Notes on Transcript Review

D1/1 Letter from Dr Morgan – G Hamblin condition "quite serious" (confidential and highly sensitive) Further discussed D4/1 can't attend Court, cannot sit for more than 10 minutes or be without facilities – surgical treatment, radiology and chemotherapy all referred to.

D1/2 Defence took statement from G Hamblin (16 Feb 2009)

D1/3 Coroner saw Prof Baker report – did not admit – "happy for it to be disclosed after the evidence" (D1/9 Mr Wilson interjected wanted it admitted)

D1/6-11 Families especially Cunningham wanted Prof Forrest called re toxicology – discussion concludes that there is no report from him – he seems to have been "asked" about some of the cases – he did a "matrix analysis" on the likelihood of prosecution/success – (part of the clinical review identifying 92 cases??)

DAY 2 = LAVENDER

D2/8-20 Alun LAVENDER – mum fairly healthy (insulin dependent and partially sighted), rehab from fall/stroke, possible move to warden flat (but problems with cat) – told GWMH for rehab – Barton was her GP – Barton said "mother has come here to die", soon after placed on syringe driver. Doesn't remember discussion re syringe driver. Says Joines knew mother. P97/228 ? strange entry – Wendy Edgar's name written in – Nurse Wilkins explains. Thrust of questions from Alan Jenkins – mother was in pain you were keen to keep pain free – reply not complaining of much pain to us (bad shoulder).

D2/20- Shelagh JOINES – retired 1997 – was nurse in charge worked closely with Dr Barton. Pain control – first tablets paracetamol to morphine tablets then where **could not swallow** syringe driver – most prescribing was done by Dr Barton – partners were reluctant to write up analgesia so it was decided "I think on a ward round of Dr Barton, Dr Lord and myself that where necessary patients could be written up for analgesia prior to it being given so that there was no delay in relieving their pain – but it was not done on a regular basis or on other wards" Nurses were able to put up syringe driver but would get a message to Dr Barton if going to increase dose. We tried to discuss it first (with Barton). We never ever put up without relatives agreeing to it. Practise of pro-active prescribing was more in exceptional than regular cases – written on the PRN side. If Dr Barton was not there it was up to us to decide whether the patient needed extra – we would let Barton know. Would observe patient to see they were in pain. Thrust of questions from Alan Jenkins – very busy ward, consultant was aware at end of (fortnightly)

ward round what treatment was being provided +ve testimonial for Barton – available and no reservations, never felt prescribing was inappropriate, we **always started with the minimum dose**.

NOTE: D/w family was 26 Feb – syringe driver went up 5 March

D2/48 BAILY – read statement 3 June 2005 re Pittock (abandoned – wrong order)

D2/50 ASTRIDGE – read statement - Clinical Manager 1996-8 – named nurse for Lavender – "painful shoulders and upper arms" urine retention and pressure sore, not eating or drinking, patient scored 10 out of 10 Mental State Exam. On 6 March at 9:45 gave 100mg diamorphine and 400[sic]mg Midazolam.

D2/55 COUCHMAN – read statement 15 December 2004 – 1992 to date – involved with Lavender – "pain in shoulders on movement" 5 March "pain uncontrolled patient distressed syringe driver commenced 9:30 son informed" "Diamorphine 100mg Midazoam 40mg" started on instructions of Dr Barton (p85) and p153 son wanted mother comfortable and pain free.

D2/57 PETERS – read statement 30 September – GP – Lavender was admitted "for long term care"

D2/58 TAYLOR – Consultant at Haslar – 9 Feb SHO saw Lavender was complaining of pain in her arms and shoulders – letter from Dr Tandy transfer to GWMH for rehab

DAY 3 = PITTOCK

D3/2 BAYLY – read – Pittock - Oct 1995 discharge letter and notes on readmission to Mulberry December 1995 – picture of deterioration

D3/14 BANKS – read – Consultant Psychiatrist on Mulberry – saw Pittock - severe mental illness and physically unwell Dec 1995 - expected to die

D3/18 LORD – read statement 28 Sept 2004 – Geriatrician – assessed Pittock on 4 January 1996 – prognosis poor unlikely to return to rest home (see letter) explained this meant chances of survival were slim unlikely to survive for long.

D3/20 TANDY – read – was consultant for Pittock – usual routine I would review drug regimes on ward round, review prescriptions. No requirement for GP to notify of every change of drugs unless sought my advice. Very infrequent doctor would phone for advice. 9 January told staff of generalised pain + Dr Barton recorded pain to right hand – also anxious and agitated. Oramorph 5mgs commenced on

ward round on 10 Jan – increase on 11 Jan would be to try to render patient pain free at night. Syringe driver commenced 15 Jan (describes drugs 15/16/17/18) comments Mr Pittock at this stage was very poorly. **I would have used a lower dosage of the diamorphine and midazolam but I did not see the patient when this dosage was commenced.** 21 January much more settled but very poorly and notes suggest he was dying. TLC means patient to be kept comfortable not in pain or distress – I had discussed with wife.

