-to-date chronology sheet in that bundle. (Copy of the same handed to the witness) It is:
D "detailed (3).doc."

Q Yes, that is the one. Dealing with Mr Cunningham, there were problems with regard to depression, Parkinson's and so on – I am not going to go over all the detail of the history. Perhaps we could move on to page 8 in the chronology. I am not seeking to omit anything but I do not think we would need to trouble ourselves with anything before then. On page 8 of the chronology, we have 21 September, which was a Monday.

E

> "Reviewed by Dr Lord at Dolphin Day Hospital in respect of sacral ulcer. Admitted to Dryad Ward, GWMH."

She set out the picture with regard to the large necrotic sacral ulcer:

F

> "Extremely offensive … continues to be very frail. Admitted to Dryad Ward with a view to more aggressive interest on the sacral ulcer as I feel this will now need aserbine in the first instance."

Dr Lord indicated in her evidence, in terms of the options, that there was an option of returning him to the nursing home and asking them to deal with the problem (but, as she reminded us, the sacral ulcer had developed there). They must have had a bed vacant at Gosport. If he had been sent to the emergency department at Queen Alexandra, she indicated
G that he would have had to wait a long time on the trolley and so on and all the disadvantages of doing that. In relation to this patient, admitted to Gosport that day, we can see at the top of page 9 a further note on 21 with regard to Dr Lord,

> "Very frail. Tablets found in mouth …"

H

A The diagnosis is set out – and I am not going to read it out again – indicating "Prognosis poor." So far as that patient is concerned, do you remember his admission to Gosport? What actually happened?

A I was on Dryad Ward at the time that the word came down from the Dolphin Day Hospital that Dr Lord wished to admit him, so Sister Hamblin and I walked up to the Day Hospital and met her and him there. We then transferred him ourselves down to Dryad Ward and admitted him.

B

Q In terms of your admission at page 10 of the chronology, it is brief. Did you examine him when you arrived on Dryad, or had you already examined him when he was in the Dolphin Day Hospital?

A I had been with Dr Lord when she had examined him, but my nursing staff insisted that I look at the sacral ulcer and smell the sacral ulcer, so I did examine him again on the ward.

C

Q Professor Ford indicated that he was obviously a sick, frail man with many problems, and he was somebody who could – could, I emphasise – die suddenly. What was your view of the situation? What was the plan as to what should happen to this man? You said:

> "Make comfortable. Give adequate analgesia. Happy for nursing staff to confirm death."

D

What was the plan that was to be followed with regard to his treatment?

A In my opinion, he was then on a palliative care pathway. We had to keep him comfortable. That depth and size of sore must have been very uncomfortable and very distressing for him, particularly when it was dressed and seen to. The aserbine, when you put it on, kind of burns and stings on the skin. It is horrible stuff to use. My priorities were that I was aware that he was very ill, very frail and I was going to keep him comfortable.

E

Q What about the possibility in terms of his ulcer being treated successfully, even if it took weeks, possibly even months?

A There was a remote possibility that with adequate protein drinks, with proper local treatment to the sore, it might improve, but I had never in my clinical career seen one survive. I was aware how disastrous this sacral sore was.

F Q We need to follow through the history and try to piece it together from the records with regard to what happened on the day and evening of admission. You set out the position when you reviewed him on arrival. You have told us as to what your view was as to the future course of events so far as you could determine them. Did your view of the unlikelihood of this man being successfully treated in relation to his sacral sore – or more than sore, ulcer – affect your treatment of him in any way to his detriment?

A No.

G

Q To your view that he was unlikely to progress sufficiently well in that regard?

A My course of treatment was exactly as it would have been, even if I thought we could heal the sore. I was minded to keep him comfortable, reduce any anxiety and distress he may have had. I was not considering him at that point in that afternoon as being terminal. I was, however, aware that he had just finished a course of antibiotics issued by the Day Hospital, and that despite that the sore was very much worse, so I was not very optimistic about his

H prognosis but I was not going to do anything to hasten his death or to his detriment.

A

Q Let us look at what the other notes show. On page 10:

> "Admitted from DDH with history of Parkinson's dementia and diabetes. Large necrotic sore on sacrum. Seen by Dr Barton. Back pain from old spinal injury. 14.50 Oramorph 5mg given prior to wound dressing."

