FFW/105/04

General Medical Council

- and -

Dr Barton

FTPH Transcripts

General Medical Council

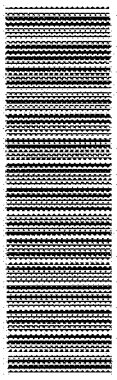
- and -

Dr Barton

20-25

PTPH Transcripts

File 4



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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 6 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWENTY)

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.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning, everybody. Mr Kark, before you call your witness, there are a couple of quick matters of house-keeping I need to raise. The first one, for the record, is that Christine Challis, the Panel Secretary, is unable to be with us at this part of the day and very kindly Lola Babatunde, is standing in for her.

Second, the matter of the drug charts. Clearly there is a great deal of evidence that surrounds the charts. If it is possible the Panel would find it helpful to receive at an early stage a blank copy. I do not know if such a thing is still available, but when we look at the photocopies it appears in some cases that two pages have been put together for the purpose of photocopying. It would assist us greatly if we were able to sort those minor issues out just by reference to a standing blank

MR KARK: We shall see if we can get a blank version but what we do have already, of course, is a file with the original prescription charts. Some of them have come apart; some have not. This is one is Mrs Lake. The only difficulty about trying to find a blank one is discovering whether the same form is being used now as it was at that time and one suspects it might not be. You do, though, have the advantage at least of having a complete folder in three sections for Mrs Lake and for others.

THE CHAIRMAN: At the moment we would only be receiving those when we went into camera at a later stage.

MR KARK: They are available now.

THE CHAIRMAN: If there is no objection. A single one that is complete would be helpful and, frankly, the less that is written on it probably the better. It is not what is written on it that interests us; it is merely the layout.

MR KARK: It is the format.

THE CHAIRMAN: Yes.

MR KARK: Shall I make that available now.

THE CHAIRMAN: Thank you. Shall we give that an exhibit number at this stage?

MR KARK: We were going to exhibit the whole file of them. We can either do them individually or as a file. They contain, I think it is, 15 and contain the original prescription sheets for Patient D onwards. So far as Patients A, B and C are concerned we only, I am afraid, have microfiche. That is why the copies in your bundle are not very good and we have not been able to do much about it. We are very happy at this stage now to exhibit this. It is available to the Panel.

THE CHAIRMAN: I think then, if there are no objections, Mr Langdale, that is how we will do it.

MR LANGDALE: Yes.

THE CHAIRMAN: Then we are not splitting them up. We will receive that in evidence as Exhibit C13. (Bundle marked C13 and distributed) It will be kept with the Panel Secretary

A if anybody needs to know where it is at any time.

MR KARK: May I mention one or two other administrative matters. So far as the chronologies are concerned, I think we are very nearly there. We are just missing one, Mrs Stevens, Patient L. Some have been printed up over the week-end and some are waiting to be amended and printed up today. I do not think that is going to cause a particular difficulty because we can produce them patient by patient as we get to them with
B Professor Ford.

We have the files of Dr Barton's statements available for you, and we can make those available to you now. Perhaps we should do that. That will be C14. That should be marked Dr Barton's statement to the police. (Document marked and distributed)

What I think you are going to be invited to do is, before we turn to each patient, is have a
C look then at those patients upon whom Dr Barton has commented. You will find that she was not asked about all of the patients that we have, of course, but we have kept in a divider, which may in fact be blank simply for continuity so you can see where she did comment and where she did not through not being questioned about those other patients.

May I mention one other matter? That is this morning at, I think, nine o'clock we received another expert report from the defence which took us by surprise. That expert starts one of
D his paragraphs by saying that he spent more than 16 months carefully reviewing all of the evidence relating to the twelve cases currently before this Panel. There is extensive criticism of Professor Ford and his report in it.

We have had a short time to show that document to Professor Ford. Mr Langdale, who gave us the report this morning, has indicated to us that he has, in light of the late service which I know he accepts, no objection to us, if necessary, talking to Professor Ford about this report
E once he has started giving evidence. That is not very attractive and we do not like doing that normally, but I do not particularly want to hold up Professor Ford in his evidence in order to do that. He has already made some comments about it, and it may not be necessary to do more but can I just raise that as a flag, as it were. I have had the opportunity of reading through it once but it may be on a second read-through I will have certain matters I will want to ask Professor Ford about specifically.

F THE CHAIRMAN: It is an unfortunate state of affairs. Obviously, if there comes a point when you feel that the best way of dealing with it is for you to have time, I am sure Mr Langdale will not object to that, although I appreciate that in terms of the Professor's own timetable the finding of that time may be very difficult.

MR KARK: Quite. I think the best thing to do is to get on, and if we need to we will ask for time and if we feel the need to Professor Ford about the report, then we will have to ask your
G permission because he will have started giving evidence.

Finally, could I hand out copies of Professor Ford's curriculum vitae.

THE CHAIRMAN: We will receive those as Exhibit C15.

MR KARK: Can I suggest that those goes behind the next free tab that we have in the Panel
H Bundle 1 which is, I think, tab 13.

THE CHAIRMAN: In that event we shall not need to give it an exhibit number, so we will put it behind the next free tab in volume 1.

Mr Kark, there is one very small point in relation to the chronologies and any that are yet to come off the press, as it were. I think that the hole punching was not undertaken by your team and we were told that there were some issues with the hole puncher. The issue, as it turns out, is that the hole puncher does not always punch holes in the places were the prongs in our files are located, so if there is to be any hole punching on your side, could we check that the hole puncher matches with the files that are being used. Thank you.

MR KARK: I do not know how it happens, but reprographics here use a different system from the rest of the world but we will cope with that, no doubt.

Can I please call Professor Gary Ford.

GARY ASHLEY FORD, Affirmed

THE CHAIRMAN: Please take a seat, Professor, and make yourself comfortable. I know that you have been in the hearing room while a number of witnesses have been sworn and given their testimony so you will be relieved to hear that I will dispense with the usual orientation speech and hand you straight to Mr Kark.

Examined by MR KARK

Q You are Professor Gary Ashley Ford. Is that correct?
A That is correct.

Q Professor Ford, you are obviously going to be with us giving evidence for some time. I will try and keep an eye on the clock and make sure that you do not have to answer questions for longer than about an hour at a time. Again, the same applies to you. If at any stage you feel the need to take a break, then I am sure the Chairman will allow us to pause and do so.
A Thank you.

Q I want to begin, please, by asking you a bit about your CV. I do not know if you were actually given a copy of your own CV when they came round?
A I have a copy, but I can remember it.

Q Very well. I think you began your medical career back in the early eighties and you became – is it – a Member of the Royal College of Physicians?
A That is correct.

Q In 1985, UK. Then a Fellow of the same Royal College in 1996. In what area of medicine have you specialised since the nineties?
A Following my training in general medicine and geriatric medicine, I was a senior registrar in geriatric medicine and general medicine from 1989 till 1992.

Q And we see that at the bottom of the page?
A Yes.

Q I was appointed as a senior lecturer in clinical pharmacology and geriatric medicine and, as an honorary consultant physician in general medicine and geriatric medicine at what at the time was the Freeman Hospital in Newcastle. My practice at that point was, like many geriatricians, even though I was an academic, quite busy. I did acute medical takes on a one in nine basis, a rota through most of the early 1990s. I was responsible for half of an acute geriatric rehab unit on the Freeman Hospital site and I had responsibilities for what became a rehabilitation ward and a continuing care ward on what was the Walkergate Hospital, which still exists. This, I think, can be described as being very similar to Gosport War Memorial Hospital.

Q When you say you had "responsibility for", what does that mean?
A I was a consultant responsible for patients on two wards. Initially it was more wards but it was a continuing care ward and then what was a continuing care ward and became a rehabilitation ward. One of the early changes that I made was to create ten stroke/rehabilitation beds within the continuing care ward.

Q Just pausing for a moment, is this at the hospital in Newcastle upon Tyne?
A This is Walkergate Hospital, which is one of the hospitals in Newcastle. I had responsibilities in three areas: acute general medicine, acute geriatrics and rehabilitation. I also worked in the day hospital and soon after arriving I became the consultant who is responsible for the geriatric medicine department and I sat on the hospital clinical policy group and oversaw a number of changes in the service over the first six years.

Q How many patients would you have been responsible for, from taking up that post in 1992? You mentioned two wards. How many patients would have been on those wards for whom you had care?
A I had responsibilities for patients on at least four wards; an acute medical unit, where I could have up to 30 patients. It fluctuated, depending if one had been the consultant on take. I had 15 patients on the acute geriatric ward and then I had 22 patients on the rehabilitation unit and initially 20 patients on a continuing care ward. Like many offsite hospital, there was a change in practice where continuing care beds were reduced as patients moved into nursing homes so eventually that ward I was responsible for closed and did not exist, and I was left with the responsibility for the geriatric rehabilitation ward on the Walkergate Hospital site. In terms of the number of patients, it varied a lot, but I do remember at one point having over 120 patients under my care which, again, you would not see now, but it was not uncommon for geriatricians to have very large numbers of patients with different medical needs under their care in the 1990s.

Q Were any of those wards palliative care wards as such?
A No. By definition patients who move into NHS continuing care wards will die on those wards and may need palliative care, but we had no palliative medicine unit on that site and I had no specific palliative medicine training or expertise, except that which obviously geriatricians need to acquire for the end of life management of patients under their care.

Q Because although they were not designated palliative care wards, obviously you were not working in a hospice. Did you have a number of patients who, from time to time, would be on a palliative care regime?
A Yes. And one of the services I did set up was a stroke service and when I took responsibility for stroke, the mortality rate then for stroke patients was around 25 per cent.

A You had a lot of experience of dealing with patients who died.

Q Being a consultant, does it followed you would have had a number of more junior doctors under your control?
A Yes. I had worked as a senior registrar in the same hospital before I became a consultant, so I was familiar with working in that role. Usually there would be a registrar, a senior registrar, working under my supervision. There would be a different senior registrar
B working on acute medicine. I used to have a registrar working for me on the acute geriatric unit and at Walkergate Hospital. Just to talk about the system of care we had at our wards at Walkergate Hospital, again it was slightly different from Gosport War Memorial Hospital. The consultants did, typically, a weekly ward round and then the wards were covered for medical problems by a registrar going down for a session. They went down about five or six times a week. There were around at this point 66 beds on the unit by the mid 1990s, of which two wards were rehabilitation, because it was three wards, then it went to two with a nurse-
C led unit. One was a continuing care ward, and there would be about five or six sessions of medical cover from a registrar.

Q So that we identify any differences or similarities between this setting and that at the GWMH, although these doctors would be doing sessions on the ward, would there still be doctors remaining within the hospital at all times as it were?
A No. Walkergate Hospital at that point did not have a resident doctor. The needs of
D patients were covered within working hours by the consultants if they were there doing a ward round with or without their registrar, and then the registrars when they were down there and if a doctor was not there, there was a registrar who could be called down to see a patient urgently. Out of hours the cover on that unit was provided. It changed over time; there was initially a rota of middle grade geriatric doctors and then it became the on-call physician registrar or SHOs who covered the Walkergate Hospital site.

E Q How different is that scenario from the one we are dealing with in this case?
A I think it was slightly larger, slightly more activity. I cannot give you the exact figures, but it had more beds and it did not have a clinical assistant. It relied on the doctors in training to provide the medical cover.

Q That is an issue I was going to come on to later, but perhaps we can deal with it now. We heard last week from Dr Reid that the post of clinical assistant is not a training post.
F A That is correct. It is a staff appointed post, usually taken by general practitioners part-time.

Q What is the difference, what is the significance between a training post and a staff post?
A In general, training posts are, by their nature, training posts and are meant to, and usually do have, a high level of supervision. Again, that has changed over time. Senior
G registrars, for example, would operate with relatively little supervision at times in the 1990s, whereas now there would be much more involvement of consultants in their actions. A clinical assistant is, again, not a specialist in the area. They can sometimes have acquired some specialist training, but is obviously more experienced in their clinical practice, as a rule, but still work under the supervision of a responsible consultant. The consultant remains responsible for the care of those patients ultimately.

H

Q Moving on in your career, I think that post took you up until 2000 when you became, as we see in your CV, the Jacobson Chair of Clinical Pharmacology, did you change role or not?
A That personal promotion from senior lecturer to Chair did not of itself change my clinical role. What happened was that I became busier and busier developing and running a comprehensive stroke service and the demands of that became more. We appointed other consultant geriatricians and it was appropriate for me to focus my efforts on developing, managing the stroke service. In 1998 I ceased to have responsibility for the Walkergate Hospital wards but continued to do geriatric medicine practice. In around the early 2000s I ceased to do geriatric medicine and continued to do acute medicine and stroke.

Q What was the date you put on that?
A I am trying to remember. I think it was 2000, about 2000, I think. It was around then that I stopped doing acute geriatrics. I then practised acute medicine and stroke with a very heavy clinical workload. In mid-1998 I was the second busiest physician, despite being an academic appointment in the Freeman Hospital. In 2005 when I was appointed to lead and direct the UK stroke/research network, I stopped doing acute medicine because that role took up a third of my time, so since 2005 I have done stroke medicine, mostly acute, and also rehabilitation.

Q Is that necessarily in a geriatric setting or are you dealing with patients of all ages?
A The stroke service is within the elderly care directorate and that is because the majority of stroke patients are elderly, but it is a comprehensive service which takes patients of all ages.

Q If it were suggested to you that you are a mere, forgive me, academic pharmacologist, what would your answer to that be?
A I realise there are academics around, particularly in London and elsewhere, who may have very little clinical practice, but that is not the way I have ever practised as an academic. My academic work has been very based around my clinical practice throughout my working career.

Q We can see, and I am not going to take you through them, you have gained a number of awards – I am looking at page 2 of your CV – mostly, I think perhaps all, in the area of geriatric clinical pharmacology and stroke?
A That is correct.

Q You have either been responsible for, or contributed to, something in the region of 128 publications?
A That is correct.

Q Let us move on to some of the issues with which we have been dealing in this case. I want to start with some the broad areas about which we have been asking witnesses before we look at the individual patients. We are going to go through the individual patients, obviously, one by one in due course. Can we start with the *BNF*, how the *BNF* is regarded in the medical world, what its uses are and what caution has to by applied in using the *BNF*.
A The *BNF* is, I think, probably one of the most used books by any practising doctor. It is a very valuable source of information about drugs, what their indications are, what the potential side effects of drugs are, what the appropriate doses that should be used are and it is

A laid out into sections about different groups of drugs with some general sections on prescribing in certain settings, such as children, the elderly, palliative care and the like.

Q One of the pieces of evidence that this Panel heard, I think it was from a doctor who we will be referring to as Dr X, was guidelines for narrow minded people. First of all, *BNF* is a protocol or a guideline?

A It is certainly not a protocol. It is a source of information which gives you guidance B about the use of drugs. In a way it is not a guideline because guidelines are generally considered to be documents that outline general management of specific conditions. I have during my professional career had quite an involvement in the development of guidelines. I was a member of NICE and the British Hypertension Society Guideline on Hypertension, I have also been on a number of stroke guideline groups at both national and European level, so I am aware of the difficulty in crafting good guidelines. An important principle is that guidelines do not apply to every patient. What they do is they provide a framework of care C based on evidence which should be looked at by doctors as the basis to underpin their practice. Patients do not always neatly follow guidelines for a number of reasons. One, is that they have other comorbidities or there are other issues you have to weigh up, and guidelines do not attempt to cover every clinical setting that a doctor may face. If guidelines could do that, you would not need all the training and experience that it necessary to be a good doctor.

D Q If one is going to prescribe outside the guidelines, what is the basis upon which one can do that? How does one approach going outside the *BNF* guidelines?

A There are two aspects. One is going outside the licence indication for a drug. If you prescribe a drug within its licence indication, you are acting and using that drug in a recognised way and you are highly unlikely to be criticised, or open to criticism, for using the drug if you have prescribed for the correct indication. Generally it is accepted that if a doctor prescribes outside the licence indication for a drug, they should justify the reasons they do so. E There are many occasions when doctors do prescribe outside the licence indication for a drug because the licence indication of a drug is decided by what the manufacturer chooses to apply for it to be used.

In a case of guidelines, now we have a much clearer system with NICE, the principle is, if you work within the guidelines your practice is defensible and cannot be reasonably criticised, but if you choose to work outside the guidelines, you need to be able to explain and F justify, not necessarily in a defensive way, but in a clear logical way why you have chosen to treat an individual patient under your care outwith established guidelines.

I often practise medicine outside guidelines. I will give you one example. Thrombolitics, for stroke, are licensed to treat people up to the age of 80, but in our unit we often treat people over the age of 80 years, but we are very careful to indicate on the basis of which we do that.

G Q What is the importance in that regard of making notes?

A Again, medical notes are the basis on which doctors record their observations, findings from history and examination, their working diagnosis and then their treatment plan. If one is working outside of accepted guidance or licensed indications, that would be the place to record it. Obviously, the reason to record it is that doctors see very many patients, at least most doctors see many, many patients, and it would be impossible to remember what one's thinking was after the event. There are other reasons why it is important to record it, H because the medical record acts as a document which other doctors refer to and other

members of staff so they can understand the reasoning behind a particular course of action and the findings in that patient at that time.

Q We know that Dr Barton was practising not only as a clinical assistant at the hospital, going in every morning, but also acting as a GP and treating patients, presumably during her daily practice, but she was going into the hospital on an almost daily basis. Does that in any way lessen or increase the necessity to make notes about the patients that she was caring for?
A I cannot see the frequency of contact is the issue. Other doctors were still being involved in the management of patients in the care of Dr Barton and the responsible consultant. I think the other reason to make notes is for your own records. To carry around in your memory when you have a very large number of patients under your care, exactly what you did and why you did it, is very difficult. One often has the experience of looking back over a set of notes of a patient you managed six or twelve months ago and you find it is often not what your memory was. Because we are so busy and see so many patients, the medical records act as the basis of what you did. There is an aphorism that we tell our junior doctors, that if you did not write down what you did, there may be the assumption that you did not do it. It does not mean that you did not do it, but if you did not write it down, it is very difficult to remember exactly what you did do.

Q Can we turn to the *BNF*. You will find it in bundle 1. Could you take out the first file and go to tab 3, and turn to page 2. This is at the very beginning of the book. We can see at the top, it is page 12 of the internal numbering under the heading "Guidance on Prescribing" and then "Prescribing in Palliative Care". Before we go through some of the guidance that is given here, it is important to remember that this is specifically to deal with palliative care. Were all of the patients that this case is concentrating upon, palliative care patients?
A At the time they were admitted to the wards at Gosport War Memorial Hospital, many of the 12 patients were not at that stage admitted for palliative care.

Q When we read this guidance, should we bear in mind that it may not be referable to other patients?
A I think one of the issues is, as I think the Panel will be aware, that there is no strict, agreed definition of palliative care, so one has to be careful when talking about it because people can use it in different ways. Clearly doctors can palliate different symptoms but when the phrase "palliative care" is being used, it often does not mean the palliation of symptoms in people who are expected to recover or have a good life expectancy ahead of them. I think it is interesting and appropriate that the first statement in this section is about providing better treatment and support for patients with terminal illness, so I think this section would be taken by most doctors to be about guidance on the management of patients who have terminal illness.

Q Reading on from where you just stopped:

"The aim is to keep them as comfortable, alert, and free of pain as possible."

A I think everybody would agree with that.

Q Again, unless it is suggested to you that you are in some way biased against the use of opiates, biased against palliative care regimes, do you, yourself, use opiates frequently in your practice?

A I do. I frequently use them where they are required and I am often impatient when I see delays in patients receiving adequate analgesia and pain relief. Relief of pain is one of the primary and most important duties of a doctor.

Q Would you look four paragraphs down on the left-hand side of the page, the heading is "Drug Treatment".

B "The number of drugs should be as few as possible, for even the taking of medicine may be an effort. Oral medication is often satisfactory unless there is severe nausea and vomiting, dysphagia, weakness or coma..."

Dysphagia being difficulty in swallowing?
A That is correct.

C Q

" ...in which case parenteral medication may be necessary"

– meaning by injection.
A That could be injection into a vein and it might be an intramuscular injection or it could be a subcutaneous injection.

D Q

"Analgesics are always more effective in preventing the development of pain than in the relief of established pain".

We will look separately, as a topic, at the concept of anticipatory prescribing. Again, do you have objection – moral, medical or otherwise – to the concept of anticipatory prescribing?
E A Not at all. I think for the provision of mild analgesia, for example, it was common for paracetamol to be routinely prescribed on an "as required" basis to patients, so that patients could be given mild analgesia by a nurse responsible for looking after them rather than any delay in a doctor having to come to the ward to write the patient up. Indeed, there are nurse prescribing protocols in place which allow nurses to provide analgesia at the lower levels.

Q Moving on from paracetamol and the lowest level of analgesia, what about anticipatory
F prescribing with opiates? Professor, is that something you would do in your own practice or have done in your own practice, or not?
A There are two issues. There is the need to prescribe variable doses of morphine to people who require opiate analgesia. So you would put a range of morphine, for example, or another opioid analgesia to be prescribed within, usually, a not-too-wide dose range, and there is the issue of patients who are expected to require opioid analgesia where there may not be a doctor available to write the patient up for that. Clearly, in most acute hospitals, or any
G hospital with a resident doctor, this is not an issue - for example, patients undergoing surgery where the analgesia is written up in advance of them coming out of the surgery, rather than waiting until the patient has pain. The issue of anticipatory prescribing in other settings really depends on the consideration of the risks and benefits, and the problem with anticipatory prescribing for opiates, in terms of in a non-acute hospital setting, is that there would have to be expected deterioration in a patient that was going to require opiate analgesia. It would be in that context. This would typically be somebody who was already
H on moderate analgesia and you might reasonably prescribe PRN as required morphine – that

would be the standard oral drug to use – in a narrow dose range, but I think I had never come across before anticipatory prescribing of wide ranges of subcutaneously infused drugs. Even in palliative care settings, my understanding, through talking to palliative care specialists, is it is not at all standard practice for palliative care units to have anticipatory prescribing with wide ranges of opiate and sedative drugs.

Q We have heard a lot about the analgesic ladder, and we will have a look, in a moment, at the Wessex Protocol. As a basic starting point, as it were, would you expect most doctors to know about the analgesic ladder?
A I think so, in broad terms of the different levels of analgesia, and that in many patients you might go through that ladder but in some patients you would not. If somebody presents with severe chest pain due to myocardial infarction or a major fractured limb, you would immediately go and give opioid analgesia; you would not go through the analgesic ladder.

Q If somebody comes into the hospital with a broken arm you might not start with paracetamol.
A You certainly would not. That would be considered poor practice.

Q So there are circumstances where you have to take a jump in the analgesic ladder.
A Very much so.

Q In terms of moving from the oral route to subcutaneous injections in one form or another, if we look at the right-hand side of the page on page 2, towards the bottom, we can see the heading is "Parenteral Route".

> "If the patient becomes unable to swallow, the equivalent intramuscular dose of morphine is half the oral solution dose; in the case of the modified-release tablets it is half the total 24-hour dose ... Diamorphine is preferred for injection because being more soluble it can be given in a smaller volume. The equivalent intramuscular (or subcutaneous) dose of diamorphine is only about a quarter to a third of the oral dose of morphine; *subcutaneous infusion via syringe driver* can be useful".

Can we pause on that topic for a moment? We have heard a lot in this case about the shift from oral to syringe driver, and there has been differing evidence as to, ultimately, who could make that decision once the prescription had been written up. First of all, in terms of the reasons why that shift has to be made, are there a limited number of reasons?
A There a limited number of reasons and I think they are mostly laid out here. The main reason is when patients are no longer able to swallow, and at that point you have to move from the oral route of administration to a parenteral one. The usual reasons for patients not being able to swallow are they develop swallowing problems or that they become drowsy, and then one can no longer use the oral route. It does not necessarily mean that one moves to continuous infusion of the drug; one can give intermittent injections, and sometimes one will see opiate prescriptions written up for either oral or IM or subcutaneous route, to allow flexibility if a patient becomes unable to swallow. In terms of moving to the subcutaneous infusion by syringe driver, the advantages are that where you know the dose of opiate that the patient needs to receive over a set period you then avoid the need for repeated injections which can be uncomfortable in, particularly, frail herpetic older people. There are also, again, some theoretical reasons that you avoid the up and down of drug concentration that one sees with intermittent oral or subcutaneous or intramuscular injections, so you get a smoother maintenance of drug concentration in the blood. However, in older people where

A the half-life – the persistence – of opiates, like many drugs, is longer, and the fact you also have active metabolites, this is in real terms probably not a particular advantage in the vast majority of patients.

Q I want to try to avoid becoming too technical, largely for my own purposes but, partly, because I hope it is not going to be necessary. As we will see, there are specific issues that are raised in relation to prescribing opiates for the elderly.

B A Yes.

Q Are you able to give us a simple explanation of why that is so?

A If you give morphine – let us take the standard opiate drug – to young and middle-aged people it has what we call a "half-life". A half-life is relatively straightforward to understand by most people. You give a drug, it is absorbed, you get a peak concentration and the half-life is the time that it takes for the drug concentration to fall to half of its value.

C

Q And then half again.

A And then half again. So by about four half-lives the drug has, essentially, disappeared. For morphine it has got an active metabolite, so the half-life is two hours but the morphine-6-glucuronide, the metabolite that is made by the liver, lasts slightly longer. You get an analgesic effect lasting for about four hours, and then the drug has gone down and you need to give another dose. An important principle is that when you give repeated doses of a drug it

D is about five half-lives before you achieve the steady state. You get accumulation as you give repeated doses of morphine or other drugs. So, in the elderly, the elimination of morphine and its metabolites is less rapid, and that is mainly through the kidney, so the half-life is longer at about three or four hours. So you get more persisting effects and you either need to give a lower dose every four hours or you give the same dose more infrequently. But, in general, we give a lower dose at the same frequency.

E Q Are you saying that, first of all, the effects of the opiate last longer?

A Correct.

Q For any given dose. Are you saying that its potency is greater?

A In general terms, for any given blood level there is some evidence that the elderly may be more sensitive, but it is mostly because they eliminate it less quickly. One point I would like to emphasise is you see large variability in the response to opiates within people and so this is

F why it is necessary to adjust the dose when you first give people opiates so you get to the right level which maximises pain relief and minimises adverse effects. That variability is greater in older people. So, in a sense, you need to monitor more carefully the dose you are going to use in older people.

Q Can we stay on that topic for a moment, and can you give the Panel some assistance as to how, with appropriate and proper prescribing, you are meant to reach that level of analgesia

G so that the patient is no longer in pain but, hopefully, still awake or at least rousable? How do you find the level?

A Typically, you have got a patient who is in pain, you are moving to use opiates, you would give initial dose and that might be, say, 5mg of morphine. Usually, the prescription would say something like: "2.5 to 5" or "2.5 to 10 mg of morphine", and the nursing staff would observe the response to that first dose and if the patient was not pain-free at two hours they would give another amount of the same dose, and then they would observe the response

H two hours later and then probably give double the initial dose that was given. So you just

titrate up gradually and usually you wait at least an hour after one dose, and often two hours, to see whether you have got an adequate response. If you have got somebody in very severe pain that you have to relieve immediately, you would prefer to give the drug intravenously, for example, and that would be in the context of acute myocardial infarction, and you would titrate in small incremental 1mg doses after your initial dose to observe them until they achieve pain relief. If at any point you start to see major adverse effects (the main concern is the development of respiratory depression - there are many other adverse effects) you would have to stop and sometimes if patients are inadvertently given too much opiate drug you would have to give the antidote Naloxone which will reverse the effect. But that is usually not necessary in the context of usual therapeutic dosing of opiates.

Q In dealing with the incremental nature of the increase, in dealing, first of all, with oral opiates, is there any distinction between oral opiates and opiates given via the parenteral route about the incremental increase?
A No, the same principles apply. When you give the drug through the parenteral route – really, through the intravenous route – you get more rapid absorption into the blood. It is immediate in the case of intravenous administration; it is slightly quicker with subcutaneous and intramuscular administration – it is quicker through those routes than it is with oral administration.

Q Can I just ask you about that? At the bottom of the page we see:

> "The equivalent intramuscular (or subcutaneous) dose of diamorphine is only about a quarter to a third of the oral dose of morphine."

Again, looking at it in my very non-medical way, is that because diamorphine is a stronger drug, or is it because it acts more effectively when given subcutaneously?
A No, diamorphine is converted to morphine. It is what we call a pro-drug. The reason is that when you give morphine and diamorphine through the parenteral route you do not get the effect of the liver metabolising a lot of it when it is absorbed, and you also do not absorb all of the drug from the gastrointestinal tract. So the usual, the literature suggests, conversion is a third – up to three.

Q If we go over the page, I am afraid we are going to spend a little bit of time on *BNF*, but it may make our task later, when we are looking at the individual patients, rather quicker. We can see that it deals with transdermal opiate, particularly fentanyl. How does a fentanyl patch compare to either the oral route or the parenteral route?
A It is really very similar to the subcutaneous route. In the case of the fentanyl patch the drug penetrates through the skin and is absorbed through the delivery system in that patch, whereas in the subcutaneous route you are putting it under the skin with a needle. One thing to say about the sustained release preparations and the patches, similar to when you move someone to a continuous infusion at a set rate, is these are appropriate strategies when you know the amount of opiate that a patient needs. So you switch people to sustained release morphine tablets when you dose them initially with ordinary morphine and then you have worked out what their 24-hour requirement is. The problem if you go to using, let us say, sustained release morphine straightaway is you just do not know if you have got the right dose, and the problem with that is you cannot see the effect until after 12 hours, so you cannot increase it until quite sometime after the dose has been given. So you run the risk of either leaving the patient in pain or of them getting unacceptable toxicity. So the patch is similar; if you do not know the dose you are not going to know until it has been on for some

time and has been absorbed, and fentanyl has a longer half-life than morphine, you are not going to be clear till about 12 hours whether you are at the right dose, because that is how long it will take for the drug to accumulate. When you are using patches you have to be aware that the final effect will be fairly delayed with a fentanyl patch, and you need to have some idea of whether that dose is going to be right or you may get toxicity. There were reports when the patches first came out of respiratory depression because they were a quite high dose of equivalent opiates.

Q When did these patches first come out? Do you remember?
A I cannot remember when they first came out. I would have to look that up, but they came out, I think it was, in the early 1990s, if I remember correctly. I would have to look that up. The dose used as shown in the *BNF*, the 15 microgram patch dose is quite a large dose of morphine. It is the equivalent of up to ---

Q If we look at it, it says it is the equivalent to a total dose of up to 135 mg for 24 hours, but that presumably means a total dose taken orally?
A Yes, that is correct. If somebody was controlled on, say, 90 or 100 mg or more, that would be appropriate, but if somebody only needed 40 mg of morphine to control them over a 24-hour period, that would be quite a large dose of opiate equivalent to give them through a fentanyl patch. This issue was eventually recognised in that there is now a 12.5 microgram patch to give a lower dose of equivalent opiates and that, in my understanding, was not available in the 1990s.

Q Can we just seek your assistance, please, of the rapidity of effect of these various routes. You have described how an oral dose would have to be metabolised by the body. It presumably would go through the stomach and would lose some of its effect by the nature of that metabolising process. How long does it take for Oramorph to have an effect ---?
A It takes --- Sorry.

Q --- on an average patient. Not dealing with an elderly patient but just on an average patient?
A The absorption does not differ substantially between younger and older people for most drugs, morphine included, so you have relatively rapid absorption and you have a peak between 30 to 60 minutes. It is not instant but it is relatively quick.

Q If the same drug, diamorphine, say, is injected directly into the body what is the rapidity of the effect of that?
A Intravenously it is essentially immediate. Intramuscularly and subcutaneously it is in between immediate and the oral route, so 15 to 30 minutes. That is to reach a peak. You may get effects, of course, before that at a lower concentration.

Q Let us turn to the issue in this field of the use of syringe drivers. Now a syringe driver is a piece of machinery, effectively. It is a syringe connected to an electrically driven screw, which gradually delivers a dose. We will have a look at one in a moment. First, have you used syringe drivers in your own practice?
A Yes, I have.

Q In terms of the delivery of the opiate, does that differ in any particular way from an immediate injection subcutaneously?

A A When you are giving it, or more constantly and continuously as defined, because, let us say, instead of giving 5 mg four-hourly, say, with repeated injections you give 5 mg immediately it is absorbed, and in four hours and 5 mg again it is absorbed, you are giving it much more gradually – the same dose – over a 24-hour period. If we were switching directly, you would give 30 mg in that syringe over 24 hours. So if you were to start somebody who was not already on opiates, it would be quite a time before you had enough drug on board, so you would not, if somebody was just starting opiates, start with a continuous infusion, you
B would give what we would call a loading dose to make sure they had some immediate analgesia.

Q That is a bolus dose?
A Yes. It is not necessarily giving an injection under the skin, a subcutaneous injection, or usually more usually what is happening when syringe pumps are being used, patients have been receiving opiates, either orally or by repeated injection, so you know how much they
C need and you convert to the appropriate amount to be given through the pump.

Q So once you have found your level, in other words?
A Yes.

Q We have a syringe driver here. I wonder if the witness could be given that. (Handed to the witness) I suspect that in terms of actually setting one of these up and inserting it into
D a patient, is that something you would do yourself or leave to your nurses to do?
A Not generally. I have set up syringe pumps with a nurse, usually in the context of delivering thrombolitics for acute stroke where we need to do things very quickly, but I would not have set up a syringe pump to deliver opiates for palliation. that is a nursing task and they have specific training which doctors generally do not. So no, I am not specifically trained or would claim expertise in the practical use of a specific ---

E Q Have you prescribed though?
A Oh yes. Like any doctor, I certainly prescribed it.

Q Can you just hold it up. I am going to ask for it to go round the Panel. Some of the Panel may have seen these before, some may not. We have a syringe in a clear perspex tube at the top, underneath which, I think, it has a little bit of machinery which contains a battery and literally there is a screw, I think, which is attached to the plunger of the syringe.
F A Yes. There is a circular screw which turns around and then that pushes along this piece of plastic here (indicating), which then presses the plunger down the syringe.

Q The end of the syringe, what we would regard as the sharp end of the syringe, would normally be connected to what?
A It is actually blunt, but it is a locking end where you put on, usually, an infusion tube or a butterfly needle, but it would lock on to a thin tube which would then go to a needle
G which would be placed in the patient's skin subcutaneously, typically on the abdominal wall or in the thigh.

Q We have heard a bit about butterfly needles.
A Yes.

Q Is there one of those in the box?
H

A There is. It is called a butterfly because the way you hold it to insert it under the skin with a bit of imagination can be seen to look like a butterfly. The orange end here screws into the end of this syringe so you have a system where then the drug in the syringe is injected slowly under the skin through the needle. The same system can be used for intravenous administration. Subcutaneous administration is used because it is easier to maintain and generally more comfortable than having to have intravenous cannulas which generally require medical attention to be replaced.

Q In terms of prescription, first of all you would need to prescribe the drug that is going to go into the syringe driver or the drugs that are going to go into the syringe driver?
A You would.

Q Would you also have to specific that the route is to be by a syringe driver, or is that not necessary?
A You would usually say "continuous infusion" or "via syringe driver," and it would say the amount of drug, usually over a 24-hour period. That would be the standard way of prescribing drugs by continuous subcutaneous infusion.

MR KARK: I wonder if it would be a convenient moment for the Panel to look at what you have been hearing about for the past month. Perhaps we can exhibit this. That would be C15, I think.

THE CHAIRMAN: That is quite right. C15 was earlier withdrawn. We will exhibit the syringe driver as C15, please.

MR KARK: This is a working version. It has a battery with it. If anybody later wants to play with it, as it were, and see it working, then the battery can be inserted. May I just sit down while that goes round? (C15 handed to members of the Panel to inspect) The whole thing should obviously be kept together, together with the leaflet.

THE CHAIRMAN: I think, Mr Kark, a member of the Panel has asked if it is possible to have at a later stage individual photocopies of the booklet?

MR KARK: Yes, certainly. (To the witness) Moving on through the *BNF*, we are going to come, I think, to another drug that we have heard about in this case. If we look at the top of page 3, and look on the right. This is under a heading "Miscellaneous Conditions", and then to the right we see:

> "Excessive Respiratory Secretion. Excessive respiratory excretion (death rattle) may be reduced by subcutaneous injection of hyoscine hydrobromide 400-600 micrograms every 4 to 8 hours; care must however be taken to avoid the discomfort of dry mouth. For the dose by subcutaneous infusion using a syringe driver, see next page."

We have seen hyoscine prescribed, I think in all, but certainly in almost all of the cases that we have been looking at. It is a perfectly acceptable drug to use, presumably for the purposes for which it was used?
A For end of life care where patients are having unpleasant secretions because they cannot swallow, it is a highly appropriate drug to use. It blocks secretions which, of course, is why it can produce a dry mouth but in general end of life dry mouth is not a problem because these patients are near death and often not very alert.

Q Again, I was going to deal with it later on, but perhaps we can deal with the issue of hydration now. Again in this case, we have heard a lot about the issue of hydration. We have heard some nurses who thought that there was subcutaneous hydration available on the wards at GWMH. Others who did not, but can we just deal with the issue generally, firstly dealing with end of life patients?

A The issue of whether to hydrate patients at the end of life is contentious. There is a lack of good evidence to know whether it improves how people feel or whether it makes things worse. I think generally it is considered quite reasonable to provide it or not provide it. We tend to make that decision looking in a broader social cultural view, whether there are strong views expressed by families about hydration. The reason to provide hydration, the arguments go, is that it maintains skin perfusion a bit better and that patients will not feel thirsty if they are awake, but observation suggests that most patients near the end of life, if they are alert, do not complain of thirst even if they have not received fluids. Reasons not to give it are that it is an intervention and it may worsen secretions. So there are arguments both for and against giving hydration. In an individual patient you have to look at what the appropriateness of giving hydration is. But in end of life care there is no strict rule that you should or you should not give hydration.

Q Let us deal with that other category of patients, who may find themselves on a syringe driver, but they are not at the end of their life. They are being treated, cared for, but their symptoms require a syringe driver to control their pain?

A If somebody is not at the end of life, they need hydration because if not they will develop complications from dehydration. Whilst it would be reasonable to wait a day or so, if somebody is not at the end of life it would generally be considered necessary and appropriate to provide hydration. One of the difficulties with hospitals like Gosport War Memorial Hospital and the Walkergate Hospital I worked in is intravenous hydration becomes difficult because doctors are not on hand to immediately put up a drip. In that context those patients, let us say they have a reversible, treatable condition like pneumonia and they are dehydrated and they are not swallowing because they are delirious, you either have to transfer the patient back to the acute hospital to provide it or an alternative, which many units developed and I introduced a protocol in the Walkergate Hospital was to give subcutaneous fluids. You can give a litre or two litres a day. You cannot give more than that, so it is not appropriate if somebody needs a lot of fluid replacement. You can give it again subcutaneously and you administer it under the skin. Typically the fluid would create a bulge and it would be slowly absorbed. You move the needle every 12 hours. This has been shown in most patients to be a reasonable way of providing hydration for a relatively short period of some days.

Q Does that cause the patient any discomfort?

A There is the needle, the small butterfly needle, but most people here will be familiar with having a butterfly needle. It is a sharp stab, but it is not particularly unpleasant.

Q And the bulge you spoke of?

A Patients do not tend to complain. The problem is the fluid. It is absorbed. The problem you can get is local site infection, so you can get – as you can indeed with, of course, a needle into the vein – cellulitis, infection of the needle site.

Q If you put somebody onto a syringe driver and they are no longer swallowing, and you do not provide them with hydration, in your view is that necessarily an end of life procedure and what is going to happen to the patient's body?
A If they are going to remain unable to swallow, I do not think the issue is about syringe drivers. It is they cannot swallow. You have to hydrate somebody and there are various ways to do that. You can put a tube into the stomach, but that is uncomfortable. You can do intravenous or you can do subcutaneous, but if you do not they will become dehydrated and will develop complications of dehydration which are quite substantial and ultimately they will die. That is acceptable where patients are at the end of life. If you think they are swallowing properly, that this is just temporary and they will be swallowing with in 24 to 48 hours, it would be reasonable not to immediately provided fluids, but beyond that one has to make a decision about what you are doing to continue to hydrate this patient if they are not an end of life pathway.

Q And if you are going to hydrate a patient, whether it is by an intravenous method or a subcutaneous method, would that require a doctor's orders or is that something that nurses can do off their own bat?
A I would say it would always require a prescription by a doctor.

Q Why?
A Because fluids can cause problems. You have to get the right sort of fluid. You also have to monitor the salts in the blood every couple of days to check the blood sodium is not too high or to low. It is not equivalent to a nurse offering a patient who can swallow fluids a drink, it is a medical intervention.

Q Would the fluid have to be prescribed by a doctor?
A Yes.

Q As a matter of fact, I do not think we have seen any such fluid prescriptions in the any of the cases that have been dealing with for those on syringe drivers, so unless prescriptions have been lost, can we take it that none of these patients were hydrated once they were put on a syringe driver?
A No, and if these patients were ---

MR LANGDALE: It is not being suggested by the defence that anything ... (microphone off -- inaudible).

THE CHAIRMAN: Thank you, Mr Langdale, that is very helpful.

MR KARK: Can we move on, I think that is accepted by the defence. We can see on the right-hand side of the page, there is a heading "Restlessness and Confusion:

> "Restlessness and confusion may require treatment with haloperidol 1-3mg by mouth every 8 hours. Chlorpromazine 25-50mg by mouth every 8 hours is an alternative but causes more sedation."

Is it methotrimeprazine?
A Methotrimeprazine.

Q "... is also used occasionally for restlessness."

If we look over the page, staying with that topic, on page 4 looking at the right-hand side of the page, this is under the general heading "Syringe Drivers", which we see on the left:

"Restlessness and Confusion.

Haloperidol has little sedative effect; it is given in a subcutaneous infusion dose of 5-30mg/24 hours."

Then below that we see:

"Midazolam is a sedative and an antiepileptic, and is therefore suitable for a very restless patient. It is given in a subcutaneous infusion dose of 20-100mg/24 hours."

Then underneath the next heading, which is "Convulsions", we see "Pain Control". Before we move on to pain control, restlessness and confusion, have you in your clinical practice dealt with restless and confused patients, elderly patients?

A I think any geriatrician will be familiar with a very large number of acutely confused and chronically confused number of the people we see. Confusion is very much a main part of the care of acutely ill older people and people with cognitive impairment dementia who often have episodes of confusion. The management of confusion in a non end of life setting is something geriatricians deal with all the time. One also sees confusion and restlessness – there is an overlap between the two – in the end of life setting where restlessness is common. I think one of the issues with managing confusion and restlessness in any patient, be they at the end of life or not at the end of life, is looking for what the likely cause is and if there is a treatable cause for that. Typical things one would see are, in a newly acutely confused patient, we look very hard for evidence of infection because you need to treat the infection and not just give a treatment to control confusion. Other problems that can cause confusion are urinary retention, in which case the treatment is to put a catheter in and relieve that.

Q Is that urinary retention?

A Urinary retention where the bladder is distended, constipation. There are very many causes of confusion so it requires a careful assessment of the patient. One of the other key issues in the management of older patients, again both in a usual setting and end of life setting, is whether the confusion or restlessness could be due to any medication that the patient is taking, so you have to also look at that. This is particularly important in the case of patients on opiate drugs, older patients, because one of the major metabolites for morphine is what we call neuroexcitatory. It will produce agitation and confusion, so you always have to look whether opiates are a cause of confusion in older people if that is what they are taking. They may not be, but they may be, so that is an important point to consider.

Q This is an important point, and I think Dr Payne raised this with Dr Reid last week, which is the question of the potential side effects of opiates and the point about whether more opiates cause more side effects. What do you have to say about that?

A The first thing I say is that opiates are not a treatment for restlessness or confusion. The *BNF* says that, the Wessex Protocols will no doubt clearly state that. Opiates are a treatment for pain and may help restlessness where it is the context of pain. They are not a treatment for confusion per se. If you have a patient who has opiate induced confusion or

A restlessness, clearly if you give them more opiate that is not going to help the problem, it is, if anything, going to exacerbate it. That is why it is important to recognise that is a potential cause.

Q You may have a patient who is both confused and in pain?
A That is true and often the case.

B Q Presumably, in those circumstances, there is no problem about treating the pain with opiates?
A The first strategy would be to treat the pain, control the pain, and then see if the patient was still confused because we are all familiar with the fact that, if we are in pain, most of us are restless and can indeed get confused if it is severe. If after the relief of pain or reasonable treatment with an opiate there was still persisting confusion or agitation, one would use treatments to treat that as well. One of the difficulties and where it is a challenge
C in looking after older people is working out the relationship between is it the pain that is making them confused or is it something else? It does take careful assessment and you have review whether what you are doing is having the desired effects and be prepared to change the approach and strategy if the treatments you give are not working, or are producing intolerable side effects.

Q What are the strategies, if any, for trying to identify what it is that is causing a patient
D pain. If you have a patient – a confused, demented patient – presumably they may on occasion not be able to tell you very clearly what it is that is causing their pain?
A Of course. This is why it is much more difficult to care for older people who cannot communicate if they are feeling pain, also true for other patient groups with communication difficulties. This is why, if the patient cannot say, "I have pain in my arm" or "I have pain in my abdomen", you need to conduct a careful examination of the patient to see if there is anything on examination. You might find they have a distended bladder, you might find they
E are constipated, you might find their leg is twisted and they may have sustained a hip fracture. There are many things one might find. The first thing is to do an assessment of the patient to see if there is a clue on examining them as to the cause of their pain.

Q Taking your example of the distended bladder by way of example, if that assessment, if that careful examination has not taken place and you simply increase the opiates, what effect is that going to have on the patient?
F A Since the opiates may well have produced the urinary retention, it is unlikely to have reduced their discomfort. It may temporarily, but it is not dealing with the underlying cause of the pain.

Q You are going to have a confused patient in pain with a lot of opiates?
A Who may become more sedated and drowsy from the increased opiate dose.

G Q Can we go to page 4. It is the same topic, but right at the bottom you can see the heading for pain control:

> "Diamorphine is the preferred opioid since its high solubility permits a large dose to be given in a small volume. The table on the next page gives the approximate doses of morphine by mouth (as oral solution or standard tablets or as modified release tablets)."

H

That would be the same as MSTs that we have been looking at, would it?
A Yes.

Q Slow release tablets?
A Yes.

Q
"... equivalent to diamorphine by injection."

Over the page we can see there is a table. It needs quite careful looking at because it is easy to get confused. If we look at the table under the heading "Oral Morphine" and concentrate on the far left column, that is dealing with morphine sulphate oral solution or tablets given every four hours, so if we want to establish what the total dose is over a 24-hour period, do we have to multiply each of those doses by six?
A We do.

Q Starting on the left-hand side of the page, not trusting my maths I did this over the weekend so that I did not get it wrong in front of the Panel and Mr Jenkins, but if we look at the left-hand side of the page, running down, the first entry is 5 mg, and we need to convert that over a 24-hour period to 30 mgs.
A Yes.

Q It may be important to perform this exercise for the first few because I think we will see a pattern. If we look to the far right-hand side of the page, we see the entry for diamorphine hydrochloride by subcutaneous infusion. That column is for a period of 24 hours, and we see – and please tell me if I am getting this wrong – that the conversion from 30 mgs oral dose is therefore halved to 15 mgs?
A That is correct, of those doses.

Q If we look at the next dose down, which, on the far left-hand side is 10 mg but we need to convert that to 60 mgs, then we go to the far right-hand side, we can see that when you convert that to subcutaneous infusion, that reduces down to 20 mgs, that is one third of the dose?
A Yes.

Q If we were to perform that exercise for all the others I think we would find, and we can do it by way of example, 15 mgs converts to 90 mgs over a 24-hour period orally, and on the far right-hand side of the page which, by subcutaneous route, would be 30 mgs so it would be a third. I am not going to perform the exercise, unless anyone wants me to, but if we go all the way down those two columns, after the very first dose, after the very lowest dose, I think we can see that the conversion rate is one third each time?
A Yes, approximately.

Q That is in order to provide the equivalent dose to the patient. This is the patient for whom you have identified the appropriate level of pain control by oral solution and then you want to convert it subcutaneous?
A It is, but I would have to emphasise that it is a starting point and the statement at the top of that table, these equivalences, are approximate only and they need to be adjusted according to response, so it would vary for the individual patient.

Q It has been underlined with a number of witnesses, and I expect you will agree with this entirely, it is extremely important to look at the state of the patient in front of you when deciding the particular dose?
A Clearly it is important that you are looking at the patient. I think there are two issues. I would say if you have a patient who is adequately controlled without adverse effects, you should switch to the one-third dose. There is a starting point and you may then need to adjust it. It may not, for that particular patient, work out exactly right. If you have somebody who is still in pain, and you are converting them, clearly you would need to increase it. If you have someone who is overly sedated or confused, you would need to reduce it, so it entirely depends on the patient. Very importantly, once you have made the change, you then need to monitor how the patient responds to that change from the oral or other route to a continuous infusion.

MR KARK: I am going to move on to the topic of prescribing for the elderly. Although we do not seem to have got very far, we have been going for an hour and perhaps it would be a convenient time to take a break.

THE CHAIRMAN: Yes, I think it would. Professor, I think you know the routine. You are on oath, you remain on oath, please do not talk to anyone about the case or allow them to talk to you, other than in so far as has already been agreed. I will not give you that warning again. I will also say this for the first and only time, you should be taken to somewhere where you will be given some refreshment. Please avail yourself of that. We will all return at five to twelve.

MR KARK: Can I raise that issue of where Professor Ford should go. There have been problems so far because I am afraid that we, as a team, have taken one of the rooms which is normally used for witnesses. It is just because of the amount of documentation we have that we needed the room. It has meant in the past that witnesses have gone out to reception where they have been, effectively, surrounded by interested parties and relatives. If Professor could be taken through to the canteen, which is completely separate area. It is only a suggestion, I just hope there is some place he could go.

MR LANGDALE: Whatever is sensible.

THE CHAIRMAN: Thank you Mr Langdale.

MR KARK: Unless there is another room available.

THE CHAIRMAN: I am told there is a room available on the first floor. In terms of timing, does that mean that the Professor will need longer to get there and get back? We are nearly at twenty to twelve now anyway, so we will say we will return for 12 o'clock and see, Professor, whether that gives you adequate time once you have got there to get some refreshment or if you are being rushed back. If you are, we will adjust the dose, as it were. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Doctor, was that break sufficient for you to get to where you had to get to, get some refreshment and get back comfortably, or not?
A Yes, I was very well looked after, thank you.

THE CHAIRMAN: We will try to keep to 20-minute breaks from now on.

MR KARK: Can I just mention that I have been ticked off because I got the exhibit numbers wrong.

THE CHAIRMAN: It was not just you, Mr Kark, we share equal responsibility. I think the real cause was that the wrong document was facing up at the time.

MR KARK: I, also, was looking at the wrong notebook, but I think our C13 should be 14, and C14 should be 15 and C15 should be 16. So the syringe driver is C16.

THE CHAIRMAN: We will move everything forward one.

MR KARK: Professor, I want to move on, please, still staying with the *BNF*, to page 6. We will find the heading here: "Prescribing for the elderly". I ought to have pointed out at the very beginning of your evidence that the *BNF* that we are referring to is September 1997. I think a new *BNF* is produced every year.
A Or even more frequently, I believe, yes.

Q We have also got 1998 and 1999, but for these purposes I am concentrating on this particular *BNF*. I think, in general terms, the sort of areas that we are looking at, at the moment, do not change hugely between the different editions.
A I think that is true. There was one drug, thioridazine, which was used quite extensively in the management of older people, which has been withdrawn from the market, but otherwise I do not think there have been any major changes in the information or guidance about the drugs under discussion.

Q When was thioridazine taken off the market, approximately? Do you know?
A It was after a colleague of mine did the research showing its toxicity, so this was early - about five or six years.

Q But post these events.
A Post all these events, yes. It was a common drug to use at the time we are discussing.

Q Could we have a look, please, at page 6. I am not going to spend a huge amount of time on this; the Panel have already looked at this on occasion. It is headed "Prescribing for the Elderly". Under the subheading "Polypharmacy":

> "Elderly patients are apt to receive multiple drugs for their multiple diseases. This greatly increases the risk of drug interactions as well as other adverse reactions."

It also deals with the symptoms, which may be relevant in this case, particularly, of sleeplessness, "... which may be associated with social stress, as in widowhood, loneliness and family dispersal." Then, if we go to three-quarters of the way down the page, we have "Susceptibility".

> "The ageing nervous system shows increased susceptibility to many commonly used drugs, such as opioid analgesics, benzodiazepines, and antiparkinsonian drugs, all of which must be used with caution."

Then, on the right-hand side of the page, we see: "Adverse Reactions".

> "Adverse reactions often present in the elderly in a vague and non-specific fashion. *Mental confusion* is often the presenting symptom (caused by almost any of the commonly used drugs)."

Then it deals with other common manifestations. Then "Hypnotics":

> "Many hypnotics with long half-lives have serious hangover effects of drowsiness, unsteady gait and even slurred speech and confusion."

When we talk about hypnotics, is diamorphine a hypnotic or not?
A No, it is not.

Q It is a pure analgesic?
A It has sedative effects but it is not a hypnotic.

Q Have we come across hypnotics in this case – temazepam?
A Yes. Usually, although not exclusively, hypnotics are benzodiazepines, but there are related drugs as well, similar in effect.

Q Of the drugs that we are dealing with in this case, first of all, temazepam, is that a hypnotic?
A It is.

Q Midazolam?
A Midazolam can be used in a number of different settings. It is often used in anaesthesia and sedation on intensive care units. It is not so commonly used as a benzodiazepine for hypnotic use; in fact, I would say it is very uncommonly used for that. As is shown in some of the guidelines, it has been used for terminal restlessness in palliative care.

Q Coming back to that issue, you were dealing with agitation and restlessness earlier. So far as diamorphine is concerned, although it may have the effect, because it is a sedative, of calming a restless patient, is it, in fact, what is called a first line drug for use of agitation or restlessness?
A It is a first line drug for the management of patients who are in pain, and restless due to the pain. It is very commonly used as part of the management of seriously ill patients in an intensive care setting, but in the context of older people who are agitated, opiates would be very far away from your first choice of treatment, so it is not indicated for that.

Q Unless the agitation is the result of pain?
A Severe pain.

Q So the concept being you deal with the severe pain and that should, hopefully, remove the agitation.
A Most agitation in older people is not related to pain; it is related to dementia and other problems; it is not exclusively a problem due to pain.

Q Can I ask you about dementia. That may cause confusion and, presumably, agitation and restlessness.
A You can get confusion in older people and it is more common to get acute confusional states in people with dementia and chronic cognitive impairment.

Q The link between, for instance, Alzheimer's and dementia. Again, can you give us a simple picture?
A I am sorry, Alzheimer's is a form of dementia. Dementia is cognitive impairment in a number of areas leading to, eventually, problems with self-care and functioning.

Q When we see that patients are commented upon as having elements of dementia or "being demented", etc., do demented patients – "patients suffering from dementia", perhaps, is a kinder way to put it – have good days and bad days, or is dementia of a level that continues throughout the rest of the patient's life?
A Dementia is usually progressive – not always – so usually patients get worse over time. Most people are familiar with that. Fluctuation is common – it is not always the case but it does happen - and behavioural disturbances, common in people with dementia, are a major concern for their carers.

Q Coming back to my question: do they have good days and bad days?
A I am sorry; I thought I had covered that with saying they fluctuate. Yes, I am sorry.

Q Can we turn to page 7, please? We see a heading: "Guidelines". This is all under the main heading of "Prescribing for the Elderly".

> "First always question whether a drug is indicated at all. Limit range: It is a sensible policy to prescribe from a limited range of drugs and to be thoroughly familiar with their effects in the elderly."
>
> "Reduce dose. Dosage should generally be substantially lower than for younger patients, and it is common to start with about 50% of the adult dose. Some drugs (e.g. chlorpropamide) should be avoided altogether."

First of all, does this passage relate to diamorphine and opiates as well as to other drugs?
A It certainly relates to opiates because, as we have discussed, the elderly are, in general, more sensitive and show a wider range, also, in their response. So, yes, it would.

Q The concept that one should start with about 50% of the adult dose – how widely known should that be?
A I think that was generally fairly widely known. It is a broad principle. One has to look at the individual patient as to whether that is appropriate to apply, but the other aphorism which is often described is "start low and go slow". Now, that is fine for many chronic conditions in older people, but, clearly, it does not always apply; if you have got somebody in severe pain you may have to go fast, if necessary, in terms of adjusting your drug dose to relieve their pain. The principle of recognising that older people are sensitive to many drugs and, therefore, you should use a reduced dose, I think, is a fairly well-known principle, and 50% is a broad rule of thumb that people have, generally, applied.

Q If we look to the right-hand side of the page we can see:

A

> "Review repeat prescriptions regularly. It may be possible to stop the drug ... or it may be necessary to reduce the dose to match diminishing renal function."

Is the concept of reviewing your prescriptions regularly one that is relatively well-known in your field?
A Yes. I think, in a way, reviewing the response of patients to their drug treatment is absolutely key, and it becomes even more important in older people with multiple problems,
B who may have subtle side effects. It is one thing to recognise an adverse problem from a drug in a fit, young or middle-aged person who is being treated for one condition, and they will tell you: "I have a problem", from managing older people who have multiple problems and may have communication difficulties. So a higher level of care and monitoring is needed, and it is why looking after older people is much more challenging and difficult than, frankly, looking after most younger patients.

C Q Sometimes they cannot tell you what their problem is?
A And there are multiple issues and problems going on.

Q Speaking of which, we move to the next paragraph: "Simplify regimens".

> "Elderly patients cannot normally cope with more than three different drugs and, ideally, these should not be given more than twice daily."

D

Is this relevant to the use of opiates?
A I do not think it is relevant to this setting – a hospital inpatient setting with very unwell, frail patients - and I think it would be disputed now, but it was in the context of an outpatient setting where patients were in the community.

Q Can we turn on to page 8, where the *BNF* deals specifically with opioid analgesics?
E I want to ask you about the issue that is raised in the first paragraph, which is that of "Dependence and tolerance". The authors of the *BNF* write on:

> "... but this is no deterrent in the control of pain in terminal illness."

Can you help us about tolerance to opiates? How quickly is it built up?
A Tolerance, just to explain, is the phenomenon where an individual has less response to a
F given dose or blood level of drug over time, so you need to increase it to get the same effect. Tolerance occurs over days and weeks; typically, in patients with chronic malignant pain, the dose will need to be increased over a period of weeks and months. It does not occur over a few hours; you are talking somewhat longer than that.

Q It then deals with side-effects:

G

> "Opioid analgesics share many side-effects though qualitative and quantitative differences exist. The most common include nausea, vomiting, constipation and drowsiness. Larger doses produce respiratory depression and hypotension."

We are going to look, obviously, at the individual patients, but are those side-effects which, in your view, we see in this case?

H

A Yes. I think the one not mentioned there is confusion and agitation. There are other side-effects as well, but nausea, vomiting, constipation and drowsiness, and the major concern, in terms of severity, respiratory depression, are the key adverse effects of treatment.

Q Hypotension, meaning low blood pressure.
A Correct. But it is generally the respiratory depression which is the more serious adverse effect that one is concerned about, particularly with early dosing. You do get tolerance to respiratory depression as well over time, which is why patients who are taking opiates with malignant disease, for example, for a long time, are at doses that if you gave that dose initially would produce respiratory depression. They do not get that because they have become tolerant to it.

Q When we talk about respiratory depression, obviously, the doctor on the Panel will know what that means, but are we talking about shallow breathing or a very slow rate of breathing, or both?
A Both, but the main thing is the rate of breathing is suppressed, so you get a suppression in the number of breaths a minute – which, typically, will be, say, 16 to 20 – and, ultimately, you can get complete respiratory arrest. When deaths occur in drug users who use drugs illicitly, abuse heroin illicitly, that is the common mode of death.

Q If you are causing respiratory depression in a patient, does that have other effects on the system? Does it lead to hypoxia and problems with the skin, the blood, etc? What does it lead to?
A The main concern is it leads to death.

Q Apart from death.
A You can get a progressive failure or it can be very sudden respiratory depression that occurs.

Q When prescribing and administering opiates, is that something that the medical personnel ought specifically to look out for?
A When you are initially giving opiates or you are making a change in the opiate dose, or you are giving it with other drugs, such as benzodiazepines, that can suppress respiration, it is important to be aware of that as an adverse effect. It would depend on the context, of course. If you are doing this for an elective operation and you are giving opiates, there has to be absolutely close, constant monitoring of respiration. If you are doing it at the end of life, it is less of an issue because the patient is at the end of their life and as long as you are giving an appropriate dose to relieve their symptoms, one is less concerned about the issue of respiratory depression; one accepts that may be a necessary consequence at the end of life for adequate symptom relief.

Q If we look below we see:

> "Morphine remains the most valuable opioid analgesic for severe pain although it frequently causes nausea and vomiting. It is the standard against which other opioid analgesics are compared. In addition to relief of pain, morphine also confers a state of euphoria and mental detachment."

We have heard that being suggested to witnesses. That is your experience?

A A It certainly can do, but it does not occur in everybody. It can actually produce, in older people, confusion and agitation. But it is certainly well-known that there is a sense of mental detachment from the pain. People will say: "I can feel the pain but it doesn't bother me".

Q If we look to the right-hand side of the page, the *BNF* deals specifically with diamorphine.

B "Diamorphine (heroin) is a powerful opioid analgesic. It may cause less nausea and hypotension than morphine."

Pausing there, again, diamorphine is morphine based.
A Essentially, you are achieving the same effect because it is converted to morphine but it is a better preparation to give, if you are giving it subcutaneously.

C Q "In palliative care the greater solubility of diamorphine allows effective doses to be injected in smaller volumes and this is important in the emaciated patient."

Would that be your experience? Obviously dealing with elderly patients do you quite often get elderly patients who are emaciated?
A Yes. You want to minimise – I do not think it is a big issue. It is the preferred drug, D so that is what we use. It is easier to prepare. It is a lesser volume to infuse. I think the volume issue is not in reality a big issue because, as we were talking about with hydrating with subcutaneous fluids, we are giving a litre there, and here we are talking about differences of much less than that. The fact is ---

Q But --- Sorry, go on.
A It is just the standard that is used, and it appropriately so.

E Q Can we turn to page 9 and there is very little I want to ask you about this. Under the heading "Morphine Salts", first of all what is a morphine salt? Are we dealing with morphine salts in this case?
A We talk about morphine, but most drugs come with another molecule attached and that is the salt, but we do not describe exactly which salt it is. I think if you look at the *BNF* now, it would not talk about morphine salts; it would just talk about morphine.

F Q If we look at "Cautions" apart, apparently, from causing hypertension, hypothyroidism, decreased respiratory reserve, then we see:

"... may precipitate coma in hepatic impairment..."

Does hepatic impairment mean ---
G A Meaning usually cirrhosis or other liver disease, but usually cirrhosis.

Q It says:

"(reduce dose or avoid but many such patients tolerate morphine well): reduce dose or avoid in renal impairment...".

H I think we will come back to that certainly with one of our patients.

A A Can I comment on this? This guidance: I think it is about carefully monitoring. If you have somebody with significant liver disease who is in severe pain, you are not going to want to deny them opiate analgesia and you would give a lower dose and monitor carefully. It is important to emphasise it is not saying these patients should not receive morphine or other opiates. In renal impairment, the problem is, again, more sensitive and there is this risk, because of the accumulation of metabolites, of a greater likelihood of getting confusion and agitation but I think now their recommendation is to use alternative opiates to morphine in
B renal impairment. I think however at this time you would still use opiates. You would just use them more carefully.

Q We see at the bottom of that paragraph:

"Palliative care: In the control of pain in terminal illness these cautions should not necessarily be a deterrent to the use of opioid analgesics."

C

That is exactly what I think you just said?
A Absolutely.

Q

"Contra-indications: avoid in acute respiratory depression, acute alcoholism..."

D Pausing there for a moment, what do you do with the alcoholic who is in pain?
A You would look at alternatives, first of all: is there another alternative since opiates are less desirable in this group. In the end, if they had severe pain and they needed opiates, you would give opiates and you would monitor carefully.

Q Does the opiate have a greater effect in those with alcoholic liver disease than it would otherwise have, or is it just a side effect that you are seeking to avoid?
E A The effect of renal impairment, to answer your questions directly, is greater than in hepatic impairment on the dose you need to give. The real concern in people with hepatic disease with cirrhosis is there is a risk of precipitating hepatic encephalopathy but in terms of acute alcoholism I am not aware that alcoholics are particularly more sensitive to opiates. I think the concern is, again, if you have somebody who is actually intoxicated with alcohol, you have an increased risk of respiratory depression and other adverse effects.

F Q I am not going to go through all the other contra-indications and side effects but can we look at the right hand side of the page:

"Dose: acute pain, by sub injections (not suitable of oedematous patients) or by intramuscular injection, 10 mg every 4 hours...".

I am not going to go through all of that.

G

"By slow intravenous injection, quarter to half corresponding intramuscular dose."

A Yes. That relates to the conversion table that we read.

Q We just read that?
A Yes.

H

Q Then, can we go down to:

"Chronic pain, by mouth or by subcutaneous injection (not suitable for oedematous patients) or by intramuscular injection .... dose may be increased according to needs; oral dose should be approximately double corresponding intramuscular dose and triple to quadruple corresponding intramuscular diamorphine dose...".

So it is in fact saying, one has to read it quite carefully. In effect it is saying the same thing.
A The reverse way, yes.

Q Oramorph is dealt with on the next page. I am not going to spend very long on that. We can see the doses set out:

"Dose: severe pain uncontrolled by weaker opioids, 30 mg every 12 hours, increased to 60 mg every 12 hours when required, then further increments of 25-50% if necessary. For lower initial doses in patients who have not received other opioids."

Dealing with the opiate naïve patient, first of all can we identify what is "opiate naïve"? If a patient has been in hospital and he has been on codeine – and we have seen some patients, I think, who have been on codeine phosphate, or one patient in particular – and then came to Gosport War Memorial Hospital and eventually was put onto Oramorph, is that patient in general terms regarded as opiate naïve or not opiate naive?
A Strictly speaking, because codeine is a mild opioid, they are not opioid naïve but in practical terms, one would consider those patients opioid naïve.

Q Why?
A Because the codeine would not produce sufficient tolerance to make you adjust or alter your initial dose approach.

Q Let us go to page 11, please. The heading is "Diamorphine Hydrochloride". Is that any different to diamorphine?
A No.

Q We can see towards the bottom of the page:

"Chronic pain, by mouth or by subcutaneous intramuscular injection, 5-10 mg regularly every 4 hours; dose may be increased according to needs; intramuscular dose should be approximately half corresponding oral dose...".

We have seen that, I think and I will not read it through again. Then on the following page we have fentanyl. There is just one aspect of this that I want to ask you about. Let us look at the top right hand side of the page:

"Administration: see under preparation, below"

and then these words:

"Long duration of action. In view of the long duration of action, patients who have experienced severe side-effects should be monitored for up to 24 hours after patch removal."

You have assisted us already about fentanyl and the way that it works on the body and the rapidity of its effect. I do not think you have assisted us as to what the effect of the removal of the patch is? How quickly would the removal take effect?

A Because it has a longer half life, because it is cleared less quickly from the blood than morphine, diamorphine, the effect is more sustained and the half life is at least six hours in older people, so you are going to have an effect – and it can be longer – that is going to last much longer. One of the issues is, although it is giving the drug incrementally, it is not an academic point. It is important for people who use it to realise that once you take the patch off, you still have significant drug there which is going to take some time before it disappears from the circulation. That is why that comment is there, particularly.

Q Right at the bottom, under the heading "Durogesic" – I have taken that to be a form of fentanyl?

A It is the trade name for the fentanyl, yes.

Q We can look right at the very bottom, the four lines in brackets:

> "(important: it may take 17 hours or longer for the plasma-fentanyl concentration to decrease by 50%, therefore replacement opioid therapy should be initiated at a low dose, increasing gradually)."

Do those words have any significance to this case?

A I think they do in some of the patients that will be discussed because this is the key point. Once the fentanyl patch is removed one still has significant effects from that. I said six or more hours, and it is saying you have to be even more cautious than that. You may not be down to half of the concentration of fentanyl till 17 hours. That means, if you are moving from fentanyl to another opiate drug you have to adjust, being aware that you have the fentanyl slowly going down and the drug you are introducing. You cannot just replace the fentanyl with a subcutaneous infusion of diamorphine. If you were just hoping to achieve exactly the same, you would have to give a lower dose of diamorphine for a day or two, and then get up to the equivalent dose, otherwise ---?

Q The fentanyl is still ---

A Because the fentanyl is still there. You would be giving much more than you were intending by the subcutaneous infusion alone.

Q Again, it is in the *BNF*, but is that something you would expect a doctor prescribing this sort of medication to know?

A I suspect unfortunately that there were doctors who might not have been aware of this, but as a prescriber you are required to know the important aspects and so it is something one should know if one is starting opiates in somebody who has been on a fentanyl patch. The information is there in the *British National Formulary* for that reason.

Q You may not be able to answer this but fentanyl presumably comes in some sort of box?

A The packets come in a box and you take off the cover and you apply it to the skin.

Q Nowadays we get a lot of information with medicines. There is almost always a leaflet with everything, but going back to the mid- to late-nineties, do you know how much information would have come with the fentanyl, and whether it would have ---?
A It would have had... Gosh – I would have to check, but it would have at least the minimum information here, and more. I am not talking about a patient information leaflet. We are talking about the information that comes with the drug for the prescribers and nurses who administer it, and it would be more information than here.

Q Could you go on to page 15, please. I can deal with this quite quickly. We have already looked at hyoscine. We have looked at what it is used for, but can we just look at the cautions and side-effects.

> "See under Atropine Sulphate; may slow heart; avoid in the elderly (see notes above);"

Hyoscine may not be avoidable in the elderly if you are trying to dry somebody's secretions?
A I think, again, one has to differentiate between using it at the end of life where most people are elderly, and you would not avoid it from using it in another context. The reason it says "in a non-end of life setting" is the high risk of causing confusion and other adverse effects in older people. But no, it does not mean it should not be used in older people at the end of life.

Q The following page, page 16, we can see on the right-hand side midazolam.

> "Indications: sedation with amnesia, and in conjunction with local anaesthesia, premedication induction.
>
> Cautions: Contra-indications; Side-effects: see under Diazepam. ... Important: profound sedation with erythromycin and possibly other drugs;"

Help us, please, a little bit about the effects of midazolam, what it can properly be used for?
A Yes. I think this can be quite confusion. Midazolam is generally used as an intravenous bolus to induce sedation and as part of a premedication drug in patients undergoing procedures or surgery. It has a very rapid effect there because it is taken up into the brain and then it redistributes and the effect does not last very long. But in the context of using it by continuous infusion the effect is more sustained; the half life is two or three hours in that context. It does not just switch off when you stop the midazolam.

Q If you are using it in conjunction with diamorphine, will it increase the sedatory effect?
A Very much so, but more importantly it would increase the risk of respiratory depression. That is why the combination of diamorphine and midazolam was first used in intensive care settings, where there is very close monitoring of patients. It was then applied to end of life settings, to deal with terminal restlessness and the use of midazolam there. In that context, the risk of respiratory depression, as long as the drug was used appropriately, would be accepted to be a reasonable risk. But you would not, for example, use diamorphine and midazolam infusions on a patient on a general medical ward who was acutely confused and in some pain, but you are expecting a full recovery.

Q Because you may ---
A Because you just could not. The risk would be too high and you would not have appropriate numbers of staff for monitoring. Used in a very high dependency setting, where you have one-to-one nursing staff, and then used in an end of life setting, there the risks are acceptable.

Q We are going to turn to the Wessex Protocol in a moment, but it may be suggested to you, as it is sometimes in cases with other experts, that you are setting an extremely high standard and that you are looking at this with the retrospectoscope, et cetera. I want to look for a moment with you at *Good Medical Practice*, which I think you comment on in your generic report. I am going to ask for the 1995 version of *Good Medical Practice* to be handed up. It is the one that was in force, as it were, between 1995 and July 1998, so it is relevant to our first three patients at least.

THE CHAIRMAN: It should be behind tab 2, I think, of the Panellists' small bundles.

MR KARK: Is this the version you have (displaying a copy)?

THE CHAIRMAN: Tab 2.

MR KARK: Oh, that bundle. I am sorry. We have one available to you, if you want one, that you can mark up and slip in to the file.

THE CHAIRMAN: It would be helpful as we are not supposed to mark these up.

MR KARK: It is very difficult now to find copies that are not marked up.

MR LANGDALE: I am sorry to interrupt. I just want to be clear. Is this the document I received earlier on? *Good Medical Practice* 1996?

MR KARK: Yes.

MR LANGDALE: Thank you very much.

MR KARK: Can I suggest that this gets popped in after the CV, into tab 14, so we do not have to give it a new exhibit number?

THE CHAIRMAN: It will go into volume 1, ladies and gentlemen. It will be the latest available tab.

MR KARK: *Good Medical Practice* is a document which we, who regularly appear at these Panels, are very, very familiar with. How commonly known is it or used in practice? What would you expect the average GP to know of *Good Medical Practice*?
A I am not sure I am qualified to comment on that. I am not a general practitioner. I can speak as a hospital physician. What I would say is, I think very few people in 1995 could recite from memory *Good Medical Practice*, but they would certainly be aware of it. I would find it very difficult if any doctor was not aware of it, and would be aware of the basic principles within it. I think it would be unusual, certainly for a senior qualified doctor not in training not to be aware of *Good Medical Practice*. It was sent out to all doctors and I think there was increasing awareness over time.

Q Can we turn, please, to page 2. We have stayed, I can see, with the internal numbering . I do not think that will cause a problem. "Good clinical care" is the heading.

> "You must take suitable and prompt action when action when necessary. This must include:
>
> • an adequate assessment of the patient's medical condition, based on the history and clinical signs including, where necessary, an appropriate examination."

Pause there for a moment. When a patient comes in as a new admission into a hospital, such as the Gosport War Memorial Hospital, in one of the wards that Dr Barton was looking after, in your view how important is an adequate assessment of that patient's condition on arrival or shortly after arrival. How important is that?

A I think it is very important. I will tell you how important it is. I remember we had problems – for example staffing, with registrars, our hospital – at some point on a Friday afternoon temporarily, and I decided, as the consultant in charge of that service, that we would not accept patients onto the ward on a Friday because they could not be clerked and assessed by the registrar. That did not go down too well with my physician colleagues at the time, but that is because we considered, as a group of clinicians, that it was important that patients were adequately assessed when they were transferred.

One would not expect a full clerking as you would do with a patient who is acutely ill, which would be a full history and examination, but it is important to document, first of all to the team coming in, familiarise themselves (the medical team) with that patient and to document what the main problems are, that, as I think is an issue in some of the patients that are being discussed here, there has been no major change in their condition since the agreement to transfer the patient has come across. So, what we would we expect? I would expect, and certainly when I was in this position, that one would go and see the patient, one would read the notes, see what the background was, one would ask the patient how they were, if they could tell you, you would perform a relevant examination depending on what their problems were and, certainly if there were any new problems you would want to examine the patient. You would summarise what their main problems were, what the plan for their admission to that hospital ward was and check that their drug therapy was appropriate because that has to be prescribed anyway. That process would take, it depends on the patient and it depends on the experience of the doctor involved, but 20 to 30 minutes would be a reasonable amount of time for most patients. Clearly, if the patient was not straight forward, it would take longer than that.

Q Two issues you raised in passing. The first issue was the notes coming with the patient. We have heard a number of different accounts in this case from Mr Beed. I think you said it was only in 1 in 10 or 1 in 20 cases that the notes were late or missing. We have heard other evidence that it was much more common than that. Let us imagine for the moment that there are a number of occasions that the notes do not come with the patient. What is the importance then?

A This is a situation I and many geriatricians have seen many times. It is extremely frustrating because you do not have a record of what has gone on. It means you have to do a lot more work which is why we do not like it, because you have to assess the patient completely and fully yourself because you do not have the relevant information. It is the same as when the patients turn up in the outpatient clinic and you do not have their records.

A You have to go back to scratch to find out exactly what is going on, but that is what you have to do because otherwise you do not know what is happening with the patient. When that happens, we would get back on to the unit and you have policies to try and stop this happening. There was a problem that some units would think it was more important that they kept the notes to do their discharge summary or whatever they needed to do. I think now that it is an absolute principle recognised that the relevant patient notes always need to transfer with the patient. If you do not have that, you have no alternative, but really, if you are going B to safely manage the patient, to go through the history yourself, ring up the unit, find out what was going on and you have to do a lot more.

Q What about making a note about it?
A I think the situation where you have a patient transferred with no notes and no summary of what is wrong with them is extremely problematic and hazardous. That is not a safe situation. I am not saying this is academic, and looking at this it is not good clinical C practice, I am saying it as a consultant who has responsibility for patients and I would be very concerned if I had patients under my care in that situation.

Q We have also heard it being suggested on numerous occasions, and it being accepted on numerous occasions, that the transfer itself can cause a deterioration in the condition of the patient. First of all, is that something that you have come across in your own practice?
A Certainly, I think there are two issues round that. I think, first of all, transferring frail, D older, vulnerable patients to a new environment often produces confusion and upset and the transfer itself, if it is a long journey, may not be well tolerated. Usually you would expect the patient to be back, to have settled in, within a day or two. I think that has to be differentiated from a major deterioration due to another event happening, such as they have developed another medical problem that has led to their deterioration. Any deterioration needs an assessment as to what the cause is. Deterioration certainly occurs, we are all aware of this. One of the problems is, when you are responsible for units like Walkergate Hospital or E Gosport War Memorial Hospital, if patients deteriorate, you have to accept sometimes that it is necessary to transfer them back, or you may even find that the patient arrives and it was not appropriate that they were transferred over at the time they were. There is a problem that the base units, particularly if they are non medical wards, once a decision to transfer is made, there is not always a close documentation of any deterioration that should have occurred. That should not happen, but sometimes it does and you have to be able to deal with that if you have a ward and you are responsible for it.

F

Q If you receive a patient and they have deteriorated and it does not appear to be a significant event. Let us take our case and take Gladys Richards out of the picture for the moment, because it is obvious in that case that something happened on, probably, two occasions where the transfer caused a significant event in that patient's care. If there is a deterioration in the patient simply because of the journey itself, is it your experience that that deterioration persists or can that deterioration resolve itself and the patient recover after a few G days?
A It can persist. You have a problem. You are dealing with a population of older, frail people who can deteriorate anyway, so the deterioration may be coincidental or it may be reversible or irreversible. Let me give you an example. An ambulance transfer, in and of itself, you would not expect to make a patient move from being able to mobilise to not being able to mobilise at all. It depends on the nature of the deterioration.

H

Q If you recognise there is a significant change in the patient's condition between the first hospital and your hospital, what do you do about it?
A If there is a deterioration, what you are trying to do is to find out, is there anything treatable? It is to assess the patient and find out whether they have developed a new infection, was there something overlooked which was evolving at the previous hospital. It is the issue of the reason to assess the deterioration, is there maybe something one can do about it? If the conclusion, once you have assessed the patient, is that you cannot find anything new, then you watch and wait and you carry on with your usual or revised treatment plan.

Q I think that probably takes us to the next bullet point which is:

"• providing or arranging treatment where necessary;

• referring the patient to another practitioner where indicated."

I think in essence you have dealt with those, the need to assess and then upon the basis of that assessment to arrange treatment.
A Yes. Can I make a comment. You made a comment that others have been critical about my holding someone to a standard which is not reasonable in clinical practice. I am well aware of the challenges of providing high quality care in older people services and the battles one has to get adequate funding and staffing and the difficulties staff in those units are challenged with. *Good Medical Practice* is *Good Medical Practice*, I did not define this. I am interpreting it in as reasonable a way as I can and in the context of what I am used to in practice. I have deliberately not looked at this as an academic exercise, but it can be very challenging sometimes if one is very over pressed to consistently deliver all aspects of *Good Medical Practice* in every patient. We can discuss what the appropriate response is to doctors who find themselves in that position, but I do recognise that issue.

Q Under heading 3:

"In providing care you must:

...

• be competent when making diagnoses and when giving or arranging treatment;

• keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed."

Pausing there, I expect we are going to hear, and it has been suggested on numerous occasions to witnesses, that Dr Barton simply did not have the time. It was a case of either looking after the patient and not making a note about it, or making copious notes but not actually looking after the patient. Have you been in this sort of position or have you dealt with people in this position before?
A I have managed a service and trained in older people's services and had to keep contemporaneous notes. I have seen juniors and other staff working with me how they have kept notes. With any important clinical contact where there is a major change of patient status or a major change in treatment, I think it is difficult to say one is too busy to write a three, four, five-line summary of what has happened. It only takes a short time to write a

brief summary. I think it is a matter of what is a prioritisation if one is very busy. My understanding was that Dr Barton had three and a half sessions a week which is, if I have it correct, 14 hours of contracted time to see and assess patients at the Gosport War Memorial Hospital in 44 beds. I may have the numbers slightly wrong. Many of those patients, because they were in continuing care, would, for the most part, be stable and that was my experience. One of the problems with NHS continuing care was that there often was not as much medical input as there ought to be. That has gradually changed in most units and consultants did more systematic ward rounds. There were, on average, around, as far as I can work out, four admissions a week. I have indicated each of those should reasonably take about, maybe, 30 minutes.

Q You have had a look at the admissions books, I think?
A No, I have not looked at the admission books. I saw the finished consultant episode figures from the charge report. Then, obviously, a number of patients would deteriorate. I think it would be a reasonable expectation that any major issues would be documented by the doctor responsible for day-to-day care. I think it would not be possible to document every patient contact or every conversation with relatives and, indeed, one would not usually do that. There would be a note, for example, in the nursing notes that a doctor has met and discussed things with the relatives. It is an issue that, even when you are very busy, one needs to, within that time, focus on documenting the main changes in a patient's status. That may mean one does not have time to do other things, like talking to relatives for example. It is weighing up what are the most important things to do.

Q I would like to move on to another topic before we break for lunch. Page 8, we can see at the bottom at paragraph 28:

> "You may delegate medical care to nurses and other health care staff who are not registered medical practitioners if you believe it is best for the patient. But you must be sure that the person to whom you delegate is competent to undertake the procedure or therapy involved. When delegating care or treatment, you must always pass on enough information about the patient and the treatment needed. You will still be responsible for managing the patient's care."

Can we ask for your assistance about the issue of delegating to nurses. We have heard a huge amount about the nurses, various descriptions of their excellence and their experience, about Sister Hamblin, how well she ran the ward. Do you delegate to nurses certain aspects of the medical care of your patients?
A I suppose there is the issue about what one defines as medical care, but clearly the answer would be "Yes". Currently, there is a much clearer framework for this. There are competences and you sign people off and there was not for many aspects of this in the mid-1990s, so it was less well defined. There are some tasks you cannot delegate legally. You cannot delegate the prescribing of drugs, for example. I would emphasise the responsible consultant also does take some responsibility for what is going on with delegation of care for patients under their care.

Q Can we stay with the issue of delegating the prescription of drugs. It is obvious that it is always the doctor who actually has to write out the prescription.
A It is and the doctor carries legal responsibility for that prescription.

Q Whether there is a consultant who is more senior to that doctor or not, legally whose responsibility is the prescribing itself?
A The doctor undertakes that prescription.

Q If a doctor writes out a PRN prescription, is it legitimate in appropriate circumstances to allow nurses to decide when that PRN prescription should be administered?
A Very much so and that is standard practice. That is how many most PRN prescriptions are interpreted.

Q If that is going to happen, what are the safeguards in place to ensure that it is not inappropriately used, what does the doctor have to do?
A It so much depends on the nature of the drug. If it is a laxative or a mild analgesia, one would generally not have a protocol for that, one would leave that to the discretion of nurses to identify a patient who has constipation or mild pain and you would need to do no more. That would also apply for patients who have angina, for GTN, who have asthma for nebulisers. Once you get on to more potent drugs, you need a clearer framework. You would not – for example, I am not aware of it being common practice for doctors to delegate the prescription of antibiotics to nursing staff because that is quite an important decision and generally requires a medical assessment. We have already talked about the fact that nurses need discretion to adjust the dose of opiates when you are giving morphine. The issue is well accepted that nursing staff had discretion about the use of opiate drugs. That is a principle you would find throughout most practice in the NHS. However, the issue around delegating the decision to commence subcutaneous infused potent drugs, such as morphine and midazolam, I think is very different. Most people would not think it desirable to delegate that in the first instance. If one was going to, one would need a clear protocol that it was absolutely clear that nurses understood when they should move to giving subcutaneous drugs and what doses they should use if you have a dose range.

MR KARK: I am going to pause there because I do not think we will finish this particular topic, which is an important one, in the next few minutes. So I wonder if that would be a good time to break.

THE CHAIRMAN: Yes, it would, thank you, Mr Kark. We will break now and return at 2pm, please.

(Luncheon adjournment)

THE CHAIRMAN: Yes, Mr Kark.

MR KARK: We were dealing with the issue of delegating medical care to nurses and, in particular, the issue of the use of opiates.
A Yes.

Q I want to ask you for your assistance. You have heard a lot of evidence in this case (I think you have been seen the transcripts which you have been looking at), and, again, there has been a difference of opinion, it would appear, between the nurses as to what level of responsibility they actually had in relation both to starting syringe drivers and, secondly, increasing medication. Can I ask you about the first issue first? So far as the decision as to when to start a syringe driver in relation to a patient who may require it, whose decision in your view should that be, in terms of the timing of the commencement?

A I would say that should be a medical decision by the responsible doctor. My comment is it depends on a broader issue of what the significance of moving to the subcutaneous therapy is, and so I am slightly wary in my comments to you. If there was a clear protocol in place, let us say, which said: "This patient is at the end of their life; they are on oral morphine and when they are unable to swallow it is appropriate to switch them to an equivalent subcutaneous infusion of opiates and an equivalent infusion of a sedative, if they are on a sedative, and they were stable on that", I can see that that could be seen to be reasonable, if everybody understood their roles and there was a clear understanding by both the medical staff who were delegating that and the nursing staff to make that switch. But if it is in the context of a change in a patient's status, that becomes more complicated because then the patient needs evaluation to see what the appropriate response is, and that response might be appropriate to switch to a syringe driver but it might not; there might be other aspects of the treatment which need changing.

Q When you talk about the change in the patient's status, do you mean switching from a curative or rehabilitative regime to a palliative, end of life, regime?
A I think that is a major change in status. I think, from my understanding of what I have heard and read from the transcripts, once a patient was receiving subcutaneous therapy with diamorphine and midazolam, they were (to use a current phrase we would use) on an end-of-life pathway. The concern one might have would be if the decision to put the patient on the end-of-life care pathway was being delegated. That, I think, would not be deemed to be appropriate by most medical practitioners.

Q What if the suggestion is: "Well, we had to leave that decision on occasions open – the decision to start the syringe driver – because the patient might suddenly find themselves in pain and they would need immediate relief, and Dr Barton might not be there over a weekend", or something of that nature? Does a syringe driver necessarily deal with that situation?
A To me that is not a very strong or sound argument because, as I indicated earlier, when you give a syringe driver, you are giving a continuous infusion and it takes a while before the effect of that has come to what we call a steady state, because it takes a while for it to build up, if you made a change in the equivalent dose. I can see the situation of somebody at a stage due a dose of oral morphine, they now can no longer swallow and you can see they are not going to have any opiates, that it would be appropriate to give some opiate to ensure they remained pain-free. I think we would all recognise the importance of that. But that opiate could be a single subcutaneous injection, which would last for four hours, and I think, from my understanding of the cover at the Gosport War Memorial Hospital, it would not be unreasonable to expect a doctor, at any time of the day or night, to be able to respond within four hours. So I do not see the very strong logic for needing to move to subcutaneous infusions as opposed to giving drugs by a subcutaneous route.

Q We will have a look at the Wessex guidelines, in a moment, but what about the issue of nurses being able to increase the dose? First of all, is that a fairly accepted regime within the medical community? If there is a PRN dose a nurse can, within limits, increase it?
A Adjust either up or down?

Q Yes.
A So it might go both ways. Yes, I think it is recognising the importance of some adjustment within clearly defined limits of nursing staff to optimise pain relief or to reduce, if there are adverse effects becoming apparent.

Q You talk about clearly defined limits. How do you, as the doctor, define those limits?
A I think if you have a patient where you are reasonably clear about what dose of opiate they need, within a two-fold dose range – so like the standard PRN dose, 5-10mg – would seem, I think, reasonable. From talking to palliative care specialists they operate within a two to three-fold dose range, typically, in hospices, but all those changes are always discussed by the nursing staff (at least, in our local area) with the available medical consultant. So one can set up arrangements like that where there is adjustment; it does not require a doctor to come into hospital but there is discussion and confirmation. The method used locally, I understand, is there is an email or a text message sent. Clearly, that was not a mechanism one could use in the NHS in the mid-1990s, but some similar check. I do not think most practitioners in this area, because palliative care units, for example, have very experienced staff dealing with this all the time, would be expecting nurses to be making significant adjustments without some reference to medical staff.

Q Let us have a look then, please, at the Wessex Protocol, or the Palliative Care Handbook. It is at our tab 4. I am not going to spend a great deal of time on this but simply to go through some of the broader principles with you. First of all, this is a booklet that you have looked at, I think, in the preparation of your reports. Can we take it, because you were not working in the Portsmouth area, that you were not applying this specific document in your own Trust?
A Yes. Before I was asked to look at this I was unaware of this document.

Q Do the principles within it broadly reflect wider medical practice across the country?
A I believe they do, and I asked a palliative care colleague was this document representative and they commented it was a very good document that reflected the principles of practice at that time.

Q Was it the sort of principle of practice that you yourself would have been applying in prescribing for your patients, if necessary?
A Yes. There is a level of detail in here which I would not have been familiar with. There is information in here and drugs that I would not have used in my own practice.

Q We will see if we come across those, but if we go to page 4, I just want to see, if I may, with you, what would have broadly known principles in any event, even if you did not know about this book, and what would have been outside the norm. If we look under the heading "General principles of symptom management", it talks about accurate and full assessment. We have seen that already in *Good Medical Practice*. Then this, halfway down the page:

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

Is that a known principle in geriatric medicine?
A I think geriatricians – and I am saying this as a geriatrician, trying to put my clinical pharmacology hat to one side – in general, as a group, are very aware of the issues of adverse drug effects in older people, and I think most geriatricians would be very aware of that principle and be monitoring patients for any side-effects of therapy. That is because older people are more likely to get adverse effects from drugs and they take more drugs, so it is an issue geriatricians have to deal with much more than groups of doctors who look after younger people.

Q And is an issue you have already dealt with of some relevance to using opiates.

A Yes, because these are drugs that are known to have significant adverse effects, and some are very predictable and need careful monitoring for.

Q If we look to the right-hand side of the page:

> "Pain is a common although not inevitable symptom in cancer. A successful treatment requires an accurate diagnosis of the cause and a rational approach to therapy."

Again, I think that reflects the evidence you have already given, that the first thing to do if a patient is in pain is to try to identify the source of the pain.
A This is a key principle because if the pain is not nociceptive, if it is neuropathic, due to nerve problems, or if it is due to somatisation, psychological in onset, opiates are not going to be a helpful treatment.

Q Somatisation. Can you help us please?
A This is a description of psychological distress manifesting itself as physical symptoms. I think most people are familiar with this: young children, for example, when they are upset will say they have got abdominal pain, but there is nothing wrong with the inside of their abdomen, it is just the way children manifest when they are upset. There are similar examples throughout a lot of adult medical practice.

Q So far as the patient is concerned the pain can be very real.
A Pain is real; pain is what the patient says it is. There is no dispute about that.

Q Page 5. Again, I am not going to spend any time on this. We can see the World Health Organisation Analgesic Ladder is set out. Again, you may not have had this particular book, but would the broad principles of this be well-known to you?
A Yes, I think most people were aware of that principle of starting with milder and going up through moderate to more potent analgesics.

Q Can we go to page 6, please, and paragraph 2, under the heading: "Use of Morphine".

> "Start by using an immediate release morphine (liquid or tablet) for dose titration giving it every 4 hours. The eventual effective dose may range from 2.5mg to more than 200mg but only a minority of patients will need more than 30mg 4 hourly."

Pausing for a moment, this handbook, we have to bear in mind throughout, is a palliative care handbook.
A Yes, and mostly framed around the management of patients with cancer, although not exclusively so.

Q It goes on:

> "Give a double dose at bedtime to avoid waking at 2-3am but ensure that at least 5 doses are given per 24 hours. Start with a low dose and increase by 30 – 50% increments each day until pain is controlled or side effects prevent further increase. Doses can be rounded up or down"

and then it gives a common dose sequence. That concept of 30 to 50% increments each day: again, we have heard a number of nurses talking about some knowledge of that. Is that a principle that you have applied in your own hospital?
A Yes, I think most non-palliative care specialists would use a principle of around 50%.

Q Five-zero?
A Five-zero, yes. Interestingly, palliative care physicians are probably more conservative in the way they increase opiates, I suspect, than many generalists. I think Dr Reid, if I quote him correctly, initially had a protocol which doubled opiates. So best practice for most people would have been increasing by 50% but some practitioners, normally in the specialist palliative care setting, would have doubled if a patient was in persisting, severe pain. Obviously, when you do that there is more of a risk of getting adverse effects.

Q Doubling over what period? Or increasing by 50% over what period?
A Generally, we are talking about every 24 hours unless you are absolutely clear, and you are adjusting it four-hourly, that the patient still remains in pain. As I indicated earlier, if you are starting opiates it is going to be a while before you see the full effect of the dose you have given because it is going to be five half-lives, so that is about 20/24 hours, in older people, before you have got to the steady state effect. Again, it depends on the setting one is in and it depends upon the extent of pain that the patient has. When you are starting off you may need to escalate quite rapidly every two hours or so, as I was indicating, to obtain analgesia.

Q If we look at paragraph 5 we read:

> "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."

Are there circumstances where if you have a patient who is exhibiting side-effects but continues to be in pain you have to continue using opiates and increasing it?
A It depends on the severity of the side-effects. What that is saying is you cannot just keep prescribing opiates if there are major adverse effects which are unacceptable. Respiratory depression is unacceptable; severe restlessness and agitation are unacceptable if it is drug-induced. So one should pull back and think about – it is really saying "Go back to the beginning and just check have you understood what the cause of the pain is? Are there other approaches to relieving pain than giving opiates which are going to relieve this patient's pain?" We have been through all that already so I will not reiterate that, but there might be other drugs that one might use as well.

Q Paragraph 7:

> "When oral administration is not possible" (and we have looked at this) "consider changing to diamorphine by subcutaneous infusion using a syringe driver. The conversion from oral morphine to subcutaneous diamorphine ... varies between one-third and one-half allowing some flexibility depending on the requirement for increased or decreased opioid effect."

That, obviously, seems, on the face of it, to go beyond the *BNF*.

A A I think what it is saying (I would interpret this – and this is just my interpretation) is that if one needs increased opioid effect go to a half and if one needs the same or slightly less go to a third, in the first instance.

Q Then it has got a table on the right of the opioid equivalents. Although it deals with syringe drivers I am not going to go into that. It is page 14, because I think you have covered it in your general evidence. You have dealt with nurses' responsibilities and you have dealt
B with the importance of making notes where there is a change in the patient's condition. I want to deal with the decision about switching a patient to a palliative care route and the process that one should go through and what notes should be made about it. You understand the broad area of the topic. It is the point at which somebody, either a nurse or a doctor, decides that this patient is now to a palliative care regime by which I mean end of life. Who should be taking that decision? How should it be taken? Who needs to be consulted and what notes should be made about it?
C A I will preface my comments by saying this is a very challenging area of practice. I think there is a recognition that end of life care was often suboptimal in medical practice. This led to the development of guidelines and protocols like the Liverpool Care Pathway, which is now used quite widely. It specifically gives an approach and system for checking that the issues at end of life are met. That is the first thing to say. This was an area where practice in general was often not as good as it would now be seen it ought to be. Again, I think we have to say that the culture has changed in the last ten to fifteen years. Now there
D would in general be a much more explicit open process of that decision being made, with discussion with either the patient or, if they lacked capacity, a discussion with their relatives, not for them to consent but to give a context and information to ensure a decision was being made in the patient's best interest.

Q Just pausing for a second, you made a very specific point – not for them to consent.
A I am in front of lawyers, so I hesitate to comment on what is a legal area, but my
E understanding is that relatives do not consent for adults. They should be part of the decision-making process, because relatives may not always – not always – have the best interests or perceive what may be the best interests of the patient.

Q If a patient needs pain relief in your view, in your – the doctor's – view, and the patient is not in a state either to say yes or no, ultimately whose decision is it to give that pain relief?
F A You would not seek consent to give analgesia to an incapacitated adult who was in pain. You would give the analgesia and you would explain for information and good practice to the relative, carers and family what was happening with the management of the patient. In terms of making the decision, because it is clearly such an important decision to put somebody on an end of life terminal care pathway, that decision in my experience was always made or discussed with the senior doctor responsible for that patient's care. There might be exceptions to that if a patient with advanced cancer or dementia came in on an acute medical
G take, who was clearly very ill. The senior registrar, possibly registrar, might initiate palliative treatment without waking up – in the nineties – the on-call consultant for that patient. But in general, in a patient where this had not been considered before, you would expect that to at least have been discussed with the responsible consultant – at least I would have, or the consultant responsible for the care of that patient.

Q And making any notes about it, we have seen on occasion notes such as "For TLC,
H keep comfortable, not for 555"? Not for 555, I think is accepted to be in a separate category?

A A I think as other people have commented it is important to recognise the decision about resuscitation is completely different from that of the level of care. Many people are not on an end of life care pathway or not for resuscitation because it is their wish, or it is generally considered it would be inappropriate for a number of reasons to attempt resuscitation in the event of a sudden cardiac or respiratory arrest. But you would expect to see documentation in the notes that a patient was on end of life care. As you say, now we are much more clear and explicit about how we write these down. A number of phrases would be used: "tender
B loving care" was one; "keep comfortable" was another and TLC was probably the most commonly used phrase for patients entering end of life care.

Q Would you just give me one moment, please.
A Can I just add another comment to that?

Q Yes.
C A Now we are much more explicit in this decision-making end of life, of deciding what the limits of care are. Even for patients not at the end of life we might decide somebody is not for resuscitation but for antibiotics and other active treatment, but not for admission to intensive care. In the 1990s there was not such an explicit consideration and usual description in the notes of these issues of the level of care, so practice has changed since the 1990s.

D Q The last document that I wanted to look at – and I hope this is already in the bundle, but I have to confess although it is in mine I am not sure if it has been given out – is behind tab 8. There should be a document headed "Pain Relief - P. Crome". Do you have that?
A I do.

Q Do the Panel? I understand now that you do, so we all have it. Can you just tell us what this book is please?
E A This is a chapter from a book that Peter Crome, the author of this chapter, and I were editors of "*Drugs in Older People*".

Q I am trying to see when this was published.
A It is on my CV. I would have to look at my CV. I think it was 1998. Perhaps we could just check that.

F Q I just wanted to draw your attention to one aspect and first of all for you to identify this. Is this regarded, without being overly modest, as authoritative or what lawyers might call "authoritative text" in your field? How would you describe it?
A There are two or three textbooks about drug therapy in older people I would not like to say whether it was more authoritative than any others.

Q I do not think it is paginated. Could we look at page 585 within the internal
G numbering.

THE CHAIRMAN: The numbers are at the top right-hand side.

MR KARK: Exactly. I am not going to spend any time on this, but I do not think it says much more than you have already told us about the broad principle, the basic principles, of dealing with acute pain.
H

A A This chapter is written by a geriatrician with some interest in clinical pharmacology like myself. I think it summarises, again, the broad principles which we have seen in the *BNF* and also in the Wessex guidance.

Q I will not take any time. We can see the words that you used earlier in the middle of that paragraph "Start low, go slow", and is that referable to elderly patients and pain relief?
A Yes, with the qualifier in the following sentence, that to avoid patients remaining in B pain, you may not need to go slow; you may need to go fast.

MR KARK: Very well. I think we are going to move on, please, to deal with individual patients. There will no doubt be other topics which arise as we begin to look at individual patients but we are going to start with Patient A. I think the Panel indicated that at this point in the evidence the Panel, first of all, would like time to remind themselves of the new chronology and also the opportunity to read Dr Barton's comments about each patient. I do C not know if that is how you want to do it?

THE CHAIRMAN: I think it is very sensible, Mr Kark. Do you have a sense of the sort of time that we are likely to need?

MR KARK: I would have thought you would need at least 20 minutes and possibly longer. Mr Langdale is saying half an hour. Can I suggest we start with 20 minutes and then you D send a message?

THE CHAIRMAN: Yes. We will send a message before the 20 minutes is up to avoid you --
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MR KARK: I only say that because if we say 30 minutes now, we have twelve patients to get to. If it becomes 30 minutes for each of those patients, we may not need that long for all of E them.

THE CHAIRMAN: Very well. We shall start with twenty minutes and after fifteen we shall let you know if we are on track.

MR KARK: In the meantime, can Professor Ford be given – I think he already has them but can we just speak to him? It is merely about the administration and making sure he has the F up to date chronologies.

THE CHAIRMAN: Yes, indeed you may.

MR KARK: Thank you.

MR LANGDALE: Do the Panel have the new detailed chronology?
G

THE CHAIRMAN: The new detailed chronology for Mr Pittock? I think they have.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Kark, it seems that on the first run with Patient A, at least, we needed nearer the half hour than the twenty minutes.
H

I note, Professor, you have been hard at work in one way or another since we started the afternoon session. Perhaps we can bear that in mind, Mr Kark, and perhaps be aiming for a break for the Professor at around 3.30. Are you fit to continue now?

THE WITNESS: I am quite happy to continue, yes.

MR KARK: May I also mention a matter in relation to the chronology – I think I have the right one. If you go to page 11 of the chronology you will see there is a note on 9 January at the moment by Nurse Barrett from the "Significant events" in the nursing notes. Over the page, there is another nursing note. In fact what we are missing there, and I have asked Mr Fitzgerald to amend it so I am afraid you will be given another page, is actually a note by Dr Barton that is in the original medical records at page 196. It is for 9 January 1996. That should definitely be in there, unless I am missing something, apologies for that. I am afraid I have only just noticed that.

THE CHAIRMAN: Very well. We will insert that when it comes to hand.

MR KARK: I refer to it specifically because Dr Barton, in her own statement, makes a comment about it and I am surprised not to see it in the chronology. That, I am afraid, is bound to happen with the best work and will in the world. I can only apologise and we will try and get it right in due course.

THE CHAIRMAN: Not at all.

MR KARK: Professor Ford, I am going to ask you to have your report open and available to you and it is the report in relation to Patient A . I going to try and not have too many documents open at the same time. I suspect, although we have the chronology, the Panel may still at least want to turn up or have available to them the clinical note made by Dr Barton. That they will find in Mr Pittock's note at page 196, and the drugs charts they will find beginning at page 199. Because we have the chronology, I am going to try and avoid going to more documents than that, if at all possible. (To the witness) This gentleman had chronic, long term depression?

A Yes.

Q And you have had the opportunity of reviewing all of his notes. He was admitted to Mulberry Ward under Dr Banks first of all in September 1995 and then he was returned to the Hazeldene rest home, and then he was re-admitted to Mulberry Ward in December 1995. He then had sacral sores which were noted and then, so far as your report is concerned, I am on page 3, where you very helpfully set out in chronological sequence the events. There is a nursing assessment on the 5 January. We will look at Dr Barton's note in a moment. It records that Mr Pittock had a

> "...poor physical condition with broken pressure areas to his buttocks and hips, and broken skin on his scrotum. He was weight bearing to a very minimal degree, was low in mood but settled in behaviour. His fluid and diet intake was noticed to be poor but that he was drinking supplement drinks."

Then we have Dr Barton's note. Again, I am not going to read all the way through these, but we can see that his current problems were immobility, depression and broken sacrum, meaning the skin on the sacrum. Then long-standing depression for which he was on lithium.

I think in your report you record his marked deterioration, in already poor condition as reflected in the nursing notes on the 19 January. Could we then go, please, to concentrate on the drugs. For these purposes we can concentrate on our chronology. Can we go to page 12 of the chronology first of all. He is on a drug, as we can see on page 12, called Arthrotec. Was that to deal with pain from arthritis?

A Yes. It is a non-steroidal anti-inflammatory drug, so it was appropriate to prescribe that and see if that improved his pain, which was thought to be due to arthritis.

Q We can see Dr Barton has made a note on 9 January:

"Painful right hand. Held" - I think it is – "in flexion.
Try Arthrotec.
Also increasing anxiety and agitation.
? sufficient diazepam
? Needs opiates."

Then the next entry is by Dr Tandy, which reads:

"Depression. Catheterised. Superficial ulcers. Barthel 0. Will eat and drink. For TLC."

Plainly that is an important note in relation to this patient?

A Yes.

Q And it reflects, does it, your understanding, as you told us earlier, "TLC" would mean that this patient was now on a palliative care regime?

A Yes, I think so. The picture one obtains from the notes is a very frail, older man with severe depression who is deteriorating, has bedsores. I think nearly everybody who saw him as a geriatrician would recognise this man was nearing the end of his life.

Q We can see at the bottom of the chronology that on that date, 10 January, there was a note from Nurse Hamblin, that the patient was seen by Dr Tandy and Dr Barton.

"To commence on Oramorph 4 hrly this evening."

Then, over the page, Arthrotec was discontinued and then Oramorph was prescribed by Dr Barton at 5 mg to be given five times daily. I am going to look at the drugs globally first and come back to the comments you have about them. Underneath that in the drug charts at page 200, we have the following prescriptions from Dr Barton. Diamorphine, for variable dose between 40-80mgs over 24 hours; hyoscine between 200-400 mcg over 24 hours; and midazolam between 20-40 mgs via subcutaneous infusion. All of those were intended to be given by syringe driver?

A Yes.

Q On the next page of the chronology we can see that Oramorph was administered. I think 5 mgs had been administered the night before, but now on 11 January began a regime for this patient of Oramorph and the patient was receiving, I think, 30 mgs of Oramorph daily, 5 mgs at 6 o'clock in the morning and at 10, 2 pm, 6 pm and 10 mgs administered at 8 o'clock at night?

A Yes.

Q Just dealing with that on this one occasion, that idea of giving a patient a higher dose in the evening, is that, in your view, acceptable medical practice if the patient requires opiates?
A I think it is generally considered good practice because it saves waking the patient up every four hours in the middle of the night if they are sleeping, so it is quite common to give a double dose of morphine as the night time dose. It sounds good practice.

MR KARK: So far as the prescriptions for 5 mgs of Oramorph four hourly, you comment in your report at paragraph 10:

> "Despite the limited medical documentation the decision of Dr Barton to prescribe 5 mgs of Oramorph 4 hourly on 10 January was in my view reasonable given that Patient A was likely to be in significant discomfort and pain from his pressure sores. It would be difficult to determine whether the restlessness and agitation in Patient A were due to pain or his depression. The decision had been made that day that Patient A was for 'TLC". This indicates that Dr Tandy considered Patient A was likely to die within days or weeks and the focus of treatment at this stage was to towards palliating any symptoms he might have rather than the initiation of other interventions to treat or prevent active ongoing problems."

MR LANGDALE: Sir, may I interrupt. I appreciate Professor Ford is an expert witness, and I appreciate he has a lot of material to get through. I have no objection to my learned friend leading where appropriate but I do rather question what appears to be emerging – it may be this is the only time it will be done – simply reading out a chunk from his report in this way. I wonder if my friend would, and I am not going over the ground that has already been covered, be careful to take the evidence from the witness rather than simply reading out a chunk from his report. Sometimes I appreciate a sentence may be perfectly sensible to put it in context, but I think we may run into difficulties if we are reading out passages like that.

MR KARK: I take my friend's point, but all I was going to ask the Professor was whether, having heard all the evidence he has, do you still stand by what you have written in your report?
A Yes. I believe the decision to start opiates, from the information present in the medical and nursing notes, was entirely appropriate.

MR KARK: I did it on this occasion because it is favourable to Dr Barton rather than a criticism of Dr Barton.

MR LANGDALE: If I give a wry smile, I am not laughing at that in another sense. I appreciate my friend, as we all do in his position, would be dealing with points which are favourable to a defendant by way of leading, but I wonder if he could bear it in mind. I am not going to criticise him every time he does it.

THE CHAIRMAN: I think Mr Kark has the point.

MR KARK: I was then going to turn to your views – and I am looking at paragraph 12 of your report, to guide you as to where you dealt with it – as to the prescription written out by Dr Barton that we can see set out in our chronology. First, diamorphine prescribed at

between 80-120 mgs PRN by subcutaneous infusion. Can we stop for a moment there. This patient is on 30 mgs of oral morphine.
A Yes.

Q Daily, every 24 hours?
A Yes, correct.

Q Having looked at the various conversion tables that we have in the guidance that is given, and I am going to ask for your mathematics rather than mine, although I think it is a simple sum, what would the normal subcutaneous dose have been if the same level of analgesia was required?
A If we use the third conversion, 30 mgs of oral morphine over 24 hours is equivalent to 10 mgs of diamorphine over 24 hours by subcutaneous infusion. If one were to accept half conversion, that would be 15 mgs.

Q That would be a small increase or an incremental increase?
A Yes, the general conversion, as we have discussed, is accepted to be a third.

Q What is your view on the appropriateness or otherwise of prescribing between a variable dose between 80 and 120 mgs of diamorphine?
A If this prescription was written in the event that Mr Pittock, Patient A, could not swallow, a replacement dose would have been 10 or 15 mgs over 24 hours, so that is what one would expect the prescription to be for if that was the purpose of the prescription, to provide an equivalent dose of diamorphine to the oral morphine. As we discussed before, allowing for some increased need and the flexibility of nurses, if it was considered appropriate one could then say a two or three-fold increase at an appropriate range to give some leeway to increase would have been, say, to go to 20 mgs, maybe 30 mgs, of diamorphine a day. You could say, in case he was getting adverse effects, you might have had the range slightly lower in case there was a need to reduce it. I cannot, from the information I have seen in the notes, understand why there was such a large increase in the equivalent opiate prescribed for Patient A, which is, using the word one-third conversion it is an 8-fold increase, at the lower dose of the range, 12-fold, if you use 50 mgs it is 5-fold, to 8 or 9-fold increase, which is not consistent with any guidance either in the BNF or the Wessex Protocols as we have discussed.

Q Is it consistent with any medical practice you have come across?
A No, not a magnitude of this increase.

Q Does it give rise to any particular danger or hazard?
A As discussed, when one increases a dose of opiates, there is the risk of developing significant adverse effects, most notably respiratory depression and decreased conscious level. That is the concern, particularly in the context of the potential administration of other drugs, notably midazolam, which will also potentially have major effects on respiratory drive and conscious level.

Q I will come on to midazolam. Even if the diamorphine were being prescribed on its own without the midazolam, consistent in your view, or inconsistent, with *Good Medical Practice*?
A I cannot see how it is consistent with *Good Medical Practice*. I cannot see how it was in the patient's interest to have such a large increase in opioid prescribed.

Q Midazolam was also prescribed as part of this prescription between 40-80 mgs. Midazolam does what?
A We discussed it is a potent benzodiazepine that is used in the management of terminal restlessness in patients at the end of life. Again, the difficulty I have is that the medical notes are not clear in explaining, and do not explain, the rationale for these drugs so that, assuming that was what the indication for it was, to manage restlessness and agitation at the end of life, that certainly is an appropriate drug to consider. There are other drugs that could have been given, such as the usual one you would use, antipsychotic drugs for the management of agitation as were subsequently used in Mr Pittock, but the starting dose is very high. The recommended starting dose in the elderly would be 5 or 10 mgs over 24 hours and a starting dose of 40 mgs over 24 hours – a benzodiazepine in a naive patient – is extremely high and likely to produce adverse effects.

Q I am looking at paragraph 14, when we look at the joint prescription of diamorphine with the lowest dose of 80 mgs and midazolam with the lowest dose of 40 mgs and then with a range above that, what, if any, are the dangers that are carried with that sort of prescribing practice?
A The problems are, first, it is unlikely he will remain alert. He is going to have a very depressed conscious level, as happened. Secondly, you will bring about respiratory depression and death at an earlier point. This man is dying, I think everybody recognises that. I think there is little disagreement by any of the experts about that or the clinicians involved, but the treatment he is receiving as a dying man should still be appropriate to his needs. The use of sedation therapy is an area of potential concerns in other countries. Sedation therapy, it has been commented, is open to misuse. I am not saying it was misused, but the problem is, because they are so powerful at producing respiratory depression, one systematic review of sedation in end of life care comments that it can ostensibly be used to relieve distress but with the manifest intent of hastening death. I am not saying that was the intent here, I am saying that is the concern about why one needs to document very carefully the use of sedation in an end of life setting, that it is used appropriately to control patients' symptoms.

Q If we look at the documentation we have, which is in relation to the specific prescription by Dr Barton, the note is limited. We have 9 January, which we have looked at, we have Dr Tandy's note of 10 January, and then the next note we have from Dr Barton, I think, is on 18 January. Is there anything in these notes that appears to justify such a prescription?
A There is a note that the patient has anxiety and agitation. Clearly, there was a good indication recorded for the use of an antipsychotic or a benzodiazepine and both were used at different times. There is some information there, it is not related immediately to the prescription, but I think one can assume this was a man with anxiety and agitation. That may have been due to the opiates, but it is not clear from the notes whether they thought the staff thought he would gain benefit from the morphine he started in terms of his pain.

Q Pausing there. He started on the Oramorph on 10 January?
A Yes. As I said in my report, it would be difficult to dissect out the cause of his agitation and it could have been due to a number of different causes.

Q If we look – and I am staying with the chronology to save time – at the entry for 13 January, there is a note made by Nurse Ring:

A

"Catheter bypassing. Mr Pittock looks distressed."

If we go over the page, there is a further comment:

"Catheter bypassing +++ so catheter removed. Tip of catheter very mucky. Pad and pants in situ."

B

On 15 January we can see that the diamorphine was started at the lowest rate of 80 mgs. Why is this catheter bypassing, from what you are able to tell from the notes, what are the possible causes for that happening and what is the remedy?
A One possibility is that the catheter has become blocked and debris accumulates in catheters placed in patients, particularly if they have them long term. The other possibility is that a larger catheter is needed. The relevant point in terms of assessing the patient would be
C to establish whether they had a distended bladder and whether that was a possible cause of their distress. There is no particular information about that I could find in the medical nursing notes, so I cannot comment whether that was or was not a cause of his distress.

Q The note that we have is that the patient is agitated, and it is in the same note, that the catheter is bypassing but we do not know if the two are linked or may be?
A That could have been a factor that was contributing to his agitation, as could the
D morphine, as could his agitated depression. There are a number of factors that could be contributing in this man.

Q There is no specific reference to pain.
A I think there was earlier on, I think there are records that he was in pain and, certainly, prior to the commencement of oral morphine there was.

E Q The patient we know had very sore areas around his genitals.
A Yes. I think the prescription of opiates was appropriate in this man to see if that improved his level of comfort. I think it was reasonable to carry on continuing a dose of opiates that was not obviously causing him problems.

Q Is there any indication that you have seen as to why a syringe driver was started as opposed to oral opiates?
F A I did not find any clear information in the notes which indicated the rationale from switching from the oral route to the subcutaneous route. I am trying to recollect whether there was an entry in the notes as to whether he was taking food and drink at the time or if he stopped eating and drinking. His intake was definitely poor.

Q If we look at the chronology, page 15, I am not sure this is going to help you?
A We certainly know that after the infusion was commenced he was unable to swallow.
G What I cannot tell from the notes is whether he was unable to swallow before the infusion was commenced.

Q Once the syringe driver has started we can see, if we look at the bottom of page 15: "Seen by Dr Barton, has commenced syringe driver" and then it sets out the amounts. "Daughter informed of father's deterioration during the afternoon". I think we must amend
H that as well; it is not "no unresponsive" it is "now unresponsive. Unable to take fluids and

diet." If this syringe driver started at 8.25 in the morning, to what effect is it going to be having an effect upon him by 7.00 at night?
A By that time he has received almost 30mg of midazolam and 40mg of diamorphine ----

Q Because it is almost 12 hours.
A Twelve hours. I think it would be highly unlikely he was not significantly sedated with that dose of midazolam and, also, he is receiving diamorphine by that time. It does not surprise me he is "now unresponsive". However, whether his level of responsiveness and whether he was able to take fluid and diet before that was commenced, I was not able to establish from review of the notes.

Q Can we go to the following day, please, 16 January? We can see that the diamorphine remains the same, I think, as does the midazolam. The haloperidol is now prescribed, and indeed administered. Haloperidol will have what effect?
A It is an antipsychotic drug, primarily used to control agitation.

Q If we look at the note underneath where the drug chart is set out on the chronology: "Condition remains very poor. Some agitation was noticed when being attended to. Seen by Dr Barton. Haloperidol at 5-10mg to be added to driver. Night condition remains poorly. All care be continued." Haloperidol can be used, I think, for agitation or to assist with agitation.
A Yes, it can.

Q Does it have a sedative effect?
A It does have some sedative effect, yes.

Q Does it follow from that the sedation will be on top of the sedation already provided by the diamorphine and midazolam?
A Yes, it would. I think there is not a clear note made by Dr Barton which indicates the rationale of using haloperidol but the nursing notes suggest that it was because he was showing signs of agitation. In that sense, haloperidol, to treat agitation, is a high starting dose; the recommended dose is start with 2.5 over 24 hours, but I think it is not unreasonable to start with 5. There, perhaps, should have been a consideration – he is on a very high dose of midazolam and is still agitated, he is on a very high dose of opiates, and could they, in fact, be contributing to it, particularly the opiates, at this point? So we have got very high doses of diamorphine and midazolam still continuing with, now, an antipsychotic added in as well.

Q Can we pause for a moment and just look at the prescribing itself and the way that it is written out, and whether that, in itself, carries with it any problems. Could you turn up the patient notes. I am trying to avoid doing this as much as possible. Could you go to page 200?
A Yes, I have that.

Q I think you commented on this in your report at page 20, if that helps you. We can see, at the top of the page, the prescription for Oramorph, and then, underneath that, a prescription for diamorphine for between 40 and 80mg, which does not appear ever to have been administered.
A Yes.

Q Underneath that, hyoscine, 200-400micrograms; underneath that midazolam for, I think, 20-40mg – none of which appear to have been administered.
A Yes, which I found surprising since this is in the regular medication section, if this is a correct copy.

Q Before asking you to comment I just want you to look at the next page, page 201. We have then got the prescription that we have just been looking at: the diamorphine of 80-120; the hyoscine 200-400micrograms, plus midazolam 40-80mg, and a further prescription under that for midazolam (I think it is) at 80mg on 16 January – the first three being on 11 January. Just looking at 11 January, and the prescription the day before, those prescriptions all appear, certainly at some stage, to be live.
A Yes, I think there was a problem that there seemed to be two open prescriptions for diamorphine and midazolam on the same drug chart, unless they were different drug charts, and the risk then is that they could both be administered. It would be usual to cross an old prescription off. They were not administered, but it is not good prescribing practice. The only alternative explanation I can think is that they are from separate prescription charts, but I assume that is not the case.

Q Unfortunately, we do not have the original sheet, and we are all on microfiche for these. If they are on a separate sheet, what is the appropriate practice if you are writing out a new prescription because you think the old prescription was either wrong or ineffective or not enough? What are you meant to do?
A You put a line through the old prescription and you sign and date, usually, the date of discontinuation.

Q And then that is clear.
A And then that is clear that that prescription is no longer active. Sometimes, if you have got a new prescription chart, the usual practice is to put lines through all of the front of it, to make clear the whole chart is inactive, so that was why I was saying if it was a new chart, but I think there is an overlap of the dates, certainly for some of these, which led me to believe it was – one cannot tell, actually, on this one.

Q Can we go on through page 16, please? We can see the diamorphine at 80mg and midazolam at 60mg and hyoscine at 400mg was administered, together with haloperidol 5mg. There is a nursing note that the patient's condition remained very poor and agitation was noted when being attended to. Then we can see that a bed-bath was given; that his right ear was very blistered and swollen and all pressure areas were marking easily. Then can we go to 17 January, please, the following page. Also page 18. It may be useful to look at page 18 first. This is a note made by Nurse Douglas at 9 o'clock in the morning.

> "Seen by Dr Barton. Medication increased, 8.25, as patient remains tense and agitated. Chest very bubbly, suction required frequently, bed-bathed, hourly turning; remains distressed on turning. 14.30 seen by Dr Barton. Medication reviewed and altered. Syringe driver renewed." Then Sister Hamblin makes a note: "Further deterioration in already poor condition."

Can we then look at the prescriptions. Diamorphine was increased to 120mg, and that was started at 8.30 in the morning on 17 January, or it appears to have been. Hyoscine was delivered at 600mg, midazolam was increased to 60mg, and then to 80mg, which was also administered, it would appear from the drug chart, on 17 January. Haloperidol was also

increased to 20mg and put into the syringe driver in the afternoon at 15.35. These sorts of increases – have you seen anything that, in your view, appears to justify them?
A I think increasing any one of them would have been a reasonable and appropriate approach.

Q Depending on what? I am sorry.
A In terms of the patient is, at this point, agitated and so you have to make a judgment, from seeing the patient, is it because they are in pain? He does not seem to have responded well to opiates so far, from what one can tell, but ----

Q Does or does not?
A Does not seem to respond particularly well to opiates, from what one can tell from the notes. But it is difficult because the information and records are limited. If it is thought not to be due primarily to pain but terminal restlessness, or agitation, I think either increasing the midazolam, if he is not unduly sedated by it, or increasing the antipsychotic drug dose of haloperidol is appropriate. I think increasing all three at once – there is a four-fold increase in haloperidol and a 33% increase in midazolam and a 50% increase in diamorphine, I think, is excessive.

Q If we then go to the following day, we can see there is a review by Dr Barton. This is at the bottom of the chronology at page 18: "Further deterioration". Pause there for a moment. We see "deterioration" all the way through these notes. What does the deterioration describe?
A Obviously, in the absence of any other information, one cannot tell. If there were more detailed nursing records one could cross-reference to those but I was not able to ascertain what the deterioration was.

Q This patient, on the basis that he is now unresponsive and on a syringe driver, I think we can take it, from everything we have heard, was not being hydrated.
A Yes, and I would suspect he had a very depressed conscious level. Again, there is no formal record so it is difficult to be certain.

Q He has got a depressed conscious level. He is not being hydrated. Will that of itself cause what could be described as deterioration, or would that be described as something different?
A Yes, I am trying to work out when he stopped eating and drinking. It was back on ----

Q We have got 11th.
A We are seven days on, are we not? So I think one would expect deterioration from dehydration itself, at that point.

Q How would that manifest itself?
A Patients move less, their skin colour looks worse, they are becoming less and less responsive and alert.

Q Their skin colour looks worse because that is related to?
A Poor perfusion. These are soft but clear signs that staff can recognise when they are managing patients. I think, obviously, the difficulty one has with Mr Pittock is interpreting what is due to drug therapy, at this stage, and what is due to him approaching end of life from natural causes.

Q Bottom of page 18:

"Difficulty controlling symptoms", writes Dr Barton, "Tried Nozinan"

Nozinan does what?
A That is a sedating, antipsychotic drug. I think that if he had agitation that was related to his depression and general condition, that was not an unreasonable drug to switch to from the haloperidol, if the haloperidol was not controlling his symptoms, but it was given, I believe, initially, from what I can tell, in addition to the haloperidol. It is not recommended one uses two different antipsychotic drugs at the same time.

Q Just to be sure that we understand you; when you just said if he is agitated because of his depression, at this stage, when you refer to his "depression" you are not talking about ----
A His general state. The other problem was if he was opiate-intoxicated he could be having myoclonic jerks which might be misinterpreted as agitation. It is very difficult to tell.

Q That is something we have not heard about. What are those?
A This is where the muscles jerk involuntarily, which you can get with opiate intoxication.

Q When you talk about "opiate" – did you say "intoxication"?
A Yes. When you have got very high levels.

Q Toxicity.
A Yes.

Q Is that something that happens naturally, or is that a sign of over-sedation?
A It is a consequence of having high – it is an adverse effect of having high levels of morphine and the metabolite, particularly in the metabolites; they accumulate.

Q If we go to page 20, we can see that the diamorphine was continued at 120, the hyoscine was – I think that is an increase to 1200microgrammes – the midazolam continues at 80mg, haloperidol is now being administered at 20mg, and now we have got Nozinan added at 50mg. Do each of those drugs have a sedating effect?
A Yes. Not the hyoscine – it does not have major sedating effects.

Q I thought you told us it had some sedative effects but it is not ----
A Some, but I think the major drugs causing sedation here, at this point, would have been midazolam and the Nozinan. To a lesser extent the diamorphine and haloperidol.

Q Then we can see, on 19 January, the same drugs are administered. If we go to 20 January, please, there are comments, at the top of page 21 of the chronology:

"Marked deterioration in already poorly condition. All nursing care continued. Breathing very intermittent. Colour poor."

You have dealt with that.
A I think he is clearly dying at this point.

Q On 20 January, the diamorphine remains the same, as does the midazolam. We know that Dr Briggs discontinued the haloperidol but increased the Nozinan. What sort of effect is that going to have on the patient?
A Well, more sedation. From the notes Dr Briggs was contacted by the nursing staff because they thought he was still exhibiting signs of agitation.

Q Then, on 21 January, we can see that that mixture of drugs continued, and on 22 January and 23 January - the haloperidol, of course, has now gone – and the patient died in the early hours of the morning of 24 January. Before we take a break, first of all, I want to ask you about the assessment so far as the notes that we have got here are concerned. In your view, did Dr Barton appear, at least, to provide an adequate assessment of the patient's condition on his admission, or shortly thereafter?
A I think the initial description summarised the problems and there was a documentation of agitation which was there. However, there really was not a documentation of more detailed assessment as to the possible causes of his agitation and a justification for the prescriptions that were written, particularly the initial subcutaneous infusions of midazolam and diamorphine.

Q In terms, again, going back to the initial prescription, of the diamorphine and midazolam in relation to the lowest doses of those two drugs - in your view, acceptable or not?
A I cannot justify an eight-fold increase in the change from oral morphine to diamorphine and, in addition, the prescription of a very high starting dose of midazolam.

Q Perhaps it goes without saying that in terms of the width of the prescription - is that acceptable in your view or not?
A The width is within the two-fold I said might be desirable, but the problem here is the starting dose for both drugs is excessively high and was likely to produce significant adverse effects, and appeared to do so in terms of his rapid deterioration, in terms of his conscious level, and then within 12 hours of commencing the infusions.

Q There is a specific charge relating to the prescription on the 18 January, adding 50 mg of Nozinan to the other drugs already prescribed. The suggestion is that that was excessive. In your view, was that an acceptable prescription, to add the Nozinan at that stage in combination with the other drugs or not?
A It goes against guidance. You should not give two antipsychotic drugs at the same time. I think it was reasonable to switch from haloperidol to Nozinan if haloperidol was not controlling symptoms, but not to give it in addition, particularly with the other drugs. I think this was a difficult area. This was a man who was dying and we are talking about what level of attention and care to adjusting his drug treatment for palliation are we expecting to see consistent with *Good Medical Practice*. That is the issue and I have laid out the areas where I think it was not consistent with *Good Medical Practice*.

Q The last question I want to ask you and it may be particularly relevant to this patient, so I will ask it now. Then perhaps we can take a break. It is the principle of double effect. Can you just tell the Panel something about double effect?
A The principle of double effect is that one may need to palliate symptoms, and that the treatment one needs to give to palliate symptoms may lead to a shortening of life through adverse effects. That is well accepted as being a reasonable and appropriate aspect that may happen when one adequately palliates symptoms. One has to give drugs and doses that are reasonable and appropriate to palliate symptoms. Then, with certain groups of drugs like

sedatives the issue is giving excessively high doses which have an effect which go beyond what the patient needed to palliate their symptoms.

MR KARK: That is all I am going to ask you about Patient A at this stage. I wonder if that would be a good time for a break. We are moving on to Patient B. I would like, if it is possible, to get started on Patient B if the Panel have the energy to carry on, but it will take twenty minutes to half an hour of reading first. I am therefore in your hands. Alternatively, we could start slightly earlier tomorrow morning. I am just aware of how much there is to get through.

THE CHAIRMAN: I am just thinking of when the Panel started to because although we were flagged for a ten o'clock start, in fact all the Panel were working at nine on pre-reading. They have put in a fair bit already.

What you are proposing is a break now, and the time that they would need to prepare for Patient B, and then to start Patient B?

MR KARK: I can see that is not getting a huge amount of positive support.

THE CHAIRMAN: There does not appear to be, no.

MR KARK: I am totally in your hands, but perhaps the reading could at least be started this evening so we get a fresh start tomorrow morning.

THE CHAIRMAN: I think we will say that we will start tomorrow at the usual time of 9.30, but by that time the Panel will have pre-read the Patient B elements, both in terms of the new chronology, if we have it, and certainly Dr B's statement, so it will be a clean start from everybody else's point of view.

MR KARK: May I hand up the new chronology?

THE CHAIRMAN: Yes, please. We are going to receive that now, ladies and gentlemen, and in the usual way simply place it in the appropriate Panel bundle so it does not require an exhibit number. (Document distributed)

MR KARK: Professor Ford understands that even though he is an expert, I am not now allowed to talk to him. At the moment I do not intend to, in relation to the new expert report that we were given.

MR LANGDALE: Sir, may I make it clear. If the need arises, I have absolutely no objection to Mr Kark talking to his expert.

THE CHAIRMAN: That is very helpful. Thank you very much indeed, Mr Langdale and Mr Kark. Professor Ford, you have noted that.

Ladies and gentlemen, we will formally break now until 9.30 tomorrow morning please. Thank you very much.

(The Panel adjourned until Tuesday 7 July 2009 at 9.30 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 7 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWENTY-ONE)

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.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning everybody. Mr Kark, Mr Fitzgerald, before we have the witness back in, I should say that the Panel have taken the opportunity to read the statements from Dr Barton in respect of Patient B. We have gone through the Patient B bundle again and, of course, the updated chronology. In so doing, we have noted on page 5 of the chronology references to correspondence on pages 242 and 244. Our bundle contains a page 242 but does not appear to contain a 244. We are wondering if we are missing something or if there is a typo?

MR KARK: First of all you are quite right.

MR LANGDALE: I think, but I may be wrong, the answer is to be found at 935 and 936 which gives the whole letter.

MR KARK: I think it is worth putting on 242 that there is a better copy at 935 and I think we had better check. We have our original files next door and we can check to see what 244 was.

THE CHAIRMAN: That does sound familiar.

MR KARK: That may be the answer, but I think we had better check it. Was that the only thing?

THE CHAIRMAN: That is was the only thing we had.

MR KARK: We are ready again for Professor Ford. I was going to make a suggestion for the Panel members to consider whether, instead of breaking and doing one patient at a time, it might speed the process up if we were to do two patients because I think one can probably keep two patients in mind and then let Professor Ford continue for a little longer. It is merely a suggestion.

THE CHAIRMAN: Your confidence is welcome. I will see what the view of the Panel is, whether you would prefer to continue as we have been, keeping one patient in mind at a time, or whether you think it would be reasonable to read two in and keep two in mind, any particular views?

MR KARK: It does not have to be decided now in any event. Perhaps we will raise it later and see whether we can move on.

GARY ASHLEY FORD
Examined by MR KARK, continued

Q Professor Ford, turning to Patient B, I think you have also have the chronology for Elsie Lavender, is that right?
A Yes, I do.

Q The Panel will have looked through that but, in essence, she was admitted to the Royal Hospital Haslar. She had a fall and apparently there were x-rays conducted of her skull and shoulders that took place on 5 February 1996. She was then placed on coproxamol and dihydrocodeine. There is a note on 14 February 1996 that she is still not able to do much

for herself because of pain in her arms. On 16 February 1996 there is this note, the patient having been since by Dr Tandy:

> "Since the fall, patient had had weakness in both hands and has been a unable to stand."

We will look at this again in due course, but I think you took a view as to whether in fact this patient had had a stroke or not?

A I thought it was unlikely on the basis of the information presented in the notes that she had had a stroke. This lady, from the description of the admission to the Accident & Emergency Department, had very probably fallen down the stairs and had a significant injury. She was found at the bottom of the stairs. The symptoms she has, pain in the arms and weakness in both arms, are not typical of a stroke at all. In the context of that fall, it is much more likely she had sustained a fracture of the cervical spine with some cervical cord injury or had some cervical cord contusion. The symptoms are really not at all typical for a stroke. It would be much more typical for a cord injury and she presented in the context of somebody who could well have had a cord injury. I think that was recognised as a possibility by Dr Tandy because she refers in one of her entries to, I assume, the writing is that she assumes that the patient has had cervical – she had her neck x-rayed, I assume it was normal.

MR KARK: I do not think she had the report or the x-ray.

A She obviously did not and she was asking the team who at that point were looking after her to check that she did not have a neck fracture, a cervical spine fracture. Ideally, with these symptoms, one would have gone on to do an MRI of the neck, but one would certainly have wanted to get an x-ray of the spine. I could not tell from a review of the notes whether that x-ray had been obtained and there was nothing in the medical notes at the Royal Hospital Haslar to indicate a result of that x-ray.

Q In any event, on 22 February 1996, she was transferred to Daedalus Ward. We have the clinical notes at page 975. I am not going to refer to much of the notes at all. It may be worth having the clinical notes, 975, for Patient B. The note made by Dr Barton:

> "Fell at home top to bottom of stairs."

That is under her past medical history:

> "Lacerations on head, leg ulcers
> Severe incontinence needs a catheter
> Insulin dependent
> Regular series BS
> Transfers with 2
> Incontinent of urine."

We know what that means now, it means the help of two nurses to get out of bed.

> "Help to feed and dress
> Barthel 2
> Assess general mobility
> ? suitable for rest home if home found for cat."

We know that in the nursing notes there was reference to a probable brain stem CVA. That was obviously being considered. Do you think it may have been wrong?
A I think almost certainly it was wrong.

Q We know that this patient was then prescribed dihydrocodeine. As far as that is concerned, is a PRN prescription not unreasonable?
A No, I think that was reasonable. I think there are various reports of pain in her hands, there is possibly pain in her shoulders – I do not think there was pain in her neck – and also pain from a pressure sore she was developing, or certainly her bottom was very sore, was referred to at one point.

Q There is a note of the 24 February, I am taking this now from the chronology at the bottom of page 8. This is from the nursing notes reviewed by Dr Barton:

"Pain not controlled properly by D.F.118."

Is that dihydrocodeine?
A Yes.

Q

"Seen by Dr Barton – for MST 10 mg BD?",

meaning twice daily. We have that prescription, if anybody wants to turn it up, at page 997. We will run through the prescriptions first and I will ask you to comment on them. She was put on slow release morphine tablets at 10 mgs twice daily and those are administered. Looking at the chronology at the bottom of page 9, there is a note in the nursing care plan that the patient appears to be in more pain, "screaming 'my back' when moved but uncomplaining when not". She is reviewed again by Dr Barton on 26 February and a further prescription is written up. We are now looking at page 11 of the chronology. As we can see, the prescription, which we can find if anybody wants to turn it up at 995 and 997, was that the MST at 10 mg was discontinued, 20 mg was commenced at night time but then she was written up for diamorphine between 80-160 mg by syringe driver, midazolam between 40-80 mg, obviously also by syringe driver, and hyoscine. We will come back to look at those in a moment. Then the MST is continued. The patient is noted, on 4 March, to be complaining of pain and having extra analgesia. We can see that the MST dose was increased to 30 mg twice daily. At the bottom of page 13 we can see:

"Pain uncontrolled – patient distressed".

We have heard reference to pain uncontrolled in the evidence and, as we have understood it, it means essentially not necessarily that the patient is screaming in pain the whole time, but that the pain is not being controlled by the analgesia that the patient is receiving. Is that your understanding?
A Yes, that is my understanding from the previous witness statements.

Q We can see at the top of page 14 that the diamorphine is prescribed at a higher dose, 100-200 mg, and on 5 March the syringe driver is started with 100 mg, the lowest dose – sorry, the chronology is shown as being on 5th?
A I had it as the 5th.

MR KARK: We can check that.

MR LANGDALE: On page 14, I am sorry to interrupt but I want to be clear, on page 14 of the chronology for 6 March I have "SC analgesia commenced".

MR KARK: Yes, that is right, but that is a nursing note which may be relating to a historical event.

MR LANGDALE: I think it is Dr Barton's note, but I may be wrong.
A May I comment. My interpretation when I reviewed the prescribing charts was that I understood that the diamorphine had been commenced on 5 March.

MR KARK: If we look on at page 991, and we heard about this from Mr Beed, I think, we can see the prescription for diamorphine written up by Dr Barton for 100-200 mg and we can see an entry under 5 March. I am afraid we are working on microfiche for this.

MR LANGDALE: If I can short cut this, no dispute, that is what is shown on the chart, therefore it may just seem a little misleading if you have "SC analgesia commenced" on the 6th.

MR KARK: The note on 6 March is relating to the historical, the fact that SC has already started, so I think it started on 5 March, although it is difficult to read exactly when it started. It looks like 09.30 in the morning. That is also confirmed by the nursing notes. I think we are there, 5 March it is started. I am turning to your report, which the Panel do not have, at paragraph 7 where you deal with the issue whether in your view there was good evidence of a brain stem stroke. How could this in fact have been ascertained?
A I think, as I mentioned earlier, Dr Tandy rightly commented that a CT scan would probably not have been helpful in diagnosing a brain stem stroke, so you would really want to do a magnetic resonance scan of the brain and also the neck because there was a clinical question of whether she had a neck injury or fracture or displacement of the cervical spine. It has to be said that MR access for patients like this was quite hard, difficult, in the early 1990s so I am not critical of them not going ahead with that. I do think that the cervical spine x-ray should have been done, which is what Dr Tandy had asked to be checked and it is not clear whether that was done or not. You would have wanted to have excluded a cervical spine fracture in this lady.

Q I want to deal with the issue of Dr Barton's plan of treatment. If you turn back to 975, and I think you comment on this in your report at paragraph 9, what if any view do you have of the initial assessment and the plan provided for this patient?
A I think it was reasonable. I would not have expected Dr Barton to question the diagnosis that had been made by Dr Tandy. I think, as I comment in my report, that the continuing pain two weeks afterwards, in my view, should have raised a question as to what the cause of that was when this was not a lady, as we understand, who complained of pain before she was admitted, so you would expect pain from musculoskeletal injuries to be subsiding by this point. One thing that is not clear to me from reviewing the notes at various points, is the location of the pain from either the medical notes or the nursing notes. There is an entry, for example, referring to the physiotherapist which refers to neck exercises. This is on the bottom of the chronology, page 12, which might suggest she may have had some neck pain and stiffness. Although there is a mention about the sore bottom in the beginning, the

location and nature of the pain is not clear to me. I think that, ideally, one would have liked to have seen a reassessment or more description of pain and possible causes.

Q The patient was started on slow release tablets for morphine. That followed on from her dihydrocodeine. So far as the conversion from dihydrocodeine to MST, do you have any particular views about that?

A We do not usually convert from dihydrocodeine. It is a very mild opiate. As I commented in my report, you would usually you start on oral morphine, not a sustained release, if you decided that opiates, more powerful opiates, are the appropriate treatment and see the response.

Q Why?

A Because of the problem that we discussed yesterday that, when you start sustained release tablets they are very slowly absorbed and you do not know whether you are going to get the right dose, you may leave the patient not controlled with their pain or it may be too excessive a dose, so those are the sort of reasons. It is recommended that you start with oral morphine, work out the dose that controls the patient's pain and convert to a sustained release preparation.

Q If we go to page 11 of the chronology. You will find the drugs charts if you want to turn them up – we just looked at them – at 995.

A Can I just comment?

Q Yes.

A I think the use of morphine may have been appropriate but I am critical that there was no assessment of the location of the pain or which might have led to using other strategies such as non-steroidal anti-inflammatory drugs or further investigation.

Q Does this come back to the point that you were raising yesterday, that the first step is to find out what the source of the pain is rather than simply trying to relieve the pain by analgesia?

A Going to opiates, using morphine may have been appropriate, but there is not a clear and strong justification, or assessment of the cause of the pain.

Q Can we then have a look, please, at the prescriptions that are written up for diamorphine. If we work from the chronology, top of page 11, the patient at this time was being administered at 10 mg twice daily, I think. Then, