GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 19 June 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY NINE)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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THE CHAIRMAN: Good morning, everybody. Mr Kark, the Panel have taken the opportunity to read through Patient L's bundle and also to reacquaint ourselves with your opening in respect of Patient L.

MR KARK: Sir, I am very grateful. The statements that are going to be read in relation to Patient L: there are two statements, one from the husband of Jean Stevens and one from her daughter. The reason that they are not able to give evidence is that both are ill, and both have provided doctors' letters. I have had a discussion with my learned friends about the reading of their statements. These statements are read not by agreement, as it were, in other words they are not agreed evidence, but it is not challenged that they can be read under the Criminal Justice Act because they are unwell. So it is not agreed evidence but it is accepted that it can be read.

You have the power, of course, to receive evidence of this nature. Section 114 of the Criminal Justice Act 2003 provides that you can receive this evidence if you are satisfied that it is in the interests of justice for it to be admissible, or one of the other categories is under section 116, that the relevant person is unfit to be a witness because of his bodily or mental condition.

You have of course in any event power under Rule 50 to allow evidence, provided you are satisfied that no injustice would be caused and that your duty of making due inquiry into the case makes its reception desirable.

MR LANGDALE: Sir, may I just confirm what Mr Kark has said.

THE CHAIRMAN: Thank you, Mr Langdale. Given the clear importance of these two witnesses' evidence and given the fact that we understand that neither are well enough to attend and given that Mr Langdale very kindly accepts that they may be read, on the understanding that they are admissible only in so far as they are those patients' evidence and that it is not agreed evidence, we are happy for you to continue.

MR KARK: Thank you. The first statement is that of Ernest Stevens. He says:

"I am the husband of Jean Irene Stevens". That is our Patient L. He exhibits a copy of her witness statement that he made for the police. He says, and this is the GMC statement so that was made relatively recently on 5 April 2008:

> "My wife did not see Dr Barton, or any other doctor, from the time that she was admitted to the hospital until the time that she died. I can be sure of this as I was by her bedside the entire duration of her stay in the hospital.
>
> I do not believe that my wife was in any sort of pain, and therefore did not require a double dose of diamorphine, as she was not indicating any signs of pain or distress, something which I would be able to identify as an ex-ambulance man.
>
> My wife has not administered any fluids whatsoever from the time that she died."

That was her GMC statement. He give a rather fuller account in a statement that he made to the police dated 8 September 2005 and he said this:

A

"I live at the address known to the Police. I am the widower of Jean Irene Stevens, who died on 22nd May 1999.... at the Gosport War Memorial Hospital, Bury Road, Gosport. I have been asked to provide some background information about my wife.

My wife was born on **Code A** ... in Gosport, Hampshire. Her parents were Harry and Eleanor Victoria Collings. She was one of five children, all girls. Two of
B her sisters died in their teens due to someting like diphtheria or TB and her other sisters, Lillian and Iris, died around the age of 70 year and 80 years.

Harry Collins died around the age of 79 .... and Eleanor died around the age of 69....

My wife worked throughout her life as a shop assistant or canteen assistant.

C We had two children, Carol in 1946 and June in 1949. Both pregnancies were straightforward with no complications.

My wife was relatively healthy but in 1994" – he says – "she began to experience stomach trouble....."

D He made a statement in due course correcting the 1994 date to the 1970s. He says:

"She was experiencing a lot of pain and discomfort.

She was admitted to Haslar Hospital in Gosport for an exploratory operation, during which they removed her appendix. The problem persisted and in 1996 she was again admitted to Haslar where she was diagnosed as suffering from diverticulitis. She
E underwent surgery and had a small part of her bowel removed.

She went on to have two further operations on her bowel. Apparently she had lesions in her bowel due to the operations and it was this that was causing her pain.

As a result of this my wife was in constant pain and was prescribed pain killers.

F She also suffered from slight arthritis in her back, but despite this she was fully mobile and able to get about without assistance.

On Sunday 25th April 1999.... we spent the day at home. Jean had cooked a roast dinner and tidied everything away as usual. We had our usual night cap before Jean went to get ready for bed.

G I heard a thud and went to see what had happened. I found Jean lying semi-conscious in the bathroom. I called an ambulance and Jean was taken to Haslar Hospital in the early hours of Monday 26th April.

By visiting hours that evening Jean was propped up in bed fully conscious. She had lost the use of her left arm and leg but was fully alert and able to speak.

H She had lost the ability to swallow and was being fed through a tube. She had to learn

to swallow again in order to be moved to a rehabilitation ward before she could come home.

At one point it was thought that Jean had suffered a small heart attack and she was admitted into the CCU (coronary care unit) at Haslar overnight as a precaution. There were no other attacks and Jean only spent one night in the unit.

I spent every day with Jean and I could see her getting better. The stroke had only affected her left side.

Jean made very good progress and was reviewed by a Dr Lord, from the Gosport War Memorial Hospital. Dr Lord said that Jean had a sufficient enough swallow for her to accept her on to the rehabilitation ward at the Gosport War Memorial Hospital. It was arranged that Jean would be transferred to the Gosport War Memorial Hospital on Thursday 20th May 1999....

During the evening of Wednesday 19th May 1999.... Jean was visited by June and her husband Ted. I had spent the day with Jean as usual and June had come in after she had finished work.

We were all in good spirits as Jean was moving towards coming home. We were planning a big family party for when she came out of the War Memorial Hospital.

I left Jean happy and in good spirits. I was told that Jean would be transferred to Daedalus ward around lunch time the following day and that I should visit her at the Gosport War Memorial Hospital after 1 p.m...."

We know from our chronology and our notes that she was indeed transferred to Daedalus on 20 May.

"At 1.30 p.m.... on Thursday 20th May 1999.... I arrived at the ward and had to wait to see Jean as the nurse said that they were settling her in.

I was shown into a cubicle opposite the nurses' desk, saw that Jean was lying in bed with her eyes closed I would describe her as being in a coma. She did not move, she did not speak, she did not respond in any way to my being there. I was stunned by her condition.

I stayed with Jean all night. I sat next to her bed and held her hand.

I did not know what was going on or why Jean had deteriorated so quickly. No one came and told me what was happening. I was totally shocked and distraught.

I could hear the noise of a machine coming from Jean's bed and I could smell a sickly smell. I used to work as an ambulance man and I recognised the smell as being morphine.

On Friday 21st May 1999,....at some point during the afternoon, I was approached by a man called Phillip. He was a charge nurse or 'sister' on the ward. He said to me something along the lines of 'your wife is in a lot of pain, can we have your

permission to double her morphine?'

I felt very confused and upset. I did not understand what was happening but I was very concerned for my wife's well being. I thought that if the staff thought that my wife was in pain then they knew best. I have my 'permission' to Philip for my wife's morphine to be increased.

He told me that he would phone Dr Barton for her permission to increase the dose.

Around 8.30 p.m.... on Saturday 22nd May 1999....Jean died.

From the time I saw her at the Gosport War Memorial Hospital, I only saw her open her eyes once.

I never head her make any sound at all, nor did I see her give any physical indication that she was in pain or discomfort.

I know that my wife had a syringe driver. I saw the tube going into her stomach and I could hear the sound of its motor.

After Jean died the driver was still going and I asked the staff to switch it off after about half an hour as I could not stand the sound of it.

Jean's death certificate gives her cause of death as cerebrovascular accident, which I understand to be a stroke.

Her death certificate was signed by Dr Barton."

As you know, I am afraid we do not have that death certificate at the moment. We are still trying to get it

"My wife is buried at Ann Hill Cemetery, Gosport.

Whilst Jean was at the Gosport War Memorial Hospital, I never saw or spoke to any doctors and the only person who spoke to me about my wife's condition was the male nurse Phillip on that one occasion."

That deals with his evidence and there follows a statement from June Mary Bailey. She has made a statement for the GMC proceedings, dated 7 June 2008, in which she says:

"I am the daughter of Jean Stevens."

She effectively produces her police statement, which was dated 16 April 2004.

In fact, I am sorry; I think I gave the wrong date on Mr Ernest Stevens' statement. I gave you the date it was printed but the date he made it was the same date as we have seen, as before, so apologies.

June Mary Bailey says:

A "I live at the address know to the Police. I have been married to Edward Bailey for the past 37 years.

I am the daughter of Ernest and Jean Stevens. My Dad is till alive and my Mum died at the
Gosport War Memorial Hospital on Saturday 22nd May 1999....

B I have been asked if I can remember the events leading up to my Mum's death.

On Sunday 25th April 1999.... my mum had a stroke, she was taken to Haslar Hospital in Gosport. By the following evening she was propped up in bed and chatting away happily. She had lost the use of her left arm and leg but she was able to talk as before and she still had all her faculties.

C My Mum continued to get better and arrangements were made for Mum to be transferred to the Gosport War Memorial Hospital to the stroke ward.

She was due to be moved on Thursday 20th May 1999.... and I visited her on the Wednesday evening. Dad and Ted were there and Mum was in good spirits. We were all laughing and joking and planning a big family party for when Mum came home. Mum and I were talking about perming her hair and she was talking to Ted
D about her garden. You would never have known that Mum had suffered a stroke to look at her, she looked so well. Her skin had a lovely colour and she was so happy and cheerful.

I left her around 9.30 p.m.... and my last words to her were 'the next time I see you it will be at the War Memorial'.

E Around 6 p.m.... on Thursday 20th May 1999.... I went to Daedalus ward at the Gosport War Memorial Hospital. I walked along the corridor with my Dad and walked past a single room where an elderly lady was sleeping. I carried on walking but my Dad called me back. He took me into the room where the old lady as asleep. I was totally stunned, this woman was my Mum. She was totally unrecognisable as the woman I had said goodbye to the night before.

F Her eyes were closed and she appeared to be in a coma. I took hold of her hand but she didn't react. I could hear the sound of a machine working. It sounded so loud as the room was very quiet. I looked underneath my Mum's bedclothes and I saw a machine lying on her stomach. Throughout my visit I didn't hear or see anything which would indicate that my Mum was in any pain. She never made a sound or movement at all.

G Around 6 p.m.... on Friday 21st May 1999... I visited my Mum with Ted. My Dad was there as always.

I talked to my Mum and held her hand. She didn't' respond in any way. We left around 10 p.m....

H During the morning of Saturday 22nd May 1999.... I received a telephone call [from] a man who identified himself to me as 'Phillip from the War Memorial'. He asked

A me if I could come over straight away as my Mum was deteriorating.

Between 1 – 1.30 p.m..... I arrived at the hospital with my son Steven. The male nurse Phillip took us in to a room. He told us that my Mum was deteriorating. Steven asked him if the move from Haslar Hospital had put Mum into a coma and Phillip replied that it didn't help her.

B I was very upset and crying. I went in to see my Mum. Dad was sat holding her hand. I stayed with my Mum until about 10 p.m.... During the entire visit she never moved or displayed any emotion.

I was taken home by my daughter Susan, and had only been indoors for a few minutes when the hospital ran to say that my Mum had died.

C I went straight back to the hospital and saw my Mum. I remember that I could still hear the sound of the motor of the pump.

I have been asked if I was spoken to by any member of the hospital staff in relation to the treatment of my Mum. I was never informed of anything apart from when Philip spoke to me on the telephone and later in his office about my Mum getting worse."

D That deals with her statement and I do not propose to read the statement of Edward Bailey unless I am invited to do so. He is the husband of June.

Just to remind the Panel, and they have checked their chronology I know, this patient was transferred to Daedalus ward on 20 May and reviewed by Dr Barton.

THE CHAIRMAN: Mr Kark, may I ask if the Phillip referred to in both of the statements
E just read is the Phillip that we are to see?

MR KARK: We cannot say but it is very likely to be. We are about to hear from Mr Beed, who is our next witness, and I think we will see that he did make various notations on the drug chart for this patient.

THE CHAIRMAN: Thank you.

F

MR KARK: So far as this patient is concerned, in fact the syringe driver seems to have been started on 21 May at 7.20 in the evening.

May I now call, please, Philip Beed?

PHILIP JAMES BEED, Sworn
G Examined by MR KARK

(Following introductions by the Chairman)

Q Is it Mr Philip James Beed?
A Yes.

H Q Can you tell us your qualifications, please?

A Registered general nurse.

Q When did you qualify?
A 1984.

Q You qualified I think when you were in the Navy. Is that right?
A I did, yes.

B

Q You left the Navy in 1989, you worked for BUPA for five years, then you worked at the Oxford Brookes University and then finally in 1998, did you take up the post at the Gosport War Memorial Hospital?
A What year did you say?

Q 1998.
C A That is correct, yes.

Q Tell us, please, what your role was there?
A I took up the post of clinical manager on Daedalus Ward.

Q What does that really mean, clinical manager?
A I am the senior nurse in charge of the ward, with 24-hour accountability for nursing
D care of the patients on the ward, managing the nursing staff and the nursing assistants.

Q Prior to coming to this role, what experience had you had of elderly care?
A I had worked in a variety of posts, both surgical and medical, dealing with patients across a whole age range, but you appreciate that predominantly in medical care, most patients are elderly, so by virtue of working as a nurse I was working with elderly patients as well as patients of other ages.

E

Q Had you had any particular training, or was it simply something that you picked up, as it were, as you worked? Had you had any particular training in geriatric care?
A Yes. Geriatric care was a component of my general training when I was a student nurse and there were aspects of nursing the patients I was looking after which was pertinent to the fact that they were elderly and there were other aspects of moving to an elderly care ward which I picked up through induction and orientation to the ward when I joined the
F hospital.

Q Prior to coming to the Gosport War Memorial Hospital, had you yourself used syringe drivers?
A I had not, no.

Q So who inducted you, as it were, into the use of syringe drivers?
G A I had an induction period. Part of that included time spent on one of the wards over at Queen Alexandra Hospital, which specifically provided palliative care, and I also had support from other senior nurses and managers in the hospital to make sure that I was familiar with all the practices involved in the hospital and the care of the patients and that would have included how to make a decision when to – how to look at patients' pain control and, if a syringe driver was required, how to set it up, how to monitor it and how to look after it and how to look after the patient.

H

Q The training that you had had at the Queen Alexandra you told us was on a palliative care ward.
A Yes.

Q So end of life?
A Yes.

Q Who held the similar or same role as yours on the other ward, on Dryad Ward, that we have been hearing about?
A That was, at the time I took up post, a nurse called Jill Hamblin.

Q So it is Ms Hamblin on Dryad Ward and you are on Daedalus Ward?
A Yes.

Q I want to ask you, please, a little bit about Daedalus Ward and also about the hospital generally. Obviously please confine your answers to the period when you were there. You started in 1998. When did you leave?
A I was there for I think about six or seven years, so that would have taken me to 2005 I think.

Q During that time, I just want to ask you about the facilities at the Gosport War Memorial Hospital. Did it have an Accident & Emergency Department throughout that time?
A It had an Accident Treatment Centre, although I do not think it had exactly that title, but in 1998 when I started, it had a Minor Injuries Treatment Unit.

Q We have heard about various other wards. We have heard about Sultan Ward. Sultan Ward looked after what sort of patient? Can you help us?
A Sultan Ward was a GP ward. So patients were admitted under the care of their general practitioners.

Q We have also heard about Mulberry Ward. Can you fill us in?
A Mulberry Ward was an elderly mental health ward.

Q So far as Daedalus Ward is concerned, was that all on the ground floor of the hospital?
A Yes, it was.

Q As was Dryad Ward?
A Yes, it was.

Q Were they connected in any way?
A No.

Q How far apart are they spaced?
A They were in separate wings.

Q Was there any interaction between Dryad Ward and Daedalus Ward? Would Ms Hamblin come over and discuss things with you or would you go over there and discuss things with her?

A A We would meet at meetings, but we would not normally, unless there was something that very particularly appertained to that we needed to communicate with one another, as colleagues sometimes do.

Q How many beds did you have on Daedalus Ward?
A 24, I believe.

B Q The beds were there to house what sort of patient?
A We had eight slow stream stroke rehabilitation beds and in 1998, when I was first appointed, the others were continuing care beds.

Q When patients came to you, first of all, did they come to you at any stage for palliative care?
A There were some patients who were admitted to us for palliative care, yes.

C Q But in general, what were they coming to you for?
A Always different things. We had eight rehabilitation beds for stroke patients and that left 16 continuing care patient beds. So either stroke rehabilitation or continuing care.

Q Can I ask you about staffing? You have told us about your role. Let us go upwards from you first of all. We know of course there was a clinical assistant, in other words,
D Dr Jane Barton.
A Yes.

Q Was she the first port of call, the doctor above you in terms of the care and responsibility for these patients on your ward?
A Yes.

E Q Who was above her?
A There was a consultant who had responsibility for the ward called Dr Lord.

Q Let us deal with Dr Lord first of all. How often would she attend the ward?
A We had initially weekly ward rounds, but then they became twice-weekly. I would not be able to tell you off the top of my head when they became twice-weekly.

F Q When they were weekly, can you remember which day of the week Dr Lord attended?
A No, I cannot remember.

Q Was it a morning or an afternoon visit?
A It was an afternoon. It was from lunchtime usually through till well after five o'clock.

Q When she did her ward round, would Dr Barton be with her, or not or sometimes?
G A Dr Barton would always be with her, unless of course she was on annual leave or absent from work for some reason. But otherwise, yes, she would always be there.