B

There is no complaint about that. Professor Ford does not suggest that that was wrong. Nurse Lloyd recorded:

LLOYD

> "Remained agitated until approx 20.30. Syringe driver commenced as requested at 23.00. Peaceful following."

Then following it thorough in the way it appears on the chronology:

C

> "Drive commenced at 23.10 containing diamorphine 20mg and midazolam 20mg. Slept soundly following. BS at 23.20."

Is that blood sugar?
A It is.

D

Q What does that mean?
A That I was aware that he had diet-controlled diabetes mellitus and the night staff would have routinely checked that his blood sugar was not too high or, alternatively, too low.

Q Right.

> "2 glasses of milk taken when awake. Much calmer this am."

E

Presumably that means 22 September.
A Yes.

Q Then:

> "Sacral sore oozing but left exposed as requested."

F

Then over the page,

> "Requires assistance to settle for the night."

That is still the night of 21 September.

G

> "Waterlow score – 20.
> Shaw: large sacral sore present on admission. Desire outcome: aim to promote healing and prevent further breakdown."

SHAW

Was that indeed the plan as you understood it with regard to the sacral sore?
A Absolutely.

H

Q It continues:

A

"Dressing applied to left buttock @ 18.30. Aserbine cream to black necrotic area + zinc + castor oil to surrounding skin. Very agitated at 17.30." Oramorph 10mg @ 20.20. Pulled off dressing to sacrum."

Then Nurse Shaw records:

B

"Catheterised on admission."

SHAW

It appears that, after his admission on that day, the first things recorded in terms of anything other than the sacral sore problem is at half-past five in the afternoon, when he is described as being very agitated. All right?

A Yes. Whether that is the episode when he pulls of the dressing and indulges in antics -----

C

Q We will come on to that in a moment. Obviously you are looking at other people's records.

A Yes.

Q Because you were not there.

A No.

D

Q The first lot of Oramorph he had received was at 2.50 in the afternoon, before the wound was dressed. All right?

A Yes.

Q Then the agitation at 17.30. If we look over the page, just to complete this part of the history, on page 12 we can see what had been prescribed, first of all by Dr Lord,

E

the Oramorph that she dealt with in her evidence. All right?

A Yes.

Q And then by you. On the day of his admission, you prescribed – anticipatorily, it would seem – diamorphine, midazolam and hyoscine. Diamorphine: 20-200 PRN by subcutaneous infusion. Midazolam: 20-80 by subcutaneous. Hyoscine: 200-800 micrograms, again obviously subcutaneously. Why did you write up for this man coming in,

F

on the day of his admission, the anticipatory prescription, first of all?

A First of all, I was aware of how very ill he was and that he would possibly very shortly be on an end-of-life pathway rather than purely palliative care. I was also aware when I saw him at the Day Hospital with Dr Lord that there had been problems with his tablets, difficulty swallowing them, and that if we were going to give adequate analgesia we might well need to give this subcutaneously rather than as tablets or orally. I know he had taken milk overnight but his eating and drinking, and his taking of tablets, was possibly a bit

G

suspect.

Q We can see on that same entry that we are looking at on page 12, again trying to piece the history through chronologically, the 5 mg of morphine at ten to three in the afternoon and then a further dose of Oramorph at quarter past eight in the evening. He had remained agitated until approximately half past eight, so perhaps the Oramorph was having some effect. All right?

H

A Perhaps.

A

Q If we look on to the next page, we have one further entry which relates to Monday, the 21st. That is the entry by Nurse Hallmann, who made this record in the morning of the 22nd but was relating in that note something that she had been informed about – that she had not actually witnessed, was her evidence. Mr Farthing has telephoned. Obviously that is something that Shirley Hallmann did deal with herself, and she explained to him that –

HALLMAN

B

> "....syringe driver being commenced yesterday evening for pain relief and to allay his anxiety following an episode when Arthur tried to wipe sputum on a nurse ..."

et cetera. We can see it is all set out and we are familiar with that and the description of that incident. She recorded:

C

> "Later: Syringe driver charged at 20.20. Contains diamorphine ... Appears less agitated this evening."

That appears to be relating to the previous evening and night. Correct?
A I think the entry about the bad behaviour refers to the 21st, but I think the entry about the syringe driver charged at 20.20 must apply to the evening of the 22nd, because the time is not the same, is it.

D

Q It is made later, and that may well be the case. Sticking with what appears to be the case on the Monday evening, we have the record of 20.20, or shortly after, it appears when we look back at page 11, as if he had pulled off the dressing to the sacrum – all right – on page 11. Yes?
A The Oramorph is given at 20.20.