D3/26 BRIGG – read - was the authorising doctor for Nozidan 100 mgs on 20 Jan – duty doctor makes decision based on information given by nurse. Thought patient was having side effects to Haliperidol (agitation and movement disorder) replaced with nozidan which also a sedative as patient agitated. Did not physically see at time but visited later – explains rationale for dose of nozidan – omission of nozidan at 15:30 recharge on 20 January

D3/29 BARRETT – nurse E grade at time – Dr Barton prescribed trained nurses administered – I have on occasion taken verbal orders but had to be given to 2 members of staff doctor had to attend within 24 hours – would examine the patient once there. Dryad initially long stay and palliative. Got on the job training for syringe drivers. I cannot remember a syringe driver being on PRN basis . Nurses would report pain to doctor. Only allowed to increase if necessary by 50% of the previous dose. Do not recall a practice of prescribing medication which was not needed at the point the prescription was made. Thrust of questions from Alan Jenkins – very busy, very nice and honest with relatives, liked/respected Barton, would always start at lower dose let Barton know if pain not controlled – would not prescribe anything if thought inappropriate

[RE SPURGIN] dealing with a fairly raw hip wound

[RE DEVINE] could be rude adamant – wandered round wards. Wd think sustained release opiates unusual if not on opiates before. Very rare to give syringe driver if still able/willing to swallow. Never concerned that a patient might have been overdosed with analgesia.

DAY 4 PITTOCK and LAKE (and SERVICE)

D4/11 WYLES - had been summonsed did not attend – read statement 8 November 2004 retired RMN – daughter of Pittock – father was physically very strong - 93/4 depressed – discharged to rest home – admitted to Mulberry – moved to Dryad for terminal care – not alarmed by morphine thought it appropriate – we did not speak to a doctor as were kept fully informed by nursing staff.

D4/13 TUBRITT – involved with LAKE - how much to give depended on patient condition – most of the time started with the lowest dose – increased by 5-10mg over 24 hour period, try other things to relieve pain and discomfort eg repositioning. **At night we would use our own initiative – if unsure would speak to doctor** – would give opinion of how much I felt was needed and get approval. **Could exercise discretion between 20-200** (if written up for that) – **was doubling or adding 20mg increments** [not as per Wessex 50%]

[SPURGIN – 28 March – encouraged to give a larger dose for night time dose – can't explain doses of Oramorph not adding up]

[DEVINE – if had doubts about dosage would query with doctor- had no concerns about 40mg diamorphine]

[1991 – had concerns re analgesic ladder D4/24 – there was a meeting - concerns were addressed by 1996]

Thrust of questions from Alan Jenkins – +ve re Dr Barton, two trained nurses checked administration of medication, thought medication given was appropriate

D2/32 TUFFY/REES/PETCH – re SERVICE = not relevant

DAY 5 – DR BLACK (skim read)

Re Pittock- thrust of questions from Alan Jenkins – a dying man, family appropriately involved, died without distress, not atypical pattern of decline. If on oral pain relief and no longer swallowing convert at 2:1 or 3:1 but if restless could increase by 50%

Re Lavender - thrust of questions from Alan Jenkins – very complex and challenging problem in geriatric medicine – (Barton says in some pain on 5 March and Couchman says "uncontrolled") – the medication resulted in the medical notes saying pain controlled

Re Lake – thrust of questions from Alan Jenkins – agitation and breathlessness are good reasons to give diamorphine (Black said "while you find and treat the underlying cause")

Re Cunningham - thrust of questions from Alan Jenkins – was in acute confusional state a month before opiate medication – nasty bed sore required strong medication for pain relief – not over-sedated on 22 Sept (re note about throwing things and exposing himself) – was managed appropriately

DAY 6 - Dr BLACK

Re Packman - thrust of questions from Alan Jenkins – cause of death was GI haemorrhage – reasonable clinical decision to provide symptomatic care – symptoms seem relatively well controlled (not unconscious) – did you know he was not for resuscitation

Re Devine – (see D6/27-28 re equivalence calculations for the fentanyl patch) - thrust of questions from Alan Jenkins – most complex and challenging problems – had previously presented challenging behaviour – lengthy discussion of half life of fentanyl patch and interaction with syringe driver – Dr Dudley (consultant nephrologist – "she was treated appropriately with strong opiods to ensure comfort") – no dissent from the family or nurses about appropriateness of care

Re Wilson – no evidence in nursing records he was in a coma

Re Spurgin – no questions

DAY 7 – WILSON and BARTON (various)