Q Did you yourself liaise either regularly or irregularly with Dr Lord?
A I liaised regularly with Dr Lord.

Q So far as Dr Barton is concerned, how often would she come to the ward?
H A She came to the ward daily.

Q At a fixed time?
A First thing in the morning, prior to starting her GP practice clinic.

Q First thing in the morning meaning what?
A I believe it was some time between 8 and 8.30.

Q How often would you be there when she attended?
A I worked shifts, as did all the staff, so it would be when I was on early shift. I worked probably three early shifts a week, but some of those might have been weekends.

Q So would it be a fairly regular occurrence that you were with her?
A I would usually expect to meet with Dr Barton once or twice a week.

Q Dr Barton, we know, had a regular GP practice, indeed still does. Do you know how far away her GP practice was from the hospital?
A At that time, probably about five to ten minutes' drive.

Q So far as you are concerned, was she available to you when she was not at the hospital? Were you able to contact her?
A Yes, I was.

Q Did she have a bleep or a mobile?
A We could contact her via the surgery and usually get her fairly quickly.

Q If Dr Barton was not available, were there other doctors at the surgery with whom you had an arrangement?
A Yes. If Dr Barton was not available, whichever of the other doctors was duty would actually cover the ward.

Q Did other doctors from that surgery on occasion attend your ward?
A Yes, they did.

Q We know that Dr Barton worked Monday through Friday. What happened at weekends and at nights?
A At weekends and at nights, we were covered by whoever was duty for the practice. So there was a doctor covering from that practice.

Q Does that mean effectively there was, to use what some think is an awful expression, 24/7 cover, full-time cover by a doctor at all times?
A Yes.

Q Apart from her regular morning visit, did Dr Barton regularly attend at any other time of the day?
A Whenever we had admissions, we would advise her and she would come and clerk the patient in on the ward.

Q What does that really mean? The patient comes in. So what do you do?
A What do I do or what did Dr Barton do?

Q What is done?
A From the nursing point of view, the patient has to be assessed and documentation written up. From Dr Barton's point of view, it is again assessing, making sure we had all the right medications written up and any other medical interventions that were required were correctly prescribed.

Q Who would carry out the assessment?
A Which assessment are we talking about?

Q If Dr Barton was there, who would carry out an assessment?
A Dr Barton would assess the patient medically, but the patient would also have a quite extensive nursing assessment on arrival at the ward.

Q Were you there on occasion when Dr Barton performed an assessment?
A Yes.

Q Did you ever see her making notes of her assessments?
A Yes.

Q You have dealt with this in your police interview. I wonder if you are able to give us any sort of idea about how busy Daedalus Ward was? You had 24 beds. How often were those absolutely full, as it were, or did you normally run at something lower than 24 patients?
A During my time on the ward, the ward was nearly always full or nearly full and very busy.

Q When you say "full or nearly full", what are you talking about?
A It would be unusual to have more than two or three empty beds.

Q In terms of staffing below you, tell us about the nurses, first of all; how many did you have who were on duty at any particular time of the day?
A My aim would always be to have at least two qualified nurses on duty during the day shifts. There were quite regular occasions when there was one qualified nurse on duty for a shift.

Q What about support staff?
A Then to have a total of six staff on an early shift and a total of four staff on a late shift; if we had more than that that was a bonus and enabled us to increase the quality of care that we could provide.

Q Were you able to use bank staff if necessary?
A We did use bank and agency staff if it was necessary.

Q Whose decision was it that the ward had become so busy that you needed extra help?
A That would be my decision as clinical manager or if I was absent the senior member of staff on duty.

Q Did you use bank yourself? Did you actually actively use them?
A Yes, we did.

Q I want to deal with the issue of pain control and your training or your knowledge of pain control and analgesia. First of all, tell us, please, about the prescribing practice on Daedalus Ward; who is entitled to prescribe?
A Prescriptions need to be written by a qualified medical doctor.

Q And during the time that you were there who would that normally have meant was writing out the prescriptions?
A It would have been Dr Barton, Dr Lord or one of the other partners in Dr Barton's practice.

Q We have seen – and we have become very used to looking at – variable does; so various doses of opiates and you know that those were prescribed, presumably?
A Yes, I do.

Q Just tell us, please, about how those would come to be administered and whose decision it would be to begin a syringe driver?
A Part of the assessing and caring for patients would involve monitoring whether they are in any pain and if they were in pain whether they required analgesia to manage that pain; and if they were in pain analgesia could be given in accordance with the current written prescription for the patient.

Q Who would make the decision to start a patient on a syringe driver if Dr Barton was not there?
A That is a decision that could be made by nursing staff and would be based on the patient's overall condition, if they are in pain and what is the appropriate course of treatment for them.

Q You said if a patient was in pain.
A Yes.

Q Just concentrate on opiate medication first of all; was opiate medication used for patients who were not in pain, to deal with other issues as it were?
A No, I have never experienced a patient being given opiates for any other reason than pain control.

Q What about agitation?
A No, I have never experienced patients being given opiates for agitation.

Q And you would not do that?
A No.

Q So were there occasions when a prescription having been written up by Dr Barton you, for instance, would make a decision that the time had come for a syringe driver to be initiated?
A That might occur, yes.

Q How would you set the dose?
A I would usually start at the lowest prescribed dose and monitor the patient and see whether that controlled their pain.

Q Would you always start at the lowest dose or were there occasions when you went above the lowest dose?
A I cannot think of an occasion when we did not start at the lowest dose.

Q If you are present and there is another nurse with you – because we gather there would have to be two nurses to make the decision to administer opiates – would you normally be the senior nurse?
A As the clinical manager I would have been the senior nurse on the ward, yes.

Q What would you know about the drugs that the patient had previously been on prior to you initiating the use of a syringe driver?
A We would have the patient's drugs chart so we would have a record of medication that had previously been given.

Q At another hospital?
A Yes; the patients who came to us would always come with their notes and their previous drug charts.

Q Were some of the patients that came to you opiate naïve: in other words, they had not had opiates in the run-up to their arrival at your hospital?
A Yes.

Q How, if at all, would that effect your decision on the application of a syringe driver?
A Analgesia that the patient was given would be in relation to their overall condition and their level of pain; so the assessment and decision-making would be based on how the patient presents on assessment.

Q If the time came when in your view a patient required a syringe driver to be initiated, provided that there is a variable dose prescription would you need to go back to Dr Barton, or would you be able to do it on your own initiative?
A It would not automatically be necessary if Dr Barton was available on duty and there was a change in the patient's condition then we would go back to her, but there would be times when those decisions needed to be made out of hours.

Q If that decision has to be made out of hours would you contact one of the other GPs available to you, or would you make the decision on your own?
A Not necessarily; a decision could be made at ward level.

Q What about the increase of the administration of opiates? Who would make that decision?
A Patients who were receiving opiates would be continually monitored to see whether their pain is adequately controlled and if over a period of time it was not adequately controlled then the decision could be made to increase the level of analgesia that they were receiving.

Q Did you do that on occasion?
A There were occasions when we did that because patients were very obviously in pain.

Q Would you necessarily have to go back to Dr Barton before you did that?
A I would not automatically have to do that, no.

Q What was your practice? Would you normally go back to Dr Barton; would you not bother unless you felt you needed to? How did it work?
A We would contact Dr Barton if we felt we needed to.

Q Are you able to give us an idea of what proportion of occasions you felt you needed to go back to Dr Barton and what proportion of occasions you felt, "I can do this; it is obvious I should use an increased dose"?
A I really could not without looking at the patients' notes from those periods, I am afraid.

Q If you yourself were making a decision to increase the dose how would you decide by how much to increase it?
A We would usually go up by the next numerical value; so you would go up in smallish increments.

Q So say you started somebody on 20 mgs of diamorphine over 24 hours what would you go up to if you felt that was necessary to increase?
A 25 or 30.

Q Why would you go up in those sorts of incremental rates?
A You would want to assess whether the patient's pain was then controlled at that level and if it was not you could consider a further increase, but usually the next incremental step would be adequate to provide adequate pain control for the patient.

Q Going back a little bit, were there occasions when a patient of yours had been on oral morphine – Oramorph?
A Yes.

Q Were there occasions when a decision was made to switch from Oramorph to a syringe driver?
A Yes, that happened on occasions.

Q What would be the catalyst for such a decision?
A The patient's pain not being adequately controlled by oral morphine or the patient not being able to take oral morphine.

Q What sort of conversion would you apply when you switched from Oramorph to a subcutaneous dose?
A We had a conversion table which was in a handbook provided by a local hospice, so it was probably documented and assessed which allowed us to convert oral morphine to diamorphine via a syringe driver.

Q Is that something called the *Wessex Protocol*? Do you want to have a look at it?
A Yes.

Q If you look to your left you will find a file simply called Panel Bundle Documents I and if you turn up tab 4 of that.
A Yes, that would have been it.

A Q Does that ring a bell?
A It does, yes.

Q Can you remember when you first read this document or a version of it?
A I would have seen that as part of my induction programme when I joined the ward.

Q If you turn to the printed number page 5 – page 6 of the internal numbering – do you
B see that there is something there which is called the WHO – World Health Organisation – Analgesic Ladder?
A Yes.

Q Is that a concept with which you were familiar?
A Yes.

C Q If you go over to page 6 you will find a heading – page 8 of the internal numbering – "Use of morphine".
A Yes.

Q Again, would you have read this during the course of your induction?
A Yes.

D Q If we go down to paragraph 3 we can see these words:

"Start with a low dose and increase by 30-50% increments each day until pain controlled or side effects prevent further increase. Doses can be rounded up or down according to the individual need. A common dose sequence is 5-10 – 15-20 – 20-30 – 30-40 – 40-60 – 60-90 – 90-120 …"

E And upwards. Would you have been aware of that guidance?
A Yes.

Q May I ask you this: do you know the difference between a guidance and a protocol? I do not mean that as an exam test, as it were, but do you know that there is a difference between a guidance and a protocol?
A I would recognise it as a difference; I do not think I could actually quote it.
F

Q Did you regard this as a protocol that you had to follow or a guidance that perhaps you would be best advised to follow?
A I would regard this as a guidance.

Q If we go down to paragraph 5:

G "Use continuing pain as an indication to increase the dose and persisting side-effects, e.g. drowsiness, vomiting, confusion, particularly in association with constricted pupils, as an indication to reduce the dose. If both pain and side-effects are present, consider other approaches.

Once pain is controlled consider converting to 12 or 24 hourly sustained release preparation for convenience using the same total of daily dose."
H

A So the concept is to get up to the point where pain is controlled and then keep it at that level if possible; is that about right?
A Yes.

Q "Always make available immediate release morphine for breakthrough pain."

Tell us what that means? What is breakthrough pain? It may be obvious, but tell us.
B A If the pain is controlled most of the time but then there are episodes when the patient is experiencing pain despite it appearing to be controlled.

Q Would that be an indication in your view to increase the dose generally or simply to use a one-off injection? How would you deal with breakthrough pain?
A In 1998 we were not using one-off injections to control breakthrough pain, so depending on the level we might leave the level as it is or might increase the level of the
C syringe driver.

Q Look at 7, please:

"When oral administration is not possible because of dysphagia ..."

Is that nausea?
D A No, dysphagia is an inability to swallow.

Q I am sorry:

"... vomiting or weakness, consider changing to diamorphine by subcutaneous infusion using a syringe driver."

E So let us look at that. It is the inability to swallow; it is vomiting, in other words not being able to keep down the Oramorph; or weakness. How would you translate that?
A If a patient cannot be given analgesia by the oral route then subcutaneous would be an appropriate route to use – might be an appropriate route to use.

Q "The conversion from oral morphine to subcutaneous diamorphine (total daily dose) varies between ⅓ – ½ allowing some flexibility depending on the requirement
F for increased or decreased opioid effect."

Did you understand that concept that when diamorphine is given subcutaneously the effect of the drug is greater than if given orally?
A Yes.

Q Would you say that you applied this guidance to reduce the dose down to ⅓ or ½?
G A Yes.

Q What about your nursing staff; would you expect them to be similarly knowledgeable or not?
A Yes, I would expect them to have the same level of knowledge.

H

Q We have heard of the concept during the course of the case of named nurses and we had a description of what that really means from a nurse called Ms Couchman – you will probably remember, I expect.
A Yes.

Q Just tell us, please, what your understanding of named nurse means?
A It is when every patient is allocated to a qualified nurse who takes specific responsibility for that patient's care plans and their programme of care, and that allows a greater degree of continuity of care for the patients but it also allows the patients and their relatives to have a particular nurse that they can relate to should they have specific issues or problems or want to discuss things.

Q To what extent would the named nurse have any particular responsibility in relation to the administration of drugs, or would they not have any particular responsibility?
A Administration of drugs – it would have been the responsibility of the nurse on duty at any particular given time and where patients had a named nurse those nurses were working shifts covering seven days a week and two shifts, so in any given 14 shifts in a week there would be significant periods when a named nurse was not on duty; so not every aspect of the patient's care could be left down to the named nurse.

Q We have heard that there was this concept that the named nurse was meant to be the patient's – somebody called it "champion" and another person called it "advocate", but let us stick to advocate. Would the named nurse necessarily be consulted prior to the syringe driver being started or not?
A If the patient's named nurse was on duty, then certainly they would take the lead in that patient's care, but that would not necessarily be the case. You could be at a point when the named nurse was on days off for two, maybe three, days, and then that would not be practical. That would leave the patient in pain until that decision had been made.

Q Let me come back again then, please, to syringe drivers and the purpose of initiating subcutaneous doses of diamorphine together with what other drugs are put into the syringe driver. How do you tell when the patient's pain is controlled? That may be an obvious question but how do you know?
A Well, because of the symptoms of pain, which might include a whole range of things, but the patient telling you they are in pain, visual expression, reaction. Those symptoms would be reduced or alleviated.

Q So far as you were concerned, was the purpose of using diamorphine to control pain by reducing a patient to a state of unconsciousness?
A No.

Q Would you, so far as you are concerned, say that you looked out for that? So would you be looking out for the point at which a patient became unconscious?
A Yes, you would but you would expect a patient on analgesia --- It would not be unusual for a patient on opiate analgesia to become unconscious, particularly if they were receiving palliative care.

Q Sorry, can you just repeat that? It would be unusual ---
A It would not be unusual for a patient receiving palliative care to become unconscious as a side-effect of the pain control they are receiving.

Q You also used the expression "palliative care". Palliative care means care given to a patient at the end of their life?
A Yes, that is correct.

Q So when do you take a decision that a patient is for palliative care?
A It is based on their overall condition and their medical problems and their likely prognosis.

Q When you initiated a patient on a syringe driver, in your mind was that the initiation of palliative care?
A It would not necessarily be but in a lot of cases it was.

Q You have told us already you would be entitled to make the decision about the deployment of the syringe driver?
A Yes.

Q Does it follow, and I simply want to understand this, that you would be effectively on occasion making the decision that the patient was for palliative care?
A Because patients were reviewed regularly, it would have been already identified that the patient's condition was deteriorating and their prognosis was poor, so I do not think we would have been making that decision at that point in time.

Q Who would?
A The nursing staff would not have been making that decision; it would have been implicit within the overall care that the patient was receiving.

Q But that would be a function that the nursing staff could deal with?
A Sorry?

Q That would be something that the nursing staff could decide – that the patient was now due for palliative care, a palliative care regime?
A We could decide to initiate a syringe driver but I do not think that is necessarily the same as the deciding the patient for palliation.

Q I am asking specifically about the palliative care regime. Would you be able, as a nurse with your other nursing staff, to take the decision that a particular patient was for a palliative care regime?
A I do not think so, no.

Q You do not think so?
A No.

Q Who would make that decision?
A It would usually be a medical decision.

Q So on your ward that would be?
A Dr Barton or a consultant or one of the duty doctors.

Q I want to ask you a bit about the hydration. At the time that we are discussing, and you started in 1998?
A That is correct.

Q And we are really interested, as you know, in this case, as far as you are concerned, in 1998/99. In 1998 and 1999 did you have facilities on Daedalus ward, once a patient was unconscious, to rehydrate them; in other words, to use what I would call intravenous methods, but you will probably correct me?
A We could not rehydrate patients with intravenous methods but we could use subcutaneous fluids to maintain hydration.

Q How would that work? Explain that to us?
A Intravenous fluids but infused in the subcutaneous layer of the skin, usually in the abdomen. It is a slower method but it is one that can be used in a community setting.

Q So you did have the facility to rehydrate patients?
A Yes.

Q If you were using a syringe driver, how would you make the decision as to whether to rehydrate a patient or not?
A In '98 when I was working in hospital, the usual practice for patients who were receiving palliative care was not to hydrate them during that period. There was evidence that that was actually making things more uncomfortable for the patients and we not actually of any benefit to them.

Q What I actually asked you was when you would make a decision using a syringe driver, not necessarily palliative care, and you told us there was a difference? So when you are just using a syringe driver, when you would make a decision not to rehydrate a patient or once you are using a syringe driver, do you just stop hydrating?
A Usually we would hydrate patients on medical advice.

Q So it would be again down to the doctor to decide whether to hydrate a patient?
A Yes.