E

Q Yes. Then the next thing that is recorded by the nurse – we will be hearing evidence from this nurse – "Pulled off dressing to sacrum". That nurse does not record anything with regard to the administration of the subcutaneous analgesia. That comes later. So when we look at what Nurse Hallmann describes, that appears to be later on because if you look at page 10 again, the syringe driver does not start until 11 o'clock in the evening or shortly after. All right?
A Yes.

HALLMAN

F

Q You were not there. That is all we can say that those notes show. What would be the rationale – I appreciate you were not there – for commencing the administration of diamorphine and midazolam that evening shortly after 11 o'clock? When I ask you that question, I would like you to deal with what Professor Ford was saying about how something should have been given to this man to deal with the psychotic episode, if that is the right way of describing it – something to relieve and deal with his agitation. What in your mind is the rationale for starting the syringe driver then?

G

A In my opinion there were two main reasons for starting the syringe driver. My advice to my day staff, when I saw Mr Cunningham that afternoon, would have been, "Start with the Oramorph, but you do have a pro-active prescription for the syringe driver should his distress and pain deteriorate and you feel you are going to be able to manage it with oral medication. Both the diamorphine and the midazolam would have been ideal medication to control his discomfort, distress, anxiety overnight, as well as the pain he was receiving. What was the other thing I was going to say? So that was what the pro-active prescription was for.

H

A

Q Yes?

A And the nurses quite correctly made an assessment of it – could even have rung me that evening, and my suggestion would have been, "Give him another dose of Oramorph. She if he settles during the evening. If he is not settling, please start the syringe driver."

Q There is no record of your having been contacted?

A No.

B

Q Do you have any recollection of being contacted?

A I do not.

Q So it may be that the nursing staff commenced the syringe driver without specifically getting authorisation from you at the time that it happened?

A It is possible, but in view of the fact that we had just admitted him that afternoon, and the concern we had all had about his general condition, it is quite possible that they actually made a phone call to me at home and I spoke to them. That would have been fairly standard procedure.

C

Q Can I approach it in this way: had you been there, and had you been aware that the Oramorph, which had been given at 20.20 – twenty past eight or thereabouts – that that had been followed not long afterwards by an incident where he had been acting in the extreme fashion, I am going to describe it as recorded at the top of page 13 – had you been there why not, with this patient, have administered to him something to deal with his agitation, psychotic behaviour, whatever one describes it as, as opposed to administering subcutaneous analgesia?

D

A Because if you felt that the underlying cause for this behaviour, which was not typical of him, was the pain and the toxicity of the sacral sore, it would seem more humane to treat it using the subcutaneous analgesia and anxiolytic, rather than giving him a major tranquiliser.

E

Q The anxiolytic being ---

A Midazolam. He was on a palliative care pathway. It seemed perfectly reasonable to give him adequate palliation.

Q There is no record of him actually being in pain. Obviously the sacral sore, the sacral ulcer, would have been very painful in any event. There is no record of him being in pain. Why not say to yourself, had you been there, "This sort of thing happens from time to time with patients of this kind." This is what Professor Ford was suggesting was appropriate. You come across this sort of thing with patients like that, an acute episode which may not necessarily last. Why not treat with haloperidol?

F

A Because it was not just an acute episode that was not going to last. In my opinion it was all related to the toxic state and the anxious state he was in due to the sacral ulcer and the indignity of being brought into the ward and the dressings being done, it was a whole picture of that man in that bed, not the theoretical elderly medical problem of somebody suddenly becoming anxious and behaving badly.

G

Q That, you would understand, leave aside whether you were informed or not, was what the nursing staff would have approached it as. When you saw him the following morning, there is no record, but would you have seen him the following morning, the Tuesday?

A I would, and I would have been very content with the improvement in his state of comfort overnight.

H

A

Q What is recorded in terms of the result of having subcutaneous analgesia administered – I am looking on page 3 of the chronology, half way down on the left:

> "Driver running as per chart. Very settled night. B/S [blood sugar] 5 @ 06.00. 23.00 dressing came off. Reapplied."

B

Nurse Shaw records:

SHAW

> "Requires assistance with personal hygiene due to Parkinson's disease. Action: Daily bed both/bath, shave … report any changes in skin condition.
>
> Barthel score: 0."