Ian WILSON – son of Robert Wilson – dad was an alcoholic for whole life had put on a lot of weight - dad would not have given up – on admission had no life in him but picked up – eating drinking chatting (at QA) – on transfer to GWMH (15th) horrified unable to move could hardly speak – wife had been told seriously ill and going to die (Ian kicked off a bit when could not speak to anyone) father said "help son they're killing me" following day he was in a coma. Thrust of questions from Alan Jenkins – was a smoker 80/day, psychiatrist had suggested dementia, he had congestive heart failure and possible MI (doctor wrote CCF congestive cardiac failure) – inconsistent with police statement (Ian says "I do not agree with my police statement because they have missed so much out" – well documented with the GMC)

DR BARTON

[Given warning not obliged to answer any questions]

Read statement D7/21-24 [generic] for much of 1998 had no effective consultant support, by 1998 increasingly dependent witnesses (*patients?*), 40+ patients per day, felt able to place significant measure of trust in the nursing staff, excessive workload for all, replaced by a full time staff grade, in 1998 I had tried to raise the issue with management, readily accept my note-taking suffered, I felt obliged to adopt a policy of proactive prescribing, giving nurses a degree of discretion and administering within a range of medication, nurses appeared to be acting

appropriately within the authority of the prescriptions. Consultants and nursing staff were well aware of practice, pharmacy did not raise concerns about prescribing

Re PITTOCK – I believe I would have seen him each weekday although not made a note – Tandy assessed on 10 Jan – I prescribed oramorph no doubt in consequence of liaison with Tandy and proactively wrote up diamorphine and hiazine [sic] and midazolam concerned oramorph might be insufficient. Increased on 11th for his pain anxiety and distress was concerned might develop significantly and appropriate medication should be available. Would have seen Friday returned Monday may have been told condition deteriorated – marked agitation and restlessness and paid – did not have time to make a clinical entry. Nursing notes show I saw him and commenced 80/60/400 previous medication clearly insufficient in relieving condition – believed he was in terminal decline. 16 Jan some agitation but tolerant to medication decided to add haloperidol. 17 Jan – tense and agitated decided to increase medication to relieve agitation and in case developing tolerance. Think he was aware (Hamblin) so not excessively sedated. 18 Jan believe agitation had returned and difficulty controlling symptoms added Nozinan. Was in process of dying. Brigg did not disagree with overall medication. Would have seen on 22 and 23 January. Felt with previous psychotic medication would not respond to 20 possibly not 40 Diamorphine

Re LAVENDER – in view of pain on admission I prescribed Dihydrocodeine, 24 Feb pain was not controlled by Dihydrocodeine so prescribed morphine sulphate in addition, was screaming "my back" over weekend so increased on Monday, saw family that day – would have discussed options for pain relief with them including incidental effect of hastening death, following discussion wrote up a proactive prescription for further pain relief should she experience uncontrolled pain when I was not immediately available, Would have seen her on 27, 28, 29 and 1 sadly she was slowly deteriorating. Again suffering pain by 4th I therefore increased MS in form of Oramorph, following morning pain relief inadequate v poor night necessary to now set up s/c analgesia a lowest end of range – pain was uncontrolled and reported to be in distress – further increases were necessary to ensure free from pain by 6 March had relieved pain and distress.

Re LAKE – I would have been aware Mrs Lake was in frail condition and quite unwell hence my note happy or nursing staff to confirm death (i.e. not necessary to call a doctor) I prescribed Oramorph for pain relief "might very well require pain relief in view of recent fracture, operation and ulcers. She was anxious during the night – Oramorph is appropriate for anxiety and distress (Temazepam might have worsened hear failure) – reviewed next day 19 August concerned might be likely to die shortly anxious she should have appropriate pain relief and to relieve pulmonary oedema so prescribed Diamorphine Hiazine and Midazolam – intention

if necessary start at the bottom of dose range. No recollection of being notified of condition at 11:50 pain was only relieved for short period and said to be very anxious accordingly syringe driver was commenced – entirely appropriate not sure if informed. Had comfortable night no distress or anxiety but perceived to be deteriorating continuing distress over next night – would have reviewed on morning of 21 August.

DAY 8 – CUNNINGHAM/PACKMAN/SPURGIN

TURNBULL Nurse – did night duty - medication would not be changed during the night – it would need approval – any kind of change would be decided between two nurses (senior nurse on duty) – any concerns in 1991 had been addressed by 1996 **Dr Barton introduced syringe drivers and the use of Diamorphine – 1991 we were "a little bit"/"very" concerned about the use of syringe drivers with controlled drugs – accepted training and explanations in 1991 resolved concerns**

Re CUNNINGHAM – involved in certifying death

Re PACKMAN – made some entries

Re SPURGIN – cannot recall cause of pain/discomfort

STEWART-FARTHING -

D3/14