Q And if you do not hydrate and keep a patient well hydrated after the use of diamorphine, what is the effect of that upon the patients?
A The patient would become dehydrated.

Q Yes. That means there is nothing presumably going through the bladder, the kidneys, et cetera?
A Yes.

Q Help us: does that lead to a deterioration of the patient?
A It could do if it was a patient who you wanted to make a recovery, yes.

Q If it was a patient that you wanted to make a recovery, would you not want to keep them hydrated?
A Yes.

Q But if you did not want them to make a recovery, you would not rehydrate them? Is that how it works?
A When I was working on the ward in 1998, the evidence that I had seen and looked up and was advised was that for patients who were receiving palliative care, that rehydration could make them uncomfortable and was not necessarily beneficial. So in those cases, patients were not hydrated at that time.

Q If we see in any of these cases, and you can only talk about the practice I suppose on Daedalus ward, that a syringe driver has been initiated and there is no hydration in place, are we to take it that that patient has been destined, as it were, for palliative care?
A Yes.

Q May I just ask you a bit about midazolam, and again this is not meant to be an exam. You can only tell us what you know about the effects of various drugs. What do you know about midazolam?
A It relaxes patients,. It is an anti-hypnotic.

Q When you say it relaxes patients; in what circumstances would it be used?
A If the pain is causing the patient agitation, then it would actually help to calm some agitation.

Q You told us earlier you would not use diamorphine for agitation but midazolam might be useful?
A If the pain was accompanied by agitation, yes.

Q Were there occasions when diamorphine and midazolam were used together?
A Yes, here were.

Q Does midazolam, so far as your understanding of it, also have a sedating effect?
A Yes, it does.

Q Does it depress the respiratory function?
A Yes, it does.

Q So using diamorphine and midazolam together, both would depress the respiratory function?
A Yes.

Q Before we move on to deal with the case of Gladys Richards, I just want to ask you a bit about the records. You were interviewed by the police in this case, were you not?
A I was, yes.

Q That was back in July of 2000 over I think really a pretty full day for you; is that right?
A Yes.

Q And you either reviewed then or had reviewed a number of the records?
A Yes, I had.

A Q Let us deal with the nursing records, first of all, and we will look at some obviously. Do you say anything generally about the quality of the nursing records?
A We worked very hard to keep the nursing records as up to date as possible. Sometimes that was rather difficult. We had to juggle the nursing needs of patients and the needs of relatives and keeping documentation. I do recognise subsequently that our nursing records probably could have been better.

B Q I am not going to ask you to comment upon Dr Barton's records because I do not think that would be fair, but when Dr Barton was doing her morning rounds, would she ever have somebody with her, normally have somebody with her?
A Yes, one of the nurses on duty would be with Dr Barton.

Q The notes for each patient would be kept where?
A The medical notes were kept in the ward office.

C Q Drug records, prescription charts and the like?
A In 1998 I think we kept those in one large folder.

Q In the office?
A In the office.

D Q Where was the office in relation to the ward?
A The office was in the centre of the ward.

Q When Dr Barton was doing her rounds, would she have the notes available to her?
A She would, yes.

E Q What about the notes from the previous hospital? Normally I think all of the patients that we are dealing with in this case, and I suspect most of your patients generally, came from either the Haslar or the Queen Alexandra, is that right?
A They did, yes.

Q When normally would you get the notes from those hospitals?
A The notes were supposed to accompany the patients on transfer. Sometimes they did not and sometimes they followed 24 hours later.

F Q Are you able to say how often they were delayed? Was that regular or irregular?
A It was a fairly regular practice. The Queen Alexandra is a very busy hospital. I suspect they came late in 1 in 10 or 1 in 20 cases.

Q So the majority came with the patient?
A Yes.

G MR KARK: Sir, I am about to move on to Gladys Richards and that is going to take a little while to deal with. The witness has been here for an hour. I do not know if you want me to start.

THE CHAIRMAN: We will take a break now. We are going to take a break now for 15 minutes, so that you will have a chance to rest and hopefully get a cup of tea or coffee.

H

Please remember that whilst you are giving evidence you must not talk to anybody other than the staff who will take you to and from. Thank you very much indeed.
A Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Kark?

MR KARK: Mr Beed, we were about to turn to the case of Gladys Richards, who is our Patient E. Could I ask you to take up, please, the bundle to your left, which is marked bundle E? you will find at the beginning a chronology and just to remind us all of what happened to this unfortunate lady, she was admitted to Accident & Emergency on 29 July 1998 at the Royal Haslar Hospital after falling in her nursing home and fracturing the right neck of her femur. The Royal Haslar Hospital seems to have had a connection with the Gosport War Memorial Hospital. I think it is just up the road, is it?
A It is very local, yes.

Q How far away is it?
A Three or four miles.

Q So was there a fairly regular transfer of patients between your hospital and the Royal Haslar?
A Yes, there was.

Q We see that she was operated upon on the following day, 30 July. I am going to ask you first of all to have a look at the drug charts to see what sort of drugs she received prior to arriving at your hospital. If we start at page 238 of this bundle, this is a record of once only and premedication drugs. I am not going to spend much time on that. Over the page, page 239, we can see that haloperidol was prescribed and it looks as though that was administered fairly regularly. Is that right?
A Yes.

Q Haloperidol would be used for what?
A It is for calming patients with psychosis or similar types of problems.

Q Is it sometimes used where a patient has dementia?
A Yes. For use in dementia management.

Q Could I ask you to go on, please, to page 243? We can see that morphine was used on the day of the operation.
A Yes.

Q You are probably very used to reading these records and we are slowly getting used to understanding them. We can see that the dosage was 2.5 mg by an intravenous route. Would that mean in this case by syringe?
A It would have been a syringe rather than a syringe driver, yes.

Q That was given on 30 July. Then on 31 July, she was given a total of 5 mg in the very early hours of the morning and then at 7.05. Then on 1 August she was given 2.5 mg and on 2 August she was given 2.5 mg. She was prescribed co-proxamol. Is that an analgesic?

A A That is an oral analgesic, yes.

Q The co-proxamol does not seem to have been in fact administered. Is that right?
A That is correct, yes.

Q She was prescribed haloperidol, which, as you have told us, may have been to deal with agitation, and that seems to have continued I think in fact throughout her time there.
B Then we can also see that she was prescribed co-codamol. I think that is codeine phosphate and paracetamol mixed together.
A It is, yes.

Q Is that an analgesic?
A That is an oral analgesic.

C Q Below morphine on the analgesic ladder?
A Yes.

Q We can see that she was given that fairly regularly up until about 7 August. Is that right?
A Yes.

D Q Then we can see on 9 August, if we look at the far right-hand side of the page, co-codamol. There is an entry for 9 August and then it seems to have been crossed through. Can you help us as to what that would signify?
A The most likely scenario would be that the medication had been got out for the patient, but actually there was some reason why it was not given or was not taken by the patient, so the entry was deleted to indicate that it had not been given.

E Q I may be missing it, but it looks as if the last time this patient had morphine was 2 August.
A That would be what the prescription here indicates, yes.

Q If we go to page 246, we can see – I am afraid it is terribly mixed up – there is a fluid balance chart, the earliest of which I think is actually on page 255. I am sorry for the order of these, but a policy decision, as it were, was taken not to re-order everything again. As you
F probably appreciate, these have been re-ordered so many times and it may have been the right, it may have been the wrong decision, but I am afraid that is why they are in the state that they are and that is why we are going to be relying on Mr Fitzgerald's chronology. But page 255, I think you will find, is a daily fluid balance chart. Would that be the fluids that were being at that stage administered to her intravenously?
A No. Those indicate oral fluids being given to the patient and urine output.

G Q Page 255 I think is intravenous.
A Yes.

Q Because that is the day of her operation, so you would expect those fluids to be intravenous.
A Yes.

H

Q We can see, as we move through the records, if we go to page 253, which is the following day, 1 August, it seems that she was able to sit up and have some tea and squash, quite a lot of it.
A Yes.

Q Then just moving to 2 August, page 251, we can see from there on she seems to be regularly taking tea, juice and water.
A Yes.

Q Do you have a recollection of this patient, who was transferred to your ward we know on 11 August?
A I have some recollection.

Q Can I take you, please, to page 22 of the records? This was written the day before she comes to you and it sets out Mrs Richards' history:

> "Gladys sustained a right fractured neck of femur on 30th July ... she had a right cemented hemi-arthroplasty and she is now fully weight bearing,, walking with the aid of two nurses and a zimmer frame."

Then it gives her past medical history, it reveals that she had had a six-month history of falls and Alzheimer's, it shows that the drug she was on was haloperidol, which we have discussed, and co-codamol and "2 prn". Does that mean twice daily as required?
A No. It would mean two co-codamol tablets. There should be a frequency with that as well. I would expect that to be four-hourly.

Q So that the pain-killing element of any drugs that she was on, that would be the co-codamol, would it?
A Yes.

Q It reveals:

> "Gladys needs total care with washing and dressing, eating and drinking, although her daughters are extremely devoted and like to come and feed her at mealtimes (although I feel they could do with a rest). Gladys has a soft diet and enjoys a cup of tea.
>
> Gladys is continent, when she becomes fidgety and agitated it means that she wants the toilet. Occasionally incontinent at night, but usually wakes."

And it reveals that her bowels were opened on 9 August.

> "Occasionally says recognisable words, but not very often.
>
> Wound: Healed, clean and dry.
>
> Pressure areas: All intact, bottom slightly red, but not broken."

Meaning the skin is not broken.
A Yes.

Q Then:

"Thank you for taking Gladys and I hope that she settles well."

Is that a classical sort of note that you would have received?
A Yes.

Q Can you help us as to whether you would have received this with the patient?
A As far as I am aware, that came with the patient.

Q Then we go to page 30. This is Dr Barton's note.
A Yes.

Q Can you just help us? Before we read through Dr Barton's note, you got a note from the Royal Haslar which says that she is fully weight-bearing, walking with the aid of two nurses and a zimmer. I will not repeat everything in the referral letter. What did you think your role at the Gosport War Memorial Hospital was in relation to this particular patient?
A This patient was transferred to us to recovery from the hip surgery and for rehabilitation.

Q So she would need help getting out of bed, presumably?
A Yes.

Q And getting her walking?
A Yes.

Q I do not know how much you know about post-operative care. I expect at your level, a reasonable amount.
A Yes.

Q Would it be important with an elderly patient such as this to get them walking fairly quickly?
A You would have to balance that with safety for the patient and the staff and my expectation of a patient with dementia is that it would probably take some time to get them mobile.

Q But that would be the purpose, the aim?
A Yes.

Q Let us have a look at Dr Barton's note:

"Transferred to Daedalus Ward ..."

You can probably read her writing rather better than we can. Can you help us?
A

"Transferred to Daedalus Ward continuing care. Fractured right neck of femur on 30 July.

Past medical history – hysterectomy @ 55

External operations
Deaf
Alzheimer's

On examination Impression frail demented lady
Not obviously in pain
Please make comfortable"

Q I think I will help you. "Transfer with hoist", is it?
A Yes.

Q "Usually continent"?
A Yes.

Q "Needs help with ADL"?
A Yes. That is activities of daily living.

Q Then we have a Barthel score I think of 2 and, "I am happy for nursing staff to confirm death".
A Yes.

Q I just want to ask you about these notes. Would you read Dr Barton's notes to see what was needed for the patient?
A Yes, I would.

Q How would you read the words, "Please make comfortable?" Are they to be read in an ordinary English way, or do they have a particular significance?
A No. I would just regard that as meaning making sure that the patient is comfortable, not in any pain at all.

Q There is a note from Dr Barton that she is not obviously in pain.
A Yes.

Q Then we see the words after that, "I am happy for nursing staff to confirm death." How often did you see those words written in Dr Barton's writing?
A This is something that would be written in patients' notes and this pertained to the fact that we were a community hospital without medical staff on duty around the clock, so it meant that if a patient's condition deteriorated and there was an expected death, we did not necessarily have to call in a doctor.

Q Can you help us as to why it might be written into the notes for this particular patient? Was this patient expected to die?
A The patient was not, but I think it had become custom and practice within a community hospital for that to be part of the instructions, so that it was there should it become necessary.

Q So it was to your understanding custom and practice?
A Yes.

Q With every patient who came into the Daedalus Ward, the doctor would write that she was happy for nursing staff to confirm death?
A It would not necessarily have been every patient, but it would have been some of the patients that came into us, yes.

Q So it would be written for some patients, but not all?
A Yes. I think that would be correct.

Q Do you know which patients?
A I think that would depend on Dr Barton's medical assessment of the patient.

Q That would mean what? What was she assessing when she wrote those words to your understanding?
A She would be looking at the patient's overall presentation and possible prognosis.

Q Can we have a look at the drug chart, because we can see what Dr Barton prescribed for this patient on admission and how it was administered. If we go to page 63, we can see that she wrote up Oramorph.
A Yes.

Q Is that 10 mg in 5 ml?
A Yes.

Q We can see that that was administered twice on the day of her admission.
A Yes.

Q The first entry. Is that yours?
A That is correct, yes.

Q That time has confused us slightly. We can see a time after that of 11.45. Do you see the first entry?
A Yes.

Q Can you help us with that?
A I would say that would be 1415.

Q Can that be right?
A I would need to correlate that to the controlled drug record to establish that.

Q We are going to try and get the original document for you. The note that follows is 11 August, 11.45. Would you, as a nurse, be taught to use the 24-hour clock?
A We would normally, yes.

Q So we ought to read that 11.45 as being 11.45 a.m.
A That could not be correct though, could it, because that is not in sequence.

Q That is what I am asking you.
A So I would think it more likely that that should read 23.45.

Q Right. So either the first entry is wrong or the second entry is wrong.

A A Yes.

Q But they do not seem to be consistent with each other, do they?
A Which is why controlled medications have to be recorded in a controlled drug register which would actually help verify the two nurses that came.

Q We have the controlled drug register behind us so we will look through those, I hope
B in a break, and see if we can find the right one for you. In any event it looks very much as if you have issued Oramorph at 14.15; yes?
A Yes.

Q And that is a dose of 10 mgs?
A Yes.

C Q Would you have been aware that this patient had not had any sort of morphine since she was last given it at the Haslar?
A I would have seen the previous drug record, yes.

Q You would have seen it?
A Yes.

D Q So would you treat this patient or regard this patient at this stage as being effectively opiate naïve?
A Yes.

Q Can you help us why you decided to initiate a dose of 10 mgs?
A It would have been to do with the level of pain the patient was observed to be experiencing.
E
Q Would you make a note of that?
A Yes.

Q We have a number of nursing notes to which I will direct you as best I can. If we go to page 38 – I want you to identify this document for us if you would.
A That is part of the patient's nursing assessment.
F Q When would this be completed?
A This would have been done as soon as practicable or after the patient is admitted to the ward.

Q Who would fill this in?
A One of the nurses that was on duty.

G Q Not you?
A It might be me or it might have been one of my colleagues.

Q I am sorry, what I meant was looking at this document, this writing.
A That has not been completed by me, I do not believe.

Q Can we then go please to page 50; is this a nursing care plan?
H A Yes, it is.

Q When is this filled in?
A Nursing care plans would be initiated on admitting the patients to the ward but if there were any other problems they could be initiated at any time while the patient is in our care.

Q This seems to have been started on 12 August, is that right?
A Yes.

Q "Requires assistance to settle and sleep at night. Desired outcome to promote a satisfactory night's rest.

Nursing action: ensure comfortable and warm in bed. Night sedation if required. Observe for pain."
A Yes.

Q "Remove dentures. Call bell at hand."

Then we can see on 12 August that haloperidol was given because she was agitated and crying at night.

"Did not seem to be in pain."
A Yes.

Q Where would you have made a note of the patient being in pain on 11 August?
A It would usually do that in the running commentary on the patient's care somewhere within the notes.

Q Would you always, do you say, make a note if a patient was in pain or is that something that might get missed?
A It is something that should always be done, yes.

Q Going back to the prescription for a moment, can I pass you the originals of these. (Same handed) Looking at that can you help us as with that date of the Oramorph and the time – is that 14.15?
A It is, yes.

Q It follows from that – going back to page 63 – that the time following must be 11.45 p.m., if they are in the right order.
A If they are in the right order it would be, yes.

Q With this patient we have a summary that we looked at, at page 36 and perhaps we should go to that. Is this where we would find the chronological nursing note?
A That would be part of it, yes.

Q This is 11 August, so this is the day of admission. Who would make this note?
A One of the qualified nursing staff would write this up either during the shift or at the end of the shift.

Q Again, it is not your note? Does that look like your writing?
A It does not look like my handwriting, no.

Q We are going to try and find the original of this for you because we have the best copy, as it were, that we will copy but it may be that the original will be clearer. It is dated 11 August 1998 and I am going to make an attempt at interpreting it, so please follow and if you think I have it wrong would you shout?

"Admitted from E6 Ward Royal Hospital, Haslar."

A Yes.

Q "Into a continuing care bed. Gladys has sustained a right fractured head of femur on 30 July 1998 ..."

A Neck of femur.

Q I beg your pardon:

"... neck of femur on 30 July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing and walking with the aid of two nurses and a Zimmer frame."

A Yes.

Q "Daughter visits regularly and feeds mother. She wishes to be informed day or night of any deterioration in mother's condition."

A Yes.

Q "Swabs taken for MRSA screening. Daughter does not want mother to return to Glen Heathers."

A Yes.

MR KARK: After that there is something of a blank.

MR LANGDALE: It is completely blank.

MR KARK: It is completely blank. Certainly the back page is completely blank. We are very happy to pass you the originals of the nursing notes if you think that that would help you. Perhaps I will do that. (Same handed to the witness) I just want to see if you can help us, Mr Beed, if you can indicate where it is indicated on 11 August that this patient was in pain and why that might require the dose that you administered.

A No, I cannot see a record of that in the notes that you have shown me.

Q What we will do, over the short adjournment – which is what we call lunch – we will provide you with a room and the notes and somebody to sit with you. I do not want you to feel under pressure, as it were, and therefore you cannot find something that is actually there. But I do not think we have been able to find anything either. Can you help us, please, why you might not have made a note to justify the administration of morphine on the patient's admission?

A The only reason I can think of would be if the ward was extremely busy and there were multiple demands on my time and it was something that I overlooked doing.

Q But in normal circumstances ought there to have been a note?

A I would expect there to be a note recording why that analgesia was given, yes.

MR KARK: Back to the drugs chart, please, page 63.

MR LANGDALE: Could I look at the original document?

MR KARK: Could Mr Langdale be given the original document? (Same handed)

(To the witness): Mr Beed, you administered a dose at 14.15 and then we can see that after that more doses were administered, one apparently at 11.45 in the evening and then the following day, 12 August, and also on 13 August, and also on 14 August.
A Yes.

Q And 10 mgs being administered on each occasion.
A Yes.

Q And you say that that would be administered for pain?
A Yes.

Q I will ask you again, do you think that it might be given for agitation?
A No, it would be for pain, although agitation may be a symptom of pain.

Q But would you have taken account of the notes that you would have read, as you told us, that if this patient seemed to be agitated it might well be because she wanted the loo?
A Yes, we would have taken account of that.

Q So you would not automatically think, "The patient is agitated, she must be in pain"?
A No, that would be one of a number of symptoms which might indicate pain.

Q Can you identify your entries here – it may be fairly obvious – you have a sort of "B" and a bit of a squiggle ---
A With the Oramorph prescription, do you mean?

Q Yes.
A The first one you identified.

Q The 14 August.
A The 14 August, 17 August, three entries and again 17 August in the third column.

Q Below that we can see a prescription for diamorphine, for a variable dose between 20 and 200 mg of diamorphine; yes?
A Yes.

Q And that is to be administered, if you chose to do it, by syringe driver?
A Yes, if a patient's condition changed and that was indicated.

Q So does that mean that if you, for instance, as the senior manager on that ward took a view that it was necessary you could initiate a syringe driver anywhere between those two variable doses?
A Yes.

Q We can see that diamorphine was not actually administered; yes?
A Yes.

Q We see that hyoscine was, but not until 17 august, so I am going to ignore that for the moment; and if we look below do we see midazolam?
A Yes.

Q That also I think was not administered until 18 August?
A Yes.

Q Could we go over to page 65? We can see that Lactulose was prescribed; what would that be for?
A That is a laxative.

Q We can see your initials, I think.
A Yes.

Q Haloperidol.
A Yes.

Q On 11 August at 18.00 hours do we see your initial?
A Yes.

Q Does that mean that you would have administered that dose because this is a regular prescription, so it means that that is to be given to the patient at specific times?
A Yes.

Q And on 11 August she would not have been with you of course at 8 o'clock in the morning.
A No.

Q So the first time you could give that would be at 6 o'clock at night.
A Yes.

Q And that is what you have done. And that would be for agitation, would it?
A Yes.

MR KARK: Then below that we can see another entry for Oramorph, but this is now under the regular prescription column and Dr Barton has set out the times when that should be administered.

MR LANGDALE: PRN.

MR KARK: Yes. Let me just deal with the time first. 6 o'clock, 10 o'clock, 14.00 hours and 18.00 hours and how would you regard that to be administered? We see on the left, as Mr Langdale has pointed out, in a big box PRN.
A Yes.

Q Which I think means *pro re nata* which means as the occasion arises.
A As and when required, yes.

Q How does that lie with the prescription on page 63 dated 11 August, also for Oramorph, also for 10 mgs in 5 mls? I want to know how this witness would read these prescriptions as to what he should do with them. Do you know why there are two prescriptions?
A I am not sure but my nursing action would be to ignore one of them because it would appear that they are a duplicate.

Q Then underneath the first Oramorph on page 65 we also have PRN – is that Oramorph again?
A Yes.

Q Is it a higher dose? In the first box under "dose" you have 2.5; is that milligrams?
A Yes – 2.5 mls.

Q 2.5 mls, I am sorry. Then in the second box we have 5 mls.
A Yes.

Q So that would be the equivalent of 10 grams.
A It would be 10 milligrams.

Q Thank you; 10 milligrams. Again, how would you as the nurse read these records as to how you were meant to deal with them?
A The first one allows for a regular dose if required with a slightly higher dose at night if required.

MR LANGDALE: I am sorry to interrupt again. Since the comparison is being made between those PRN Oramorph on page 65 and the Oramorph on page 63, perhaps the witness' attention should be drawn to he dates if it is being suggested there is a duplicate.

MR KARK: The first one is dated I think 11 August on page 63. Is that right?
A Yes and this one is dated 12th.

Q And the second one is dated 12th.
A Yes.

Q But the one dated 11 August you have actually acted upon throughout the patient's time there?
A Yes.

Q Could you have acted on either of them?
A You would not react on both because it is obviously a duplicate. Usually when a drug is re-written, it would be normal to score through the drug which it is replacing.

Q Again, just as part of nursing practice, I want to understand this. On page 65 somebody has marked a number of Xs in the boxes. The purpose of that would be what?
A To indicate that the dose was not given at that time.

Q And the reason for that lies presumably on page 63. That prescription was being acted upon?

A A Yes.

Q Then, over to page 67, we can see another prescription I think for haloperidol dated 13 August.
A Yes.

Q Let us try and come back now, please, to this patient. She was admitted to your ward
B on 11 August and she was started on Oramorph on the basis of the prescriptions that the doctor had written?
A Yes.

Q Were you I think aware that on 13th the patient had an accident?
A Yes.

C Q If we go to pages 46 and 51 of our notes, at page 46 we will see at the top "13 August 1998". Whose note is this? Is it yours?
A It is not mine and I cannot ascertain the signature there.

Q I am glad you have the same problem we have had but let us not worry about that for the moment.

D "Found on floor at 13.30 hrs. checked for injury, none apparent at time hoisted into safer chair."

Then is it 19.30?
A Yes.

Q "Pain right hip internally rotated. D r Brigg contacted. Advised X-ray."
E

Now, Dr Brigg was who?
A One of the partners at the practice.

Q We have heard from him. Would he be contacted because Dr Barton at this stage would not be on duty?
A Yes, because this was out of hours.
F

Q Dr Brigg would be able, if necessary, to prescribe analgesia, would he?
A Yes.

Q We have looked at this before. We can see that the note is timed at 1300 hours but seems to relate to an event that happened half an hour later. So can we take it that the timing must be wrong?
G A Yes, one of those two times must be wrong.

Q We know that she was kept at your hospital on the night of 13 August. She was given Oramorph, as we have seen, and the following day is you aware that her hip was X-rayed?
A Yes.

Q Where would the X-ray have taken place?
H A The X-ray took place at Gosport War Memorial Hospital.

Q And I think it was found that a dislocation had taken place?
A Yes.

Q And, as a result, was the patient to be transferred back to the Haslar?
A Yes.

Q For reduction of the dislocation?
A That is correct.

Q Is that what happened on 14th, she was taken back to the Haslar and operated upon?
A Yes.

Q Can you remember members of the family being around and about with this patient?
A Yes, I can.

Q We have seen notes about the two daughters. Do you have a recollection of the two daughters?
A I have some recollection.

Q Were they, either one of them, unhappy abut what had happened with their mother?
A Yes, they were.

Q In terms of her falling out of a chair and what had happened?
A Yes, what I would expect.

Q If we now go to page 23, please, is this a note that you made on 14 August, the day that she went off to the Haslar?
A Yes.

Q Can you just read it for us?
A "Haslar A&E

Patient to A&E for reduction of dislocated right hip. No change in treatment since transfer to us 11 August '98, except addition of Oramorph PRN. 10 mg Oramorph given at 11.50. We will be happy to take her back following reduction of the dislocation."

Q We know that the patient then remained at the Haslar until 17th?
A Yes.

Q Then she transferred back to your ward?
A Yes.

Q 17 August I think was a Monday. If you go to page 46, so back to the nursing note, would you just shout out, please, if any of these notes are yours, but do we see against the date 17 August,

"Returned from Haslar. Patient very distressed, appears to be in pain".

Then there is a note:

"No canvas under patient. Patient transferred on sheet by crew."

What is the relevance of that entry, please?
A We would normally expect to transfer a patient with a stretcher canvas under them, which would enable stretcher poles to be inserted, but would enable the patient to be safely transferred from an ambulance trolley to a bed or vice versa, and this patient did not have a canvas under them.

Q Sorry?
A This patient did not have a canvas underneath them.

Q And the effect of that would be what?
A It meant that the ambulance crew transferred the patient using the sheet they were on and stretcher poles rather than the proper equipment.

Q And the effect upon the patient would be?
A That could cause them to be in pain; it could cause further injury.

Q When she came back to you, as she did on 17 August, had this incident with the sheet not happened, again, what would have been your normal understanding of why she was coming back to your hospital?
A For us to continue rehabilitation.

Q We know that the patient appears to be in considerable pain on 17 August as a result of this transfer?
A Yes.

Q There is a note that she is very distressed and we know, if we go to page 47, this is a note by Nurse Couchman.

"13.05 In pain and distress .....Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an X-ray."

Then we see that an X-ray was performed in the afternoon:

"Films seen by Dr Peters and radiologist. No dislocation seen. For pain control over night and review by Dr Barton in the morning" – mane.

A Yes.

Q Can we go to page 31, please? We can see in the middle of page 31 that there is an entry for 17 August '98.
A Yes.

Q This appears to have been made after readmission.
A Yes.

Q So after the transfer on a sheet?
A Yes.

Q And again your understanding, please: when she was transferred, would she have been placed directly on to her bed?
A Yes.

Q If she is coming back from an operation at the Royal Haslar, she is not going to be sat on a chair, or is she?
A No, we would transfer her initially from trolley to a bed.

Q Dr Barton's note, and it is not timed obviously although it is dated, is –

"Readmission to Daedalus from RHH. Closed reduction under intravenous sedation. Remained unresponsive for some hours. Now appears peaceful.

Plan: continue haloperidol."
A Yes.

Q Then, is it "Only…"
A Yes. "Only give Oramorph if in severe pain".

Q Then "See daughter again"?
A Yes.

Q The next day we have this note from Dr Barton, 18 August: "Still in great pain." Is it "Nursing a problem"?
A Yes.

Q Do not agree with me because I may well be wrong.
A That looks like "Nursing a problem".

Q And then I am not sure what the next is.
A "I suggest subcutaneous diamorphine/haloperidol/midazolam. I will see daughters today."

Q I think it is, "Please make comfortable".
A Yes.

Q So that is 17 August. If we go back to the drug chart at page 63 first of all, do we see that she was administered Oramorph on 17 August by you?
A Yes.

Q On four occasions?
A Yes.

Q And on 18 August? If we look below we can see that midazolam was started on the 19th, I think it is. Is that right?
A Yes.

Q If we go over to page 65 --- I am sorry, I think that date actually is 18th. If we go to page 65 we can see the diamorphine by syringe driver was started. Can you help us with this, because I think this is your entry? Towards the bottom of the page, "Diamorphine 40-200 mg"?
A Yes.

Q Just help us please: what did you administer, when and why?
A On 18th at 11.45, 40 mg of diamorphine via a syringe driver and 5 mg of haloperidol by syringe driver.

Q If we keep a finger in page 65 and go back to page 63, we can look at the Oramorph that this patient had been receiving. I will come back to the midazolam. Can we have a look and see the Oramorph the patient had been receiving. On 18 August somebody has given her 5 mls at is it 12.30?
A I need to cross-reference on the controlled drug record because I cannot make that time out.

Q It may not matter the exact timing but she has plainly been given I think it is at 0.1230, so in other words in the early hours of the morning is the idea, and then also at 4.30 in the morning she is being provided with two doses of 5 ml each. Yes?
A Yes.

Q And that would be the equivalent of what 20 mg?
A Yes.

Q Because the dose written up by Dr Barton is 10 mg and 5 mls?
A Yes.

Q I think even my maths allows for that to be 20 mg on 18th.
A Yes.

Q The intravenous or the subcutaneous diamorphine that she is provided with, 40 mg, would you yourself have queried that at all?
A I would have wanted to check that dose before giving it.

Q Why?
A To make sure that it was the right amount for the patient.

Q Because what you told us earlier was that you were aware of the conversion rate?
A Yes.

Q And the normal conversion rate to keep a patient on the same level of pain relief, I appreciate there might have been an intention to increase it, the same rate of pain relief for this patient would be no more than 10 milligrams, would it?
A Correct, yes.

Q In fact it has gone up to 40 mg of diamorphine. If we now go back to page 63, we can see right at the bottom that the prescription for midazolam which Dr Barton wrote on 11 August now gets initiated on 18th?
A Yes.

Q And it is initiated by you?
A Yes.

Q And that would add, would it, as you have told us I think, to the sedating effect?
A Yes.

Q Whose decision would it be to add midazolam as it were to the cocktail?
A That was in the medical instructions from the patient being reviewed by Dr Barton.

Q So when you filled up the syringe driver, on what basis were you doing it? Why were you filling it with those drugs?
A Because the patient was in a great deal of pain and wanted to relieve that pain.

Q And the calculation about how much pain relief they should receive would be whose?
A The prescription was written by Dr Barton but we were able to assess and see that the patient was in a great deal of pain.

Q May I just ask you this: did you think at this stage you were applying the Wessex Protocol?
A Those were guidelines, so obviously the patient was in a great deal of pain, so we were actually increasing the analgesia beyond what we might normally do.

Q Now we know that that level I think of analgesia continued through 20 August, the same rate I think of midazolam, is that right, and 21 August. Just have a look, please, yourself.
A Yes, that is right; it continued the same.

Q Prior to initiating that syringe driver, would you, do you think, have tried to obtain anybody's consent?
A Yes, we would have spoken to the family about the patient management of Mrs Richards' pain.

Q "We" would be who?
A I know Dr Barton saw the relatives and I also spoke to the family myself.

Q Who do you say you spoke to?
A I spoke to one of the daughters, Mrs Lack.

Q Just remind the Panel, that was Mrs O'Brien, who we heard from. Was this patient at the time that you initiated the syringe driver provided with any hydration?
A No.

Q What did you think – you, as a nurse – was causing this patient's pain?
A The doctor who reviewed the patient felt that the patient was most likely to have a significant haematoma at the operation site.

Q At the time that you initiated the syringe driver, did you appreciate what the likely consequence was going to be of that?
A We did feel that the patient's condition seemed to be deteriorating at that time.

Q At the time that you initiate the syringe driver, if the patient is not kept hydrated, the patient is going to deteriorate. Is that right?
A Yes.

Q I am only repeating what you told us earlier.
A At that point in time, the patient was being offered oral fluids if she would take them.

Q Just keeping a finger where you are, can you turn to page 300? This is dealing with 16 and 17 August, when the patient was still at the Haslar. We can see that the patient was in fact drinking a fair amount.
A Yes.

Q Quite a lot.
A Yes.

Q I do not think we have any fluid charts for your hospital. Can you recall that this patient was not in fact hydrated?
A The patient would have been offered oral fluids whilst awake, but I do not believe we have a fluid chart.

Q Can you remember how long the patient remained awake once the syringe driver had started?
A That is not something I can remember, I am afraid.

Q Once the patient loses consciousness, would you ever try to reduce the dose so that the patient could become conscious again to speak to her?
A It would not normally happen if a patient was receiving palliative care and in Mrs Richard's case her care had been decided as palliative by that time.

Q So somebody had made a decision, had they, that this patient should receive palliative care?
A Yes.

Q Who?
A Dr Barton.

Q It may be you cannot remember, but can you remember if there was any discussion about any active methods to reduce the haematoma?
A I cannot remember in the case.

Q When you talk about palliative care – I just want to make sure we all understand – we are talking about the stage where it has been decided no longer to attempt to cure the patient.
A Yes.

Q We know that this patient died on 21 August in the evening. I am going to move on, please, to Patient D, Alice Wilkie. Could you put away that file and take up file D, please? I want you to help us, please, rather more briefly with two other patients. We have some updated pages for file D, so I wonder if those could be handed out now? They are better copies of what we have. (Same distributed) Can I just make a suggestion? If we leave them

as they are for the moment, carry on with the evidence and if we get to a stage where we need the better copies, hopefully it will be in the clip you have been provided with. Alice Wilkie had been admitted, just to remind ourselves, to the Queen Alexandra Hospital on 31 July for an unresolved urinary tract infection. She had been given some haloperidol there, she was reviewed by Dr Lord and then transferred to Daedalus ward. This was the patient in respect of whom we were examining the note made "Do not resuscitate". So far as this patient is concerned, Mr Beed, could you turn to page 145 of the notes? Do you have any recollection of this patient at all?

A I cannot remember this patient, no.

Q I am not going to ask you to comment on her generally, but I would just ask for your assistance, please. If we go to page 145, do we see a drug chart for this patient?

A Yes.

Q We can see I think your initials.

A Yes.

Q Can you just read this through for us? This is 20 August. We know that a prescription had been written out by Dr Barton I think on 17 August, although in fact it is undated. It must have been prior to 20 August. We know that.

A Yes.

Q We can see the prescription on page 145. It says "Diamorphine". Is it 80-200?

A 20-200.

Q Have you administered some drugs to this patient via syringe driver?

A Yes. At 1315, I cannot read what the dose is of diamorphine, and also 20 mg of midazolam.

Q How would you have fixed on the dose of 30 mg?

A 30 mg would have been based on the level of pain the patient was perceived to be in.

Q Can I ask you this? If we were to go through these records and find you administered diamorphine and I ask you why you administered it, although you cannot remember the patient, can we take it you are always – and I do not mean this rudely – going to say, "It was because of the pain the patient was in"?

A Yes. There would be no other reason for giving diamorphine.

Q Underneath that, we can see midazolam was also initiated at the same time.

A Yes.

Q Should we take it with this patient that she, at this time of the initiation of the syringe driver, was designated, as it were, for palliative care, or not?

A I would not be able to remember that.

Q If we find, again generally, that patients are started on a syringe driver and then they are not given any fluids, or there is no note of them being given any fluids, is that an indicator of palliative care?

A Again, that is indicative of palliative care, yes.

Q Could you have a look at page 194, please? Is this a note made normally on her admission?
A Yes. This is general information as part of the nursing assessment.

Q Your name appears simply as manager.
A Yes.

Q If we look at the bottom left box, the very last box that is filled in, would you have filled this document in?
A No. This would have been filled in by one of the other nursing staff.

Q If I ask you questions about this patient's care, you are not going to be able to assist us, because you cannot remember the patient.
A I would have to refer to the notes to jog my memory.

Q I think your notes are limited in this case simply to the drugs that you administered. Can we turn, please, to the last patient, Patient L? Just to remind ourselves, you were the manager of Daedalus Ward and you did not get there until 1998.
A That is correct, yes.

Q It follows that you would not have had anything to do with the care of any patient on Dryad Ward.
A No.

MR KARK: Sir, I have prepared an expanded version of our patient identification schedule, which includes what ward the patient went on to, when they went on to it and when they died. I have certainly personally found that helpful, because it is sometimes difficult to remember which patient went on to which ward.

THE CHAIRMAN: I am grateful.

MR KARK: I will show it to Mr Langdale first. (Same distributed) May I suggest we put at the beginning of C1 and treat it as part of the working document? We can see that in fact Mr Beed would have been in place, as it were, on Daedalus Ward for Patients D and E and then only for Patient L, because although Patient B was admitted to Daedalus Ward, it was before Mr Beed started work there. (To the witness) Just turning to Patient L – and again, I am not going to spend very long on this patient – she is the lady called Jean Stevens. Again, do you have any recollection specifically of this patient?
A No, I do not.

Q We have been dealing with her this morning, so I expect the Panel remembers that she had been admitted to the Royal Haslar Hospital in April, having collapsed at home, and then she was looked after at the Haslar for about a month before she was transferred to Daedalus ward. If you could take up bundle L, the first page is 1299. This is a nursing note. Again, I do not think your writing actually appears here, does it?
A No, that is not my writing.

Q But we can see it is a transfer from the Haslar following a right CVA. We can see from the bottom:

A "Her speech is slurred ... but [she] appears to be quite alert and aware of her surroundings."

In fact, the next note we have is two days later, when the unfortunate patient died. Can we go to page 1309, please? Again, can you just glance through those notes and see if your writing appears?

A Yes. There is an entry by me on 21 May 1999 at 1800 and a second entry at 1945.

B

Q Could you just take us through those?

A Yes.

"Uncomfortable throughout afternoon, despite 4 hourly Oramorph.
Husband seen and care discussed, very upset. Agreed to commence syringe driver for pain relief, at equivalent dose to oral morphine with midazolam. Aware of poor
C outlook but anxious that medication given should not shorten her life. Father David (Roman Catholic priest) asked to come and see Mr Stevens.
Daughter, Jane Bailey, called in and informed of situation.
Message left for 2nd daughter, Carol Whilliam, at Rockley Park Holiday Camp to contact us.

Then at 1945:

D "Commence syringe driver
20 mg diamorphine, 20 mg midazolam in 24 hours"

Q Could you just go to page 1342? That is the drug chart for this patient.

A Yes.

E Q We can see that on the day of her admission, 20 May, she was administered three doses of Oramorph.

A Yes.

Q Is that right?

A Yes, that is correct.

F Q Again, I may well need help with my maths, I am afraid, but the dosage prescribed by Dr Barton is 10 mg in 5 mls.

A Yes.

Q So at 1430 she is given 5 mls, is that, or is that mg?

A That is mg.

G Q Because it seems to switch between milligrams and millilitres. This is 5 mg, is it?

A Yes. It is an oral suspension, so 10 mg in 5 mls. Normal practice would be to put both the volume and the amount, but of course it is not a very large box to do that in.

Q I am not going to criticise that, but I just want to work out what she was getting. The first administration of Oramorph that she gets is actually 5 mg.

A Yes.

H

Q That is not your initial, I do not think.
A No.

Q The next dose she gets on the same day and that looks like 2.5; is that millilitres?
A That would look to me like 2.5 mls and 5 mgs – so 5 mgs and 2.5 mls.

Q So the total being 5 mgs?
A Yes.

Q Then the next one, is that also effectively 5 mgs?
A 5 mgs and 2.5 mls, yes.

Q So on 20th, the day of her admission, she has received a total of 15 mgs.
A Yes.

Q Then the next day, sticking with Oramorph for the moment, does she get another 5 mgs at 07.35?
A Yes, 2.5 mls which would be 5 mgs.

Q So the day before the syringe driver starts she is on 15 mgs total of morphine?
A Yes.

Q Then the next day you have administered to her via a syringe driver 20 mgs; is that right?
A Yes.

Q And 20 mgs of midazolam?
A Yes.

Q I think we have looked at that. On 21st in the morning at 07.35 you administered 5 mgs. Is there more after that? Sorry, would you just give me a moment? (Mr Kark and Mr Fitzgerald conferred) Mr Fitzgerald has pointed out something under his chronology and I am trying to find it in the notes. I think there are further prescriptions for Oramorph on page 1344 but it does not look as though any of it was given. I will come back to that. Please just confirm this: if we look at 1344 and 1346 there are prescriptions for Oramorph but do they have a cross against them? Sorry, 1346 – Mr Fitzgerald, I suspect, is right: is this you administering?
A That is not me administering but there has been a dose given at 10 o'clock and again at 14.00.

Q Of Oramorph?
A Of Oramorph, and that would have been the 5 mls four-hourly, so 10 mgs at 10 o'clock and 10 mgs at 14.00.

Q So that is 20 mgs on that day, 21st?
A And 5 mgs at 07.33

Q 25 mgs.
A Yes. 7.33 there was a dose of 5 mgs; a further dose of 10 mgs at 10 o'clock and a further dose of 10 mgs at 14.00. So, yes, 25 mgs.

Q Going back to page 1342, can you help us – and it may be obvious from the prescription from which you were working – why you started at 20 mgs subcutaneously?
A If I look back to the nursing note it was indicating that despite those four-hourly doses of Oramorph the patient was still in pain and that was not controlling the pain; and that would have been increased from the dose that was being given. On 20th we had increased the dose from 5 mgs up to 10 mgs and we were giving that regularly and the patient was still in pain.

Q Can we take it from the start of the syringe driver on 21 May: would the patient lose consciousness on those doses?
A Not necessarily so; 20 mgs is quite a low dose.

Q Going back to the note at 1309, that you made:

"Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with midazolam."

Would you have explained what the effect of the midazolam would be?
A Yes, I would have done.

Q "Aware of poor outlook but anxious that medication given should not shorten her life."

How would you account for that when you decide how much drugs to administer?
A The drugs would be given purely for pain relief and to keep the patient comfortable.

Q Then we can see your note says that at 7.45 p.m. – or 19.45 hours – commence syringe driver. And the note underneath that:

"Condition has deteriorated. Very bubbly."

That is not your note, I think?
A No.

Q But is that something that you found once you had instituted a syringe driver – that if the patient is lying in bed that they would quite often get a bubbly chest?
A They could do yes; that is something that did happen.

Q Was that something that you came across?
A Yes.

Q Is that why hyoscine was prescribed?
A Yes.

Q I have been leading; I did not think there would be any objection to that piece of leading. We see hyoscine through the notes; what would it be given for?
A It helps to dry up the secretions if the patient has a very bubbly chest that is making the breathing difficult and making them uncomfortable.

Q Would there be any other reason for giving it?

A A No.

MR KARK: Sir, that, I think, is all that I want to ask – and conveniently it is now one o'clock – but I would quite like to reserve my position so that I can check my notes.

THE CHAIRMAN: By all means. We will rise now and return at two o'clock.

B Mr Beed, I remind you that you remain on oath and you must not speak to anybody about the case. I think you are going to be taken to a room that has been arranged for you in accordance with what Mr Kark was saying earlier. Thank you very much everybody, two o'clock please.

MR KARK: Sir, we are happy to provide the original notes. Somebody will have to remain with Mr Beed whilst that is done.

C

THE CHAIRMAN: Yes, we understood that.

MR KARK: If the Panel is content for us to do that we will speak to him purely administratively for that to happen.

THE CHAIRMAN: Yes, we are perfectly content with that.

D

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Mr Beed, I hope you managed to get some lunch whilst doing your homework?
A Yes.

E THE CHAIRMAN: Excellent. I will pass you back to Mr Kark and remind you that you remain on oath.

MR KARK: Mr Beed, I have very little more to ask you. First of all, on the homework front did you find any notes revealing the pain that you were talking about?
A No, I could not find anything in those notes.

F Q Did you find any fluid charts for the GWMH?
A No, I could not.

Q You told us a little earlier about how busy the wards were. You were interviewed, as we know, back in July 2000; we are now pretty much nine years on from that and can we take it that your recollection back when you were interviewed by the police was significantly better then than it would be now?
G A It would be, yes.

Q I am going to remind you, if I may, of what you said to the police about how busy the wards were. For my learned friends it is the first interview, page 8 of 37, at the bottom. I can show it to you if you want to have a look at it but perhaps I can just read it to you:

H

"We have 24 beds on the ward. We have only actually been full on about three or four occasions in three years that I have worked at the War Memorial, but usually we run about 17/18 patients."

Does that trigger a memory? Would that be about right?
A If that is what I said on that occasion that would be correct.

Q Then you say:

"For 18 patients the ward gets very busy so you have to prioritise your work. If we went above 18 we need to bring in bank staff."
A Yes, that was correct.

Q You said also:

"We should never cross that line because I can bring in bank staff."

Meaning that you would bring in bank staff if you felt you needed to?
A Yes.

Q One other matter about which I wanted to ask you and that is in relation to Mrs Richards. Again, I can remind you, if necessary, of what you told the police but can you remember whether Dr Lord ever reviewed Mrs Richards?
A I cannot remember, no.

Q I think certainly at the time when you were interviewed you did not think she had seen her on admission on that first occasion.
A If that is what I said on interview then that would be a correct recollection, it being nearer to the time.

MR KARK: Thank you very much indeed; would you wait there.

Cross-examined by MR LANGDALE

MR LANGDALE: Mr Beed, I am going to ask you some questions on behalf of Dr Barton. I would like to take up, while we have it in our minds, the point which you were just asked about in terms of numbers of patients and so on – back to that first interview at page 8. Leave aside the precise numbers because one appreciates that it is very difficult to remember exactly and things no doubt changed over a period of time, but in general terms in terms of the patients who you were receiving on Daedalus, you have described the general position, but did you find that sometimes – not just on a few occasions – patients just were not well enough for rehabilitation?
A Yes, that was very often the case.

Q We have heard something about this from other witnesses. Did you find, in your view, that there was perhaps a tendency of the hospitals where these patients had been treated to pass them on to you, to Gosport War Memorial Hospital, perhaps a little bit before they were ready on occasion?
A It certainly felt that way, that the patients really were not in a position where they were ready for rehabilitation when they arrived with us.

Q We had the example with regard to Mrs Richards – weight bearing, so the transfer letters say, but when she gets to you, was there ever a situation where in fact she was able to walk about with the aid of a Zimmer frame or anything else?
A When she was transferred to us we were having to use a hoist to transfer her.

Q And I think something that Dr Barton recorded on her clinical notes on admission. When we see that expression does that signify really that the patient does not appear to be able to mobilise herself or himself?
A That would indicate that, yes.

Q Did you find too on occasion – this is not a criticism of them – relatives had a rather higher expectation of what was going to happen to their relative who was a patient than was really practical or realistic?
A Yes, that was sometimes the case.

Q A feeling – perhaps understandable – that the relative concerned who was a patient at the Gosport War Memorial Hospital would be back home before too long, whereas in fact that was rather unlikely?
A Yes. Patients often needed quite slow, gentle rehabilitation with us and then were with us for some time.

Q In any event, whatever the transfer letters said about the patients you obviously needed, in terms of your resources, your staff and your experience, in a lot of cases to take the time to assess the needs of the patient.
A Yes.

Q It was not always possible to immediately decide precisely what was feasible and what was not?
A No.

Q I think you can also speak just by way of a general situation – this is with regard to patients' transfer to Gosport War Memorial. I appreciate with Gladys Richards that it was a pretty bad transfer from her point of view for the reasons you have indicated when she was readmitted on 17th, but in general terms did you often find with elderly and frail patients that the transfer itself had rather taken it out of them?
A Yes. I think the move from one hospital to another and the journey often seemed to take them a step back further in their rehabilitation, if you like.

Q Did you also find, perhaps particularly with patients who were suffering from some form of dementia – whatever it technically was, Alzheimer's or something else – that the transfer itself would be thoroughly disorienting for them.
A Yes, it often could be.

Q And had a tendency to increase their confusion.
A Yes.

Q And might that also of itself create a situation where deterioration took place rather than improvement?
A Yes, it could.

Q Because it was a very broad-brush approach.
A Yes, it could.

Q In terms of patients deteriorating, again dealing with frail, elderly patients who received some form of surgical treatment or whatever it might be, did you find that deterioration in some cases – not in every case – could be quite rapid?
A Yes, in some cases it could.

Q In terms of the pressures on you and the staff under you, you spoke about that and you have been reminded of certain passages with regard to it, and it meant – as you expressed it to the police – that you always had to be wary of whether you got to a point where you simply could not cope.
A Yes.

Q But in general terms you managed to keep the right side of that line, even if it was very much under pressure.
A Nurses are very much used to working under pressure, so having a busy ward was not something that was unusual to us and it was how do we make sure that it remains safe for patients and safe for staff, and sometimes that was easy and sometimes that was quite a challenging thing to do; but it was something as manager to try to ensure at all times.

Q You could bring in bank staff, but only occasionally; is that right?
A I had the authority to bring in bank staff – that was dependent on bank staff being available – and of course bringing in bank staff or having extra bank staff is not always as beneficial as having your own staff who know the ward and who know the patients.

Q And of course you had patients who were suffering in some instances from a number of medical conditions or medical problems.
A Yes, lots of patients have multiple pathologies.

Q And at times on the ward you might find several patients being poorly at the same time or needing attention for one reason or another?
A Yes, that would be a regular occurrence.

Q You could have patients who might fall out of bed, that sort of things?
A Yes.

Q And indeed you needed, apart from performing your nursing duties or general care duties, to try to get to speak to relatives and find the time to explain things to them?
A Yes.

Q No doubt relatives of different patients would vary as to quite how many demands they made on your time in some instances?
A Yes.

Q May I just ask you this generally in terms of your feeling at this time? We are focusing, in terms of 1998 and 1999, in terms of your role in this case. What was the general attitude of the nursing staff towards relatives? Did people tend to think they were just a bit of

A a nuisance or did people try and do their best to explain things to them when they were asked and to pay attention to them?
A We very much felt it was important to keep them informed and involved and listen to them and talk to them and try and find the time to do that.

Q If a relative was particularly demanding and was wanting to know on a number of occasions what was going on, did you try to make sure that you, as it were, bent over
B backwards to make sure their concerns were properly dealt with?
A Yes.

Q I am going to come on to the case of Mrs Richards in a moment. I am just dealing with in general terms as you saw it and what you tried to do?
A Yes, I can think of lots of occasions when we spent a lot of time with relatives to try and help them at what was a difficult time for them.
C

Q In particular, with regard to the fact that their relative, the patient, was receiving controlled drugs, and obviously we are focusing in this case on Oramorph and then the step back to diamorphine and midazolam, what was the general practice there when the time had come for those drugs to be administered in terms of contacting relatives, assuming there were relatives there at the hospital? What in general did you try to do?
A Our aim usually would be to talk to relatives and involve them in that decision so they
D knew what was happening and try and make that discussion prior to changing the patient's drug regime.

Q You also spoke or mentioned as well slightly earlier on in your evidence when Mr Kark was asking you some questions a moment or two ago that with all the pressures that were on you, not impossible pressures but pressures and a busy ward, you needed to prioritise. Can you help us a bit with what that actually means in practice?
E A Trying to determine when there are multiple demands on our time which patients' needs were the greatest or what other activities were the most important to do first, and then work through those in that order, so that everything that needed to be was done. I think on some occasions there were things that we just physically could not do, making sure that what we deemed were the most important things were the things that actually got done.

Q I think you were indicating that if one found an example where something which
F should have been recorded was not recorded, the most likely explanation was really the pressures on staff at the time?
A When I think back to 1998, I know that one of the reasons our documentation was poor was because we spent time and prioritised care of the patients and talking to relatives and documentation and therefore did not get the time that it required to be done at the level that we would have wished it to be.

G Q Again in general terms, everybody is different and obviously the nursing staff all had their individual personalities, but in general terms, did you find that the staff, that is those of whom you were in charge, were experienced and competent?
A Yes, I had every confidence in the staff that worked with me.

Q Did you ever feel there was any real risk of anybody on the staff choosing to up a dose for no reason at all with regard to a patient?
H A No, I had no reason to think that could occur.

Q I am going to put this to you as well as a general proposition. Was there ever any question, so far as you were concerned, of patients who maybe were difficult to manage, difficult to nurse, being given controlled drugs in order to keep them quiet because they were causing a bit of a problem – anything of that kind?
A No, I never knew that to happen or had the expectation that that would occur.

Q If you had thought that it was happening, what would you have done about it?
A I would have dealt with it accordingly with the patient and the person concerned.

Q With the staff, there are obviously periods in the day, late in the day, early in the morning and so on when there was a hand-over between for example day staff and night staff, that sort of thing.
A Yes.

Q People coming on to a shift, people going off a shift. Did you feel in general terms that the nursing staff were unaware of what the general picture was with regard to patients in the sense they were not able to get information, or did you feel that nursing staff were keeping track of patients' progress or lack of it?
A Nursing staff were keeping track and there were good hand-overs between the shifts.

Q We have heard evidence already of how a pharmacist used to visit obviously more than Daedalus but we are focusing on Daedalus as one particular ward. Is that right?
A That is correct.

Q Was that pharmacist, maybe not on every single occasion, called Jean Dalton? Does that ring a bell?
A Yes.

Q Would you help us, please, with what the pharmacist would do in terms of her visits?
A She would check all the patients' drug charts, check our controlled drug record and check our stock levels, and if any of those have any cause for concern or there is anything needed discussing or checking, she would bring those to the attention of the nurse in charge to deal with or bring it to the attention of the medical staff if that was necessary.

Q So the pharmacist would be able to see what the patients were being prescribed?
A Yes.

Q What was being administered and would obviously be able to see dose ranges and dose combinations?
A Yes.

Q Did the pharmacist ever express to you any concern about the dose ranges with regard to controlled drugs?
A Not that I can recollect.

Q What sort of things were pointed out? Can you remember?
A The ones that I can remember were when drug doses appeared incorrect on drugs other than uncontrolled drugs or when patients were on medications that could interact with each other.

A

Q And the pharmacist would visit I think weekly, is that right?
A That is correct.

Q Was she somebody, so far as you could tell, who was pretty thorough in carrying out her job?
A Yes, I felt she was.

B

Q What would be available to the nursing staff if they needed to check or wanted to check on a particular dosage or any conversation or anything like that, any conversion between one type of drug and a variation of the same drug? What would they have available to them, apart from talking to people?
A They had the Wessex Palliative Care Guidelines but also in the BNF of which we had least one copy in the ward; there was information about drug doses and ranges. There is a

C

conversation table in the BNF as well.

Q I would like us to take a moment, with your assistance, to look again at volume 1. You were looking at this earlier today so it is going back to the same document. I just want to draw everybody's attention, through you, to certain things at tab 4 in that file. The document itself makes it clear that these are guidelines to assist relevant staff in relation to clinical management. I think, following common sense but we are able just to get it

D

confirmed by you, from time to time a guideline might not be followed because there was a reason?
A Yes, that would be correct.

Q Looking at the page numbering which is peculiar to the file itself, in other words, page 3 of tab 4, the bottom right hand corner as one looks at the file, it shows in the introduction what palliative care is in terms of the description given by the guidelines. Do

E

you see that on the right at the top?
A Yes.

Q "...active total care of patients and their families, usually when their disease is no longer responsive to potentially curative treatment, although it may be applicable earlier in the illness"

F

That just is a very rough description. Is that something you would agree with in general terms?
A Yes, I would.

Q May I just ask you this in the context of palliative care? There would presumably quite often come a time with the patients on Daedalus where it was appreciated that palliative care was all that anybody could do?

G

A Yes, that would be correct sometimes.

Q That it was not going to be feasible or sensible to seek any further surgical or other intervention?
A Yes.

Q Maybe because of the state of the patient, their frailty, their deterioration, things of

H

that kind?

A A Yes.

Q And a decision would have to be made, I appreciate you would not be the arbiter of it but it would be something you would be concerned to have an eye to, as to whether in the best interests of the patient dealing by way of palliative care with the symptoms was in fact preferable in their interests to seeking to have them undergo something which might cause or was likely to cause further pain and discomfort without any successful result?

B A Yes.

Q When it was clear that palliative care was what as to be provided to a patient, did that mean that you just gave up hope or did it mean that you still tried to see what could best be done? Describe it in your own words?

A If it was decided a patient was going to receive palliative care, then the principal aim was to make sure the patient is comfortable and well looked after. Obviously you still

C continued to assess and observe and monitor the patient. So if a patient's condition changed in either direction, that would guide the care that was being provided for that patient.

Q And it may be that these terms are used in a rather loose way but would you see palliative care or a patient who was in need of palliative care being in a situation different to being terminally ill or were both things pretty much the same?

A Terminally ill is usually a term that someone who has got a specific illness which is

D reaching its end stage, whereas I think the patients that we were dealing with often had multiple pathologies and complex problems as opposed to a specific terminal illness.

Q In terms of entering the terminal phase of their lives, for whatever reason, is that something different to a patient being in need of palliative care? Presumably it is because you might come out of palliative care if things moved in your favour?

A Yes. I guess that could happen.

E

Q I appreciate these are not, as it were, scientific terms. Just looking back to the page we were looking at in the palliative care handbook, towards the bottom of that section:

> "Cautionary note: some of the drug usage recommended is outside product licence, either by way of indication, dose or route of administration,. However, the approaches described are recognised as reasonable practice within palliative medicine

F in the UK."

A Yes.

Q Would you move on to the next page, page 4 in the handbook, on the left hand side, to that section is headed "General Principles of Symptom Management" and indicating for example at the third bullet point down:

G

> "When symptoms are difficult to control there may be more than one cause, or there may be hidden emotional, psychological, social and spiritual factors."

Yes?

A Yes.

H Q And the next bullet point down but one:

A

"Be careful that drug side effects do not become worse than the original problem".

Was that something that you were aware of?
A Yes.

Q Is that something you have an eye to in your treatment?
B A Yes.

Q Then over on the right, a section headed "Pain". The first paragraph is really relating to cancer patients and I am not going to trouble you with that. It goes on in the next paragraph:

"Most pains arise by stimulation of nociceptive nerve endings; the characteristics may
C depend on the organ involved. The analgesic ladder approach (see over) is the basis for prescribing but careful choice of appropriate adjuvant drugs such as anticholinergics for colic, NSAIDs for bone pain and benzodiazepines for muscle spasm, will greatly increase the chance of effective palliation."

Again, you are aware of that?
A Yes.

D

Q Moving a little further down:

"Diagnoses

There is no easy way of measuring pain in a clinical situation; as such, it is generally held that pain is what the patient says it is."

E

Let us jus think about that. Did you find with a number of patients who came on to Daedalus that they were not able to communicate very well?
A That would have been the case with some patients, yes.

Q And obviously in cases of patients who were suffering from some form of dementia that could be a real problem?
F A Yes.

Q And indeed I think in the case of Gladys Richards she was really saying very few words before she ever came on to Daedalus which anybody could comprehend. It may be that her relatives could understand a bit more, but very often you could not ask a patient for a proper history?
A That is correct.

G

Q Did you therefore, in trying to assess the pain and the degree of pain that a patient was in, have to use your experience and observation of what others might be able to tell you?
A Yes, using things like non-verbal clues to what is happening.

Q You told us, and I am not challenging you on this for a moment, that you would not specifically use diamorphine to treat agitation but agitation in patients of this kind might
H often indicate that they were in pain?

A A Yes, it could.

Q Because you have got to look to that sort of thing, what is causing the agitation, sometimes your considered judgment was that it was obviously pain that was causing it?
A Yes.

Q Similarly distress generally with a patient is another sign of them being in pain?
B A Yes.

Q Obviously if you take an example like screaming, a patient might be screaming because they were in pain; a patient might be screaming if they had dementia or some similar problem, because of the disturbed state they were in generally.
A Yes.

C Q So sometimes it was quite difficult to make a judgment.
A Yes. It would be difficult in some cases.

Q Can I just ask you this? Whatever the difficulties may be, you would only administer controlled drugs if there was a prescription, but when you did and you were seeking to administer a drug to deal with pain, did you always satisfy yourself that as best you could judge it, it was pain that they were suffering from?
D A Yes. Before giving he controlled drug for pain relief, I would need to do that, unless you were as certain as you could be that the patient was in pain and that was the necessary treatment for that patient.

Q In general terms, would you say that was the attitude of your nursing staff, those under you?
A Yes, I would.
E

Q Then in the same handbook causes and risk factors are dealt with. There are physical causes, and it sets out those sort of matters. Then non-physical, in terms of causes of pain and risk factors:

"Anger, anxieties, fears, sadness, helplessness, spiritual, social and family distress."

F True to your experience, those factors need to be considered.
A Yes.

Q It goes on:

"If pain is difficult to control, remember:

G All pains have a significant psychological component and fear, anxiety and depression will all lower the pain threshold. Remember also the likely effects of life changes associated ...."

It then goes on. I am not going to trouble you with the rest of it. Again, looking at that first sentence, do you agree with that as affecting the pain threshold?
A Yes, I would agree.
H

Q Did you find in a number of patients that anxiety and fear were something that weighed pretty heavily in their minds and in their attitudes?
A Yes. That was certainly the case with a lot of patients that we looked after.

Q I am not going to trouble you with the next page, page 5. We may have to look at that again in the course of the hearing. Can you move on to page 6, where the handbook is dealing with the use of morphine and talking about initially instructions to the patient. In some instances, was that something which was really a non-starter, with the state of some of the patients?
A It would be if the patient was not able to understand verbal information, yes.

Q But you would, in such cases, endeavour to inform the relatives as best you could, assuming there were relatives there.
A Yes. We always felt it was very important to keep relatives informed and to communicate well with them.

Q It sets out matters to do with what happens if oral administration is not possible and so on. I am not going to go over that with you. Over on the right-hand side of that page, under the subheading "Opioid equivalents", did it register with you that although that was a useful, if you like, table to give you an idea of the equivalents, it was only an approximate guide?
A Yes. I would regard that as a guideline.

Q Similarly, in general terms, as a general underlying guideline, if somebody is on Oramorph and you had to switch them to diamorphine, for whatever reason, a rule of thumb is that you reduce it by half or maybe a bit more.
A Yes.

Q That sometimes would be appropriate.
A That would sometimes be appropriate, yes.

Q But on other occasions it plainly was not.
A If the patient was in a great deal of pain, then that might ---

Q Did you also have to bear in mind that if Oramorph was not controlling the pain and the doctor had made the decision that it was appropriate, having prescribed of course, for analgesia to be given subcutaneously – and here, diamorphine – if that had been decided to be the case, you would need to up the dose to cope with the fact that the Oramorph had not been controlling the pain.
A Yes.

Q In other words, it is not a straight conversion, but it is a conversion with a raise to take care of the fact that the patient needed further pain control.
A Yes.

Q We are going to come on to a case, because it is referred to in the notes, where in fact you endeavoured to do a straight conversion from one to the other – we can look at that in a moment – but in general terms did you find that that quite commonly was the case: that once the stage had been reached where the switch had to be made to subcutaneous analgesia, diamorphine, there would be an increase, not just a straight conversion?
A Certainly that occurred on occasions. How often that was the case, I could not say.

Q I am sure you could not possibly, but in general terms that could happen. Again, it was all determined by what was regarded as the right dose to make the patient as comfortable and as pain-free as possible.
A Yes.

Q That is all I am going to ask you about that Palliative Care Handbook. You have given evidence already, and I am not going to ask you to repeat it, about the use of syringe drivers. I think we have probably all now heard enough about what the advantage of using a syringe driver is, so I need not take you through that in any further detail at this stage. In general terms, did you feel confident that your staff, the staff under you, knew how to first of all properly operate syringe drivers?
A Yes. I was confident of their ability to do that.

Q And that they had maybe not gone on specific courses, but certainly at the very least received on the job training so as to make them proficient in their use.
A Yes. They had all received the necessary on the job training.

Q In terms of patients who were at the stage of palliative care, you were seeking to administer – subject to what the doctor had prescribed, we must not forget – but in general terms, particularly if you had a dose range, you were seeking to achieve a level of sedation, or whatever word one uses, which kept them pain-free.
A Yes.

Q Did you sometimes find that patients who were having diamorphine and midazolam administered would become more and more drowsy?
A Yes, that was sometimes the case.

Q And at times unrousable?
A Yes, at times.

Q In such instances, did you find patients who might be drifting in and out of consciousness?
A Yes. Some patients, their level of consciousness varied.

Q So a patient might appear to be unconscious at some stage in the afternoon, but in fact when being moved at night or something of that kind, would make it clear they plainly were conscious.
A Yes.

Q Obviously you would not be seeking to render a patient unconscious.
A No. We would want to try and keep them relatively pain-free for the majority of the time.

Q But obviously there might come a time when they were virtually unconscious.
A Yes.

Q Help us with that, as to what the approach was.
A If the patient became ---

A Q If the patient is becoming more and more drowsy, less and less rousable, maybe unconscious at times, maybe coming into consciousness at others. How did that affect your monitoring of the pain control that they were receiving and the midazolam's sedative effect?
A The overall condition of the patient in terms of their pain relief, their level of consciousness would be constantly monitored, but especially so at times when the patients were being attended to, which would perhaps be – patients were observed constantly, but patients would need typically to receive intensive care with help in washing and dressing and
B keeping clean every three hours or so and that would involve moving them to stop them getting pressure sores. That sort of time is when you would really observe whether the patient was comfortable. Patients often would become uncomfortable on being moved, but it was judging whether that level of pain and discomfort was tolerable for them or intolerable for them. Then future drug doses and future treatment could be based on how the patient was reported at those times.

C Q Bearing in mind obviously the perfectly proper in every sense of the word desire to keep a patient pain-free, what do you say to the suggestion that a patient should be taken off subcutaneous analgesia to enable them to suddenly be able to speak? Do you see that as sensible or what?
A If patients were clearly receiving palliative care and they were getting some break-through pain when they were being provided with nursing care, then it would have been my view that removing or reducing the syringe driver would be likely to increase their pain levels
D and make them uncomfortable again.

Q We are talking about pain in general terms in these sorts of situations. We are talking about real pain; we are not just talking about a bit of discomfort.
A No. We are talking about patients being significantly in pain and often generalised pain, so in no particular area.

E Q Patients with sacral sores, pressure sores. What about that in terms of causing people pain in your experience"
A That would be uncomfortable and we would have to nurse the patient to try and prevent that sore worsening. Of course, the sore itself would probably be uncomfortable for the patient.

Q So just to give us the picture, you would be used to patients being in pain so that they
F were sometimes crying out.
A Yes.

Q Maybe screaming in pain.
A Yes.

Q And maybe exhibiting real signs of pain, even if briefly, when moved at night.
G A Yes.

Q When a nurse recorded something like "Pain on moving" at night or a patient had a distressing, uncomfortable night, we are talking about real pain, rather than a moan or a groan?
A Yes.

H

Q Before you ever get to the Gosport War Memorial Hospital and were in charge of Daedalus Ward in 1998, you had had some experience of dealing with patients who needed palliative care, had you?
A I had some experience, yes.

Q Did you find the experience that you had acquired helpful in terms of assisting you to make a proper judgment about what was required in terms of a patient's needs so far as pain control was concerned?
A My experience prior to Daedalus, yes, it was helpful.

Q And no doubt on Daedalus your experience was ---
A It increased my experience significantly moving to Daedalus ward, yes.

Q Was it the case that the nursing staff, not only you, but also the staff so far as you were aware, were good at communicating with the doctor, in this case, Dr Barton, the clinical assistant, or other doctors who appeared or indeed consultants, good at communicating what they had observed with regard to a patient's condition?
A Yes. We had a multi-disciplinary approach on Daedalus ward and I think communication between doctors and nurses and the therapists was very ...

Q Was that something you tried to foster yourself?
A Yes. We developed and built on that, but it was already there when I arrived and we worked to develop it further.

Q It is certainly not your fault, but the attendance of doctors was in a sense far from 24-hour attendance. Shall we put it in that way?
A Yes. It was a community hospital.

Q Dr Barton would be there in the morning doing her morning round, as it were, or morning check, with particular patients being drawn to her attention if there was a particular problem.
A Yes.

Q She would be there for 8 to 8.30, that sort of time. She would come back on a lot of days about lunchtime or something like that and would deal with clerking in new admissions. Yes?
A Yes.

Q And might indeed have to come back on other occasions during the day.
A Yes.

Q And come back on occasion to see relatives.
A Yes.

Q Then you would have the consultants, Dr Lord or whoever it might be, coming round and doing their rounds in the sort of timescale that we have heard about. But for very large parts of the day and night – indeed, all night – it would be the nursing staff who were dealing with the problems that there were.
A That is correct, yes.

Q May I ask you about Dr Barton, please? Did you find her somebody with whom you could readily communicate?
A Yes. Dr Barton was very easy to talk to and I felt we had a good professional relationship.

Q So far as you could judge it – you are not a doctor obviously – did she seem to be making sensible, professional judgments about the patients she was dealing with?
A Yes. In my experience, she was.

Q Did she also seem to you to be somebody who was very hard-working?
A Yes, she did.

Q And very committed to the best interests of the patients under her care?
A Yes. I always thought she had the patients' best interests at heart.

Q In general terms, what did you observe of her manner with and her general approach to relatives who might want to find something out or needed to ask something? How did you see it?
A Dr Barton was always willing to talk to relatives if that was required and would find the time to do so. I think, like all of us on the ward, time was a difficult factor for us, but I think she always found the necessary time and answered their questions and gave them relevant information.

Q We have heard about note keeping maybe not being as good as it should have been and things of that kind. Did you have any difficulty, whatever the brevity or otherwise of Dr Barton's notes, in knowing what her medical judgment and opinion was about patients?
A I always felt I could understand what had been said or written and, if I was not sure, I always knew that I could ask for clarification.

Q When she was called out or indeed when she was at the hospital in any event dealing with the admission of a new patient, did you, from what you could see and what you could judge, think that she took care over her clinical assessments of patients?
A Yes, I did.

Q I am going to turn now, if I may, to three particular patients you were asked about this morning. First of all, we can deal with the patient Gladys Richards and perhaps you could take file E. On the day that she was first admitted – and we have looked at Dr Barton's clinical notes at page 30, if we can just take a minute to remind ourselves of them.
On page 30 we can see the notes made on 11th and I am not going to read through all of those again. But as you indicated to us "Please make comfortable", did in effect mean make sure that she is not in pain.
A Yes.

Q We have to bear in mind that this lady, who I think was in her early 90s, if I remember correctly?
A Yes, that is correct.

Q Had had this operation – a far from uncommon kind of problem with people who fell. You were quite used, no doubt, to patients in that sort of state.
A Yes.

Q And somebody who, so far as your experience was concerned, might very well be in some pain soon after admission.
A Yes, that would be quite typical.

Q Even if not obviously in pain on admission.
A Yes.

Q We have been through all the records to see what record there was of your actually administering Oramorph and you say that you definitely did but there just does not happen to be a record of it; obviously that is because Dr Barton had prescribed it – you could not have done it otherwise – and we have seen the prescription.
A Yes.

Q Can I ask you this, Mr Beed: what sort of degree of pain would cause you to administer Oramorph, which has been prescribed by the doctor; can you give us an idea?
A The patient was very obviously in significant pain and showing signs – crying out, very agitated and pain was made worse on movement.

Q So we can take it that there was something that you had observed or other nursing staff had observed which caused you to think it was right to give her Oramorph.
A Yes.

Q In your experience, with patients of this sort of age and a lady in her circumstances – a frail, demented lady – what was the prognosis like in general terms in such cases?
A Elderly demented patients who suffered a fracture in their femurs, the outlook is not always terribly good.
Q That was not something that meant you simply did not bother but you would have in your own mind the fact that there was a possibility this patient might go downhill.
A Yes, that was something that you regard as a possibility.

Q In general terms – and we will take this lady's case as an example – Dr Barton on occasion might prescribe in an anticipatory fashion a dose of diamorphine often coupled with midazolam.
A Yes.

Q The purpose of that – and we have heard from other witnesses – was to enable the staff to be able, if it was necessary, to administer subcutaneous analgesia if for some reason the doctor was not available or could not be obtained.
A Yes.

Q Can I ask you this: in such a case where you have a prescription that is there – it is not saying it is to be administered straight away or anything like it, but it is there available for use – and there is a dose range, and let us say it is 20 to 200 just to take a figure – if a patient was already on Oramorph or any other opiate, MST, whatever it might be – normally the staff, whether it was you or anybody else, would endeavour to check with the doctor before starting subcutaneous analgesia.
A We would usually endeavour to do that, yes.

Q Obviously if Dr Barton comes in in the morning and the Oramorph is no longer controlling a patient's pain the staff can tell her that and she can say, on the information given, "I think it right that it is started" – or examining the patient or whatever it might be.
A Yes.

Q But on occasions, if no doctor was available and no doctor could give the okay to it, if I can use that expression, you as the senior person on the ward or any other senior member of the nursing staff could institute it, could start it.
A Yes.

Q In general terms, you have told us, it was clear that you would start at the minimum dose prescribed.
A Yes.

Q In general terms, if you or any other member of your staff considered that the patient's pain was not being controlled at whatever the lowest dose was and that the dosage ought to be increased, normally you would endeavour to speak to the doctor about it.
A Yes, we would.

Q Is this right: it was only in cases where the doctor was not available and there was no other on-call doctor available that the staff – and senior staff again, it is not just an ordinary nurse doing it as she feels like it – we have heard about two nurses being told every time controlled drugs are administered, and so on – have the authority to increase the dose if they felt it was justified.
A Yes, that is correct.
Q And any increase in dose coming about in those circumstances would be picked up by the doctor the next day.
A Yes.

Q Assuming it was a weekday and if it was a weekend it might take longer.
A Until the next working day.

Q But if there was a problem you could always contact the on-call doctor over the weekend.
A Yes.

Q Assuming that you could get hold of them and they were not already engaged on other matters.
A I would say that contacting doctors out of hours was sometimes easier than at other times.

Q I would like to deal with the question of hydration, about which you were asked a number of questions, although it did not arise at this stage so far as Mrs Richards was concerned. It may well be that things changed but in 1998 and 1999 in general terms there were not the facilities to provide intravenous fluids, is that right?
A That is right, yes.

Q We have heard from another witness – and I will not trouble you – that change came and later on it was possible to do that.
A Yes.

Q In terms of the equipment being available.
A Yes, it was possible later on.

Q And if you are providing intravenous fluids to a patient to keep them hydrated and so on, what is the importance of there being a medical presence or availability in the sense of a doctor?
A It would have needed a doctor to insert a venflon and if at any time that venflon was not patent and became blocked then you would need a doctor to re-site the venflon.

Q So did it come about that there was this change when more doctor assistance was provided at the hospital?
A Yes. We started giving intravenous fluids to patients when we had a full time associate specialist working on the ward.

Q We will be hearing about Dr Barton resigning and therefore ceasing to be in post. After that was more medical assistance or cover provided in terms of doctors being available?
A Yes. After that we had a doctor who was available during working hours from Monday through to Friday.

Q So in general terms there every day of the week, as it were, or available every day of the week, and is that the time when the supply of intravenous fluids was something that was carried out and the equipment was there to do it?
A Yes, that was introduced at that time.

Q I am not going to go over it again with you but you pointed out that the view in any event in 1998 was that in terms of palliative care patients to seek to re-hydrate them would cause more problems than it solved.
A Yes, that was the view and there was evidence in the literature which would back that view.

Q Would you help us with how you saw it – what was the problem if you tried to re-hydrate somebody who was in that sort of condition?
A The giving of fluids subcutaneously, which was the route that was available to us, could only be done for a limited amount of time and was felt to cause the patient discomfort at the site of infusion. So the benefits of hydrating were outweighed by the disadvantages for the patient.

Q We have seen the picture with regard to Mrs Richards in general terms but initially things moved along fairly satisfactorily.
A Yes.

Q Her pain was being controlled.
A Yes.

Q And then came the occasion when there was the fall and, as you say, you were not surprised that the relatives were rather unhappy about the fact that she had had this fall on 13 August, as it was. You told us about Dr Briggs being consulted and advising an X-ray but it should be done the following morning; and Dr Briggs saying that she should have analgesia during the night.

A A Yes.

Q On the 14th – if we can look again at page 30, that same page in the file, the clinical notes made by Dr Barton and the bottom of that page, 14th August:

"Sedation/pain relief has been a problem. Screening not controlled by haloperidol but very sensitive to Oramorph."

B

Do you see that?
A Yes.

Q What does that signify? Maybe you will not be able to specifically remember the detail but if you can, do say so. What does that signify to you – "very sensitive to Oramorph"?
C A That the Oramorph at that time was helping to control the pain.

Q It says: Screening not controlled by haloperidol ..."

And there is something after that, but I do not know what it is:

"...but very sensitive to Oramorph."
D A Yes.

Q "Fell off chair last night. Right hip shortened and internally rotated. Daughter aware and not happy."

That covers what you have already told us about.
A Yes.

E

Q "Plan X-ray."

Then Dr Barton raising the query:

"Is this lady well enough for another surgical procedure?"

F

Just a query she was raising. Could you have been aware of that query she had?
A Yes. I think that would have been a relevant thing to ask of anyone who is elderly and frail and had only just had a surgical procedure, as to whether they were fit for a second procedure if it was necessary.

Q Because that was a problem which had to be seriously considered.
A Yes.

G

Q Are you in fact going to be causing more misery to the patient or are you going to be doing something which helps them.
A Yes.

Q Over the page, page 31, still the same day, Dr Barton's note, as it were, to Commander Spalding, saying:

H

A "Further to our telephone conversation ..."

Obviously she has been on the phone to him:

> "Thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her right hip. An hemi-arthroplasty was done on 30th. I am sending X-rays across. She has had 7.5 mls of 10 mgs in 5 mls Oramorph at midday. Many
B thanks."

So obviously she had concluded that it was right for her to go back and see what could be done by way of any surgical procedure.
A Yes.

Q And we know of course that she was there for two to three days and returned to
C Daedalus on 17th.
A Yes.

Q In terms of that return to Daedalus, this was the occasion when she had been brought back or placed in bed, whatever the mode of transfer was, in a way which had obviously caused her significant pain.
A Yes.
D

Q And obviously attempts were made to try to deal with that and this, we have heard, was a lady who was screaming when she was there at the hospital; do you remember that?
A Yes.

Q There is just a particular matter about which I need to ask you in connection with that, if I may. You had by this time been having a conversation with the daughters about the
E situation – one or other of them or both of them – is that right?
A That is correct, yes.

Q They could see that she was in discomfort themselves, obviously, because they were there and it was apparent to anybody. You indicated that you had given pain relief – this is when you were speaking to the police about it – at one o'clock. Are you able to help us on the drug chart – it may be the best place to look – at page 63 – and I want to pick it up on the
F 17th – Oramorph at the top, do you see in the middle section of the columns?
A Yes, at 13.00.

Q So that is you, giving it and recording it in the usual way.
A Yes.

Q It has been suggested that you gave two injections directly into Mrs Richard's thigh in
G addition to doses of Oramorph; is that right or is that wrong? There is no record of it.
A No, I did not do that; that is wrong.

Q Can you be confident that if you had given two injections directly into her thigh – those were the words that were used – that you most certainly would have recorded that?
A I could not have done that without a prescription to do that and there is no prescription for that.
H

Q Thank you. That brings me on to something about which I wanted to ask you. At every turn, where we are talking about administering Oramorph or any morphine equivalent or indeed anything else like diamorphine – but let us stay with Oramorph and other forms of morphine – were there ever circumstances when you could administer such a drug without there being a prescription?
A No. A nurse cannot prescribe a controlled drug without a written prescription and that is not anything that I have ever done.

Q So we can effectively rule that out as something that occurred?
A Yes.

Q Thank you. I do not want to go into what may have been somewhat troubled past history, but can I ask you this: did you find with regard to Mrs Richards that she was a lady who obviously was very confused and could not communicate with the nursing staff at all?
A Yes, that was my experience.
Q Her daughters indicated that they could understand or they knew what she was saying. Did you yourself ever witness or hear any communication when you were in the room with Mrs Richards and daughters – one or other or both of them? Did you ever hear her communicate with them?
A No, I did not; I did not personally experience that.

Q Did you on occasion notice that there appeared to be a disparity between what the daughters were saying about Mrs Richards and what the other nursing staff had observed?
A Yes, sometimes that was the case.

Q I think you indicated in your statement made to the GMC that Mrs Richards was agitated and that in your professional view that was because she was in pain?
A Yes.

Q Again, I am not concerned with the detail at all but did there at times seem to be something of a contradiction between what the daughters were saying about Mrs Richards – one daughter saying one thing and another daughter saying another?
A Yes, that was the case.

Q We can take it I think from what you have been telling us that you were doing your best to listen to their concerns and to deal with them?
A I spent a lot of time with both of Mrs Richards' daughters individually and together trying to communicate with them and help them and reassure them and answer their questions, as best I could.

Q In terms of the setting up and use of the syringe driver and the administration of the subcutaneous analgesia, is it the case that the daughters were aware of what treatment was being provided, the medication?
A Yes. One of Mrs Richards' daughters was a retired nurse, which obviously helped her understanding, but, yes, I felt they both understood explanations that were given to them by myself and colleagues, both nursing and medical colleagues.

Q Apart from the fact that they were understandably pretty unhappy about their mother's fall on 13th at Gosport War Memorial Hospital, did they ever complain to you about anything

A that was being done by way of the treatment that was being given to their mother, the medication?
A No, they did not.

Q If we can take up again Dr Barton's clinical notes, and we were at page 31, do you see that on 17th where she is dealing with the readmission – the date is a bit confused but we have been through that – she says towards the last line but one of that entry, "Only give Oramorph
B if in severe pain".
A Yes.

Q Did you follow that in terms of your dealing with this patient?
A Yes, we did.

Q "See daughter again", and the following day, 18th, the patient is still in great pain.
C Correct, so far as you are concerned?
A Yes.

Q "Nursing a problem. I suggest diamorphine, haloperidol, midazolam. I will see the daughters today. Please make comfortable."

Again, in accordance with what you can recollect of the history of this case?
D A Yes, that is correct.

Q It may not be that the daughters were both present at every moment but one or other daughter or both of them were made aware of what was going on?
A Yes.

Q The type of drug that was being administered?
E A Yes.

Q The reason?
A Yes.

Q And the possible course of events that might take place?
A Yes.
F

Q Did either of them ever say to you, or to any other member of staff in your presence, that they did not want that to happen?
A No.

Q Can we just move on to the contact record? We have already looked at large parts of this. Would you go on to page 47, please? We have looked more than once at the entries
G with regard to 17th but, looking at the bottom of the page, the entry for 18th, and I am sorry it is my mistake, is that in your handwriting?
A That is my handwriting.

Q I thought so. Thank you. This is the 18th:

"Reviewed by Dr Barton for pain control via syringe driver. Treatment discussed
H with both daughters."

A Yes.

Q That is your record of that having happened?
A Yes.

Q "They agree to the use of syringe driver to control pain to allow nursing care to be given."

You record at 11.45 syringe driver commenced. Over the page, still on 18th, is this right:

> "She was peaceful and sleeping, reacted to pain when being moved – this was pain in both legs. Daughter quite upset and angry about her mother's condition but appears to be happy that she is pain-free at present."

Now, that is not your note. Does that accord with your ---
A Can I check where I am looking? Am I on page 48?

Q I have moved on to 48. I think it is Nurse Joyce for 18th at 8 o'clock in the evening. You would not have been there at that time I suppose, or might you have been?
A Probably not if I was on in the morning; no I would not.

Q That has been recorded at that stage. Then on to 19th, when it appears you would have been back ---
A Yes.

Q The grandson had arrived, we can see nearly half-way down the page:

> "Grandson arrived in early hours of the morning. He would like to discuss grandmother's condition with someone – either Dr Barton or Philip Beed later today."

Later on that same day, 19th, in the morning, "Mrs Richards comfortable. Daughters seen. Unhappy with various aspects of care. Complaint to be handled officially by" – the nursing co-ordinator.
A Yes.

Q Did you actually see the grandson? I do not know whether I am testing your recollection too far?
A I did see the grandson. I cannot recollect what, if any, discussion I had with him. I think I remember him being there briefly and then leaving.

Q In any event, in any contact you had, either with these relatives or with other relatives, did you try to hide things from them or conceal things in any way?
A No, I would have no cause at all to do that. That would be unprofessional.

Q I think that is probably all I need to ask you about that patient. I am going to turn now to two others, and I can take them pretty briefly, and those are the two others you were asked about earlier on. Can I go, please, to Patient D, Alice Wilkie? Do you remember you were asked about that? Can we look, please, with her in her file at page 206?
A Yes.

Q We can see there a contact record sheet showing a note on 17 August, if you can pick it up at that point, in the morning:

"Condition has generally deteriorated over the weekend."

That is your handwriting?
A It is, yes.

Q At 7.45 in the evening:

"Daughter seen – aware that Mum's condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain."

A Yes.

Q First of all, does that note record what happened?
A Yes.

Q Would it be right to say or to suggest, as has been suggested, that you on this occasion --- First of all I had better ask you this. Did you at any time --- I am going to interrupt my own question and rephrase it again, I am sorry. I am looking at a transcript of certain things that have been said. Is it right that you had explained to the daughter that a syringe driver was going to be commenced?
A Looking at that, it looks like I discussed that option with the daughter so that it commenced if pain ---

Q It cannot mean anything else, can it?
A No.

Q Would that be your normal practice with a relative with whom you were in contact, to explain what you were doing and why?
A Yes, that would be the case in all aspects of patient care, to involve relatives and make sure they were informed and had the opportunity to ask questions and understand what was happening.

Q So it would be quite wrong to suggest that a syringe driver had never been mentioned or strong doses of pain relief?
A I would find that very surprising.

Q It has also been alleged by this same witness who observed that her mother, and this is not disputed, was very, very drowsy and unresponsive for a period of time before the syringe driver was commenced. I do not mean for a matter of hours but over a period of more than one day.
A Right.

Q That is attributed by her to her mother being neglected – neglected by the nursing staff. What do you say to that?

A A As far as I am aware that was not the case. We worked very hard on Daedalus ward to make sure that all patients received the necessary care and were looked after as best we possibly could.

Q We can see the next entry, which is four days later, 21 August:

"Condition deteriorating during morning. Daughter and granddaughters visited and
B stayed. Patient comfortable and pain free...."

– and then she died later on that same day. I would just like to pick this up. I think we have already dealt with you about the signing of the prescription chart for diamorphine and midazolam, page 145, and I do not think I need to trouble you with any further matters with regard to that patient. Lastly, please, we turn in this section of the matter to Patient L. Can we look please again at page 1309? We can see there on 21 May at 18.00 a note made about
C this patient. Is that your note?
A Yes, that is.

Q "Uncomfortable throughout afternoon despite 4-hourly Oramorph. Husband seen and care discussed. Very upset."

Again, I am sorry to ask you questions in this way but I must so that we can have it clearly
D from you. When you made these notes, were they accurate?
A Yes.

Q So you discussed her care with the husband. "He agreed", does that mean he agrees to commence syringe driver for pain relief?
A Yes.

E Q So he knew what you were doing and why?
A Yes.

Q "...at equivalent dose to oral morphine with midazolam. [He is] aware of poor outlook but anxious that medication given should not shorten her life."

A Yes.
F

Q "Father David", who is a Roman Catholic priest, "asked to come and see Mrs Stevens". Is that right?
A Yes.

Q "Daughter, Jane Bailey, called in and informed of situation." Again, does that mean she was told what was happening and why?
G A Yes.

Q Involving clearly the use of the syringe driver and the use of diamorphine and midazolam?
A Yes.

H

Q Again this is not said by way of criticism at all but did you find that some relatives were much better at understanding what you were talking about when you explained what it was you were using and why than others?
A Yes. People are all individual and some would have a greater degree of understanding and obviously a relative's level of anxiety and distress might have a bearing on their understanding of things.

Q Then it goes on, after she had been informed, "Message left for 2nd daughter, Carol" and I cannot read the name, at a particular holiday camp for her to contact the hospital.
A Yes.

Q So informing it seems all relevant relatives.
A Yes.

Q Then at 19.45 the syringe driver was commenced with that dosage of diamorphine and midazolam in 24 hours?
A Yes.

Q I am not going to go through all the totting up of the Oramorph again but what you were endeavouring to do in this particular case was to work out a direct equivalent?
A Yes.

Q To see whether that would control the pain?
A Yes.

Q How did you see it? Mr Beed, perhaps I can just ask you this. Was it your view, and say if you do not agree or you do not think you are qualified to answer, that the administration of subcutaneous diamorphine and midazolam, assuming it was given for proper reasons, might play any part in the decline of a patient in these sorts of circumstances because of their effect?
A Yes, they are both mediations which have a depressive effect on the respiratory centre, respiration, so they can affect the patient's decline as a side-effect of their use to control pain.

Q Again, can I ask you this generally? When the husband, Mr Stevens, in this particular case made the point he did not want her life shortened, was that something you always had in mind yourself in terms of the administration of the drugs? Obviously you are following the doctor's prescriptions but, in general terms, was that something you were conscious of, not as it were deliberately shortening the patient's life?
A Yes, we would have to be aware of the medication's side-effects, especially strong medication such as opiates and hypnotics, so you would be aware of that when you prescribed them and the overall effect on the patient.

Q Bearing in mind your experience and the gathering experience you got in the course of 1998 and 1999, from what you had learned, either by talking to people or your experience on the ward, if you had ever felt the doses that were being administered of diamorphine and midazolam were too high, can we take it you would have said something about it?
A Yes, we would have said something and we would not have administered a dose which we felt to be incorrect because that is part of the procedure for checking and administering medication, any medication.

MR LANGDALE: Sir, I think, and never trust a barrister when he says this, that is just about all I have to ask Mr Beed. If the Panel was going to take a break at some stage, I wonder if I might just use that time to see if there is anything else I needed to ask him. The alternative, depending on the Panel's wishes, is that Mr Kark re-examines and we then adjourn but I do not want to find myself having to come back with something else to provoke Mr Kark into some further re-examination. It might not; I do not know.

THE CHAIRMAN: It might assist us if were possible to have an indication from Mr Kark at this stage about how long he would expect to be in re-examination.

MR KARK: I have got a bit, I would have thought about 10 minutes, but I am also conscious that the witness has been in the witness box for about an hour and a half.

THE CHAIRMAN: Yes, indeed, and what is also attracting my attention is the large number of yellow post-its that are appearing on the panellists' papers, which indicates to me that there will be a fair amount of additional questioning from the Panel. As on the last occasion when faced with that situation, we find it very helpful to spend some time in private working out which questions will be asked and by whom so that we do not have duplication.

MR KARK: I am in the Panel's hands. I certainly could re-examine now but it is a matter for the witness, and witnesses are not always very forthcoming in saying that they are tired.

THE CHAIRMAN: I agree. I think the witness in any event should have a beak now. Whilst he does so, the Panel may spend two or three minutes first of all just getting a sense of how much we will have. What I am leading up to is whether we are realistically going to be able to complete today or whether it would be better for us to finish with the questions from the Bar, as it were, and then resume with Panel questions on Monday. I know that would be very inconvenient to the witness but it might be the only way to go until we have had a chance to discuss amongst ourselves. I cannot be sure how much we may have.

MR KARK: I know that Mr Beed was only warned for one day. Perhaps it could be checked with him through you, sir, whether he has further availability.

THE CHAIRMAN: If it were necessary for you to return on Monday, Mr Beed, I would anticipate it would only be for the answering of questions from the Panel and any questions from the barristers that might arise out of the questions from the Panel. In other words, I would have thought it would be half a morning at most. Would that be something that would be possible for you?

A I had anticipated that possibility and I could, if required, do that, yes.

THE CHAIRMAN: That is most helpful. Thank you. What we will do now is rise for 15 minutes, give you a chance in any event to have a break. The Panel will use part of that time to consider amongst ourselves where we think we are likely to be. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Langdale, you had reserved your position.

MR LANGDALE: Thank you for the opportunity. I have nothing further to ask at this stage.

THE CHAIRMAN: Thank you very much. Mr Kark?

Re-examined by MR KARK

Q Just going back again, please, to the file of Gladys Richards, file E, you were asked some questions by Mr Langdale about how patients would sometimes arrive and the previous hospital would suggest they were in a better state than you found them to be. With Gladys Richards, we have a note from Dr Barton at page 30, "Transfers with hoist".
A Yes.

Q Can you just explain what that actually means?
A It means we were using a ceiling-mounted hoist and sling to transfer Mrs Richards from a bed to a chair or bed to commode or vice versa.

Q This patient I think was certainly meant to be, according to the notes at page 210, in a straight knee splint. Would that affect how she had to be transferred? In other words, would that affect how much help she needed to get out of bed?
A I do not remember Mrs Richards being in a straight knee splint when she arrived on Daedalus.

Q Dealing with 17 August – that is what page 210 is dealing with – do you see "Treatment recommendations on discharge: to remain in straight knee splint for four weeks"?
A Yes. I can see that, but I do not remember there being one and I cannot think why you would be in a straight knee splint for hip surgery. It does not quite tally, I am afraid.

Q Is it possible that a patient who requires a hoist to transfer, to get out of bed, would nevertheless then, once she is out of bed, be able to bear her own weight on a zimmer with assistance?
A It might be possible, yes.

Q Page 188 was the better copy of the note that you had from the Hasler dated 10 August which indicated to you that she was admitted to E6 ward and:

> "She had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a zimmer frame."

I just want to have your evidence clear, as it were. Are you saying that you distrust that note, or are you saying that you accept the accuracy of that note at the time that she left the Hasler and came to you?
A I would accept that at Hasler, if that is what the staff say was happening, it was happening, but in our experience we would have to re-assess patients' mobility as appropriate and we often found it to be the case that patients' mobility had deteriorated during that period of transfer and it may be that it would take us a day or two to get them back to the point they were pre-transfer and that would have been the case with Mrs Richards.

Q Does the transfer time make a difference? If somebody is transferring from the Queen Alexandra, that is a rather longer journey, is it not?

A A It probably does, but I think even a short transfer can be quite traumatic for elderly patients with complex pathology.

Q Did you have a zimmer available for Mrs Richards?
A Yes, we would have done.

Q And two nurses to help her get out of bed to use it?
B A Yes, we would have done.

Q Did that ever happen?
A That would have been part of the assessment when she was admitted to the ward before we determined that we needed at that point to be using the hoist.

Q I understand that, but you have looked through the notes. Did it actually ever happen
C that she was got out of bed and walked?
A That would have been tried on admission.

Q Is there a note to that effect?
A I could not find one when I looked through the notes.

Q Page 41 is the Barthel score.
D A Yes. That would have included assessing mobility and transfers.

Q How would mobility have been assessed?
A Given that the transfer letter said that the patient could transfer with two and zimmer frame, we would have attempted that the first time the patient required a transfer to see how we got on with it.

E Q Apart from this Barthel index, would anybody have made a note of that event?
A It would not appear to have been done in the case of Mrs Richards, other than the Barthel record.

Q Dealing with the notes, I think you have accepted that the documentation was poor.
A Yes.

F Q And you have accepted that there was no note of this patient's pain, justifying the Oromorph.
A Yes.

Q You were asked by Mr Langdale what would happen if you had found that diamorphine was being used to keep a patient quiet.
A Yes.
G

Q I think you said, but I might not have heard you properly, "We would have reported that person." Did you say that or did I misunderstand you?
A Well, it never occurred, so it is a hypothetical question, but if I had felt that was the case, then that would have been dealt with. I would have discussed that with a senior nurse manager so that it could be dealt with appropriately.

H Q You also told Mr Langdale that there was good handover between teams.

A A Yes.

Q Could I just ask you about the note making and the importance of note making? Is the reading of notes part of the transfer of a patient between teams?
A Notes could be used for reference when handing over between teams, yes.

Q Would they be an irrelevance, as it were, or would they be an important part of such a
B transfer?
A Yes. They would be useful in handing over and useful for looking back at the care that the patient received.

Q You say useful for looking back at the care the patient has received, so that you can keep an idea, as it were, in your mind as to whether the patient is improving or deteriorating.
A Yes.
C
Q So it is not only important for the handover between teams, but so that you know where the patient is in terms of their recuperation.
A Yes.

Q This is going back a little bit, but could you just go back to page 36? This is jolly difficult to read, I am afraid, but it is a note made on 11 August. Where would this note be
D made? Is this a Gosport War Memorial Hospital note?
A Yes. This is part of Mrs Richards' nursing notes at the War Memorial.

Q In the fifth line down, it says:

"She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a zimmer frame."

E

Is that simply a reflection of what was in the transfer letter, or is this something that happened?
A Given that we know Mrs Richards to be hoisting and that that does not tally with the Barthel, I think that looks to me to be a transcript of what was written in the transfer letter.

Q You told us I think that if you felt it was appropriate, you would yourself challenge a
F prescription.
A Yes.

Q May I ask you this? In the time that you were there on Daedalus Ward, during the period that we are talking about, did you challenge any of Dr Barton's opiate prescriptions?
A No.

G Q You also told us that the pharmacist would challenge any prescription that she felt was wrong. To your knowledge, did the pharmacist ever challenge an opiate prescription by Dr Barton?
A I cannot remember that ever happening.

Q Did you ever think that a dose should be reduced of opiates that Dr Barton had started?
H A I cannot remember that happening.

Q You were asked about the Palliative Care Guidelines and you quite rightly pointed out that they were guidelines only.
A Yes.

Q Could you help us with this? To what extent would you be attempting to follow them?
A Guidelines would help in guiding care, but you also have to take into account patients' individual specific needs and make sure that the patient is receiving the right care. If the right care does not coincide with the guidelines, you have to weigh up the needs of the patient against the guidelines and make professional decisions as to what is appropriate.

Q That is exactly what I was going to go on to ask. If you are going to go outside the guidelines, do you have to take any particular care?
A Oh, absolutely, yes.

Q Because the sort of drugs that were being administered, the opiates that were being administered, could actually kill a patient, could they not?
A In high doses, yes.

Q You were also asked about the importance of keeping a patient pain-free, but monitoring the level of consciousness.
A Yes.

Q Would it be important to keep a careful note of the level of consciousness once a syringe driver had been initiated?
A Yes, it would.

Q Did you to your recollection ever decrease the level of diamorphine as being too high because a patient had become unrousable?
A I cannot recall having done that.

Q You told Mr Langdale that Dr Barton was very easy to talk to and that she demonstrated sensible, professional judgment and that she found time to talk to relatives.
A Yes.

Q Can I just ask you this? Is that something that relatives had to request? We have heard, as you will appreciate, from a number of patients' relatives, some of whom never saw Dr Barton in the entire time that their relative was there. Is that something that a relative would have to request – "Could I have a meeting with Dr Barton?"
A It could happen in a number of ways. It might be a request from a relative or it might be a member of nursing staff saying, "It would be helpful if you saw this patient", or it might be Dr Barton saying, "It would be helpful if I saw the relatives." So it could be in any of those three ways.

Q If a patient is near death, would that necessarily trigger a meeting with a relative, or not?
A Not necessarily.

Q In relation to Gladys Richards, you have told us now on a number of occasions that it was obvious to you that she was in pain.
A Yes.

Q Otherwise, you would not have started Oramorph.
A Yes.

Q Given that Dr Barton's assessment when she saw the patient was that there was no obvious pain and that the Hasler noted that she was weight-bearing and there was no note there of pain, did you consider that anything might have gone wrong with this patient's operation?
A That would be something that would be considered when assessing the patient's pain, yes.

Q If the patient is effectively pain-free when she arrives at your hospital, or appears to be, and then you think she is in significant enough pain to prescribe opiates to her, would you want to have examined what had gone wrong, or if anything had gone wrong?
A Yes. That would be part of the assessment of what sort of pain is the patient in and where is the pain.

Q How did you perform that assessment in this case? Other than prescribing Oramorph, what did you do?
A Looking at where the pain is, what the nature of the pain is and in particular looking at the site of the surgery to see whether anything looked abnormal there.

Q What did you conclude?
A That there was nothing abnormal with the hip at that time.

Q Did you record that?
A I cannot find it in the notes that you showed me.

Q But you remember that now, do you?
A Yes.

Q Are there any circumstances where an injection into the thigh directly might have helped? I appreciate you say you did not do it, but I just want to know.
A That could be a route of administering analgesia medication and could be prescribed that way, yes.

Q Directly into the joint?
A Not into the joint. You would give an intramuscular injection into the upper/outer quadrant of the thigh.

Q And that might be an effective way of relieving pain?
A Yes.

MR KARK: Thank you very much.

THE CHAIRMAN: Thank you, Mr Kark. The Panel took the opportunity in the break to compare notes, as it were, and to see how much work we felt we had to do together before we

would be in a position to put our questions. The view is that we would be keeping you here fairly late if we were to embark on that process now. So what we are proposing is this.

We will rise now. Individually we will be considering the issues that we wish to raise over the weekend. The Panel will come in earlier on Monday morning and we will have our own private discussions before we all sit formally. The normal starting time is 9.30. We think if we come in at nine o'clock, we will need a little longer than 9.30, so out of an abundance of caution, we are going to say a 9.45 start on Monday morning. That should cause the least disruption possible to the schedule whilst at the same time ensuring that the Panel have had adequate time to reflect on what their questions should be. So on that basis, unless there is any other business?

MR KARK: I think this is the first occasion we have had a witness go not only overnight, but over a weekend.

THE CHAIRMAN: Mr Beed, I should remind you that you are on oath now and you will be on oath when you return, so you are effectively in the middle of your evidence and it is absolutely essential that you talk to nobody about any aspect of this case, the evidence that you have given, the questions that you have been asked or what is likely to happen. You can have perfectly normal conversations with people otherwise, but please draw a line about this.

THE WITNESS: I understand.

THE CHAIRMAN: Very well; thank you very much indeed. We will see you back again, please, ready to start at 9.45 on Monday.

(The Panel adjourned until Monday 22 June 2009 at 9.45 a.m.)