C

That is what is recorded for the 22nd, the Tuesday, so the day after the 11 o'clock-ish or 11.30-ish administration of subcutaneous analgesia the evening before. On that Tuesday, there is no record of you seeing him, but you say you would have done. Are you able to say whether he was rousable on that day or not? If you do not remember please say so, but I just wanted to see if you had any recollection?

A I have no recollection.

D

Q Moving on to the Wednesday, on page 14 of the chronology, a note that you reviewed him. That would be a morning visit, presumably?

A Yes.

Q Nurse Hallmann recalls:

HALLMAN

E

> "S/B [seen by] Dr Barton. Has become chesty overnight. To have hyoscine added to driver."

Is that something you would have instructed.

> "Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to commencement of syringe driver. Informed that Cunningham on small dosage which he needed."

F

That is Nurse Hallmann recording that. Then just we look just to see in relation to the rest of that day:

HALLMAN

> "Became a little agitated at 23.00, syringe driver boosted with effect. Seems in some discomfort when moved. Driver boosted prior to position change. Sounds chest this morning. Catheter draining, urine very concentrated."

G

Mr Farthing says that on that Wednesday, Wednesday the 23rd, when he saw him, he says his stepfather was unconscious. We have seen what the nursing notes have recorded. Do you have any recollection yourself when you saw him on that day, the 23rd, as to whether he was sleepy, drowsy, unconscious, rousable or anything to do with that sort of situation?

A None at all, but on my assessment of him that morning, I obviously did not feel that he was over-sedated because I would have had the option at that time to alter the medication in the syringe driver had I felt it was excessive.

H

A

Q And if this patient was exhibiting signs of respiratory depression or over-sedation, would there have been any problem for you as the doctor in reducing the diamorphine and the midazolam?
A None at all.

Q Over the page, on page 15, just looking at the drug charts, diamorphine was administered at 9.25, and then again the syringe driver is reloaded with the same dosage which was commenced at 8 o'clock in the evening of that day. Midazolam administered at half past nine in the morning, then discarded and then 60 – in other words the midazolam has gone up three times – to 60 administered at eight o'clock in the evening at the same time the hyoscine added as we have seen. Professor Ford said this was a very high dose, a very large increase, and would definitely produce very marked sedation. You saw him the following day, the Thursday, in the morning but why was the midazolam increased from 20 to 60 on the Wednesday evening?
A This would have been the picture of a man whose pain relief seemed adequate, so the diamorphine was kept at the same level but that he was becoming now terminally restless. This would have been in association with the broncho-pneumonia he was now developing, hence the reason for administering the hyoscine and also increasing the midazolam. We wanted reduction of anxiety. There must be nothing worse than listening to your secretions in your throat and not being able to clear them, and also a muscle relaxant for him.

Q Whose decision was it to raise the dosage from 20 to 60?
A It would have been in discussion with me.

Q That evening?
A If not that evening, it would have been discussed in the morning, that if it became necessary the dose range was written up and they should do what they felt was appropriate, but I would have been aware of what they were going to do.

Q Was it in your mind to consider that the signs of broncho-pneumonia were in fact brought about by the administration of subcutaneous analgesia rather than his condition?
A Broncho-pneumonia was brought about by the sepsis started by the huge sacral sore.

Q Might the subcutaneous analgesia have played some part in the broncho-pneumonia developing?
A It could have played a part in the broncho-pneumonia developing, but it is much more likely that it was bacteria circulating from the sacral sore.

Q When the midazolam was increased from 20 to 60, was it in your mind that that would produce, or be very likely to produce, very marked sedation?
A Adequate sedation to make him comfortable during this terminal phase of his life – not excessive sedation, but adequate, so that he was not frightened and anxious as he approached death.

Q Looking then at what happened on the Thursday, when you saw him and reviewed the patient. You recorded:

H

A

"Remains unwell. Son has visited again today and is aware of how unwell he is. SC –subcutaneous] analgesia is controlling pain just. Happy for nursing staff to confirm death."

What was the picture there? Subcutaneous analgesia is controlling pain just: what does that mean?

A I suspect the nursing staff would have reported to me that when he was not being seen to, that he was peaceful and comfortable, but he was uncomfortable when they were dressing the sore or seeing to him in any other way. So he was just receiving adequate analgesia.

B

Q Was he in any way over-sedated when you saw him on the Thursday?

A He was not.

Q If you had formed the view that he was, would there be any difficulty or any problem for you in reducing the midazolam?

C

A None at all.

Q At what stage had this patient reached the end of life care, entering the terminal phase and being cared for in that sense – if you can indicate that?

A At what stage did that happen?

D

Q Yes, at what stage, looking at the history?

A It happened overnight on the 23rd, when he became chesty, when he started to develop broncho-pneumonia.

Q So when you saw him on the 24th, the Thursday morning, this was somebody who was in the terminal stage of his life?

A Yes.

E

Q The CPN notes: can you just remind us as to what that means, following on page 15?

A Community Psychiatric Nurse.

Q This is somebody who comes in what, or ---?

A No, no. They pop in occasionally to find out what is happening to their clients, so she would have got a snapshot view since she last saw him in the nursing home, I would expect.

F

Q Would such a nurse normally see you if you were there?

A No.

Q Let us just look at the note:

G

"Physical decline, pressure sore's developed, admitted to Dryad Ward. He is terminally ill & not expected to live past the W/E [week-end] according to sister on ward." HAMBLIN

That would be Sister Hamblin, presumably?

A Presumably.

Q On Dryad. I am just going to complete the records for the Thursday before I ask you about any discussion or meeting you had with Mr Farthing. Over the page, on page 16, we

H

A can see what Sister Hamblin recorded. He was in pain when being attended to; that he was in pain with the day staff as well, so that is the night staff and the day staff, especially his knees.

HAMBLIN

MIDAZOLAM

> "Syringe driver renewed … diamorphine 40 mg, measles immunisation 80 mg and hyoscine … Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition. In the event of death Brian is for cremation.
>
> B 21:00: Nursed on alternate sides during night, is aware of being moved. Sounds 'chesty' this morning. Catheter draining."

Carrying on on that left hand side;

> "All care given. Nurse … Peaceful night's sleep. Syringe driver running. Starting to sound chesty this morning."

C

The drug charts; The diamorphine has gone up in the morning, shortly before 11 o'clock in the morning, to 40, and this then increased at a time that is unclear to 60. Midazolam is now 80 at 11 o'clock in the morning, and the hyoscine. Whose authorisation is it for those increased doses on the morning of the Thursday?

A Mine.

D Q Why was it you increased the dose of diamorphine or asked that it be increased and why did you ask for the midazolam to be increased?

A On the basis of that report from the night staff given to me by Sister Hamblin that he was in pain when being attended to, so that he was becoming inured, he was becoming tolerant of the diamorphine he was receiving and we needed to increase the dose a little bit to give him the same level of comfort.

E Q Dealing with mention of Mr Farthing, I have reminded you that on the 23rd he said that when he saw his stepfather he was unconscious; that was the Wednesday. In his evidence to the Panel he said that on the Thursday, the 24th, he had seen you and said that he wanted to speak to his stepfather – that is speak to the patient – you had refused and said something about not being able to authorise the stopping of the syringe driver because of the pain, and he claims that he said something to you like "You are murdering him". What do you recall of seeing Mr Farthing in relation to his stepfather?

F A I have absolutely no recollection of the meeting with Mr Farthing and I have no recollection of being accused of being a murderer.

LIAR

Q Can I ask you this: it is difficult to remember precisely what is said years later but did he say anything to you like "You're murdering him"?

A I think it is unlikely.

G Q He says also that you had said – he described it in this way: "She told me quite bluntly he was dying from the poison or poisons in the bedsores." Might you have said that to him?

A I would have attempted to explain in a manner to be understood by a lay person that the toxins from the bedsore were now spreading around the body and were giving him his bronchopneumonia.

H

A

Q And what about him saying that he wanted to speak to his stepfather, do you remember whether that was said or not?
A I cannot remember but I did not feel, with the discomfort that Mr Cunningham was having, that it was appropriate to reduce any of his medication at that point in time.

B

Q I would like you just to deal with that point. Why not reduce it so that at least he was able to speak to his stepfather, even if that meant that Mr Cunningham might, for a period of time, suffer more pain? Where does the balance lie in your mind in a situation like that?
A With the patient, totally with the patient, to keep him comfortable. I know Dr Lord said she had delayed starting analgesia for someone to meet a long-lost relative; this was not that sort of situation. Mr Cunningham was my first and only priority. The other slight problem I had was that Mr Farthing was not his next of kin at that time.

C

Q I wonder if we could just deal with that. If we look at the medical records in the file, in the main body of the file, we need to insert page 857 which I will ask to be distributed now. (Same distributed).

THE CHAIRMAN: Thank you, Mr Langdale, we will insert this in the bundle at the page preceding the existing page 859.

D

MR LANGDALE: Thank you. If we just take a moment, Dr Barton, to register what that says. It is the general information sheet, we have Mr Cunningham's name top left, next of kin underneath, "Shirley Sellwood" whose statement was read to the Panel. There are details of her address and contact number and then underneath that "Stepson, Rodney Farthing" with a telephone number and then another telephone number as from a certain date for him. The rest of the details I do not think I need to trouble you with. You said there was a problem with regard to his position; would you just explain that, that he was not next of kin.

E

A In those days I think any major decisions to be made on behalf of or with the patient would only be considered with the next of kin that we had down as notified, so if anything should have been discussed with anyone it should have been with Shirley Sellwood.

LIES
DIS-
TORTION

Q Do you remember whether anything like that was said by you to Mr Farthing or not?
A No, I have no recollection. The whole idea of waking this unfortunate man up was so abhorrent to me that I did not go into who was the next of kin and who had the right to ask even.

F

Q Does it follow that it may be, although you cannot remember details of the conversation, that you did say to him that you would not authorise or could not authorise the stopping of the syringe driver because of the pain?
A Yes.

G

Q Do you remember the incident, the conversation or conversations that you had with Mr Farthing amounting to some sort of row or were they conducted pleasantly or what, do you have any recollection?
A I have no recollection of a row, I can only recollect it being a polite, civilised discussion.

LIER

Q The nurse – it was Nurse Hamblin I think – recorded the fact on page 16 of your seeing Mr Farthing on the afternoon of the 24th – it just says:

H

Hannon

A "Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition."

If we can move on to page 17 and deal with Friday, 25 September, it was Dr Brook who saw him that day, not you. How would it come about that you would not have seen this patient on the Friday?
A If I was not available, if I was away, if I was on leave. My partners visited the wards,
B the duty doctor for the practice would go. She would only go if requested to see a patient by the staff, I do not think she did a routine ward round.

Q On the 25th the driver was recharged at 10.15 with diamorphine 60, midazolam 80, so it remains the same. "Son present", so a different relative. "Remains very poorly" says Dr Brook's note, "on syringe driver for TLC." A peaceful night on the Friday it seems, the diamorphine is shown with the midazolam, 60/80, we need not repeat that, and then we can
C move on to Saturday, 26. It appears that you did not see him that morning; are you able to say one way or the other?
A I did not see him that morning.

Q "Condition appears to be deteriorating slowly" and so on, diamorphine 80 and midazolam now up to 100. The midazolam has gone up on the Saturday shortly before midday. Whose decision would that have been?
D A Presumably that was on the say-so of the duty doctor.

Q He continued to deteriorate and his death is recorded shortly after 11 o'clock that evening. Again, you have heard the comments and criticisms made about your treatment of this patient from Professor Ford; do you stand by what you did on those days in September 1998 or does his evidence or view cause you to change your mind about anything?
A I totally stand by what I did for Mr Cunningham that week.
E
Q Patient H, Mr Wilson. This gentleman, the patient with a background of alcoholic liver disease, taken into Queen Alexandra following a fall which fractured the left humerous. He was somebody who did not want surgery to do anything about the fracture. Analgesia administered, which plainly was not controlling pain generally speaking throughout the period of time that we are concerned with. Then if we move on, please, to when he is admitted, the best page for us to start is page 23. We have seen in the history that his
F prognosis was poor, that he was at times not eating or drinking, at other times he was, the pain control was not working, on paracetamol a lot of the time which does not appear to have stopped the pain, and that picture really continues as we go through the history up until the time that he is transferred to Dryad. He is transferred on 14 October, having been admitted to Queen Alexandra on 21 September, so something just over three weeks since he was admitted to Queen Alexandra. On page 23 you saw him, the 14th was a Wednesday, "Transferred to Dryad Ward, continuing care." You set out the fractured humerous, alcohol
G problems, recurrent oedema, CCF (congested cardiac failure).

"Needs help with ADL, hoisting, continent, Barthel 7, lives with wife. Plan: gentle mobilisation."

What was significant to you in terms of the features that you noticed on your examination of this patient?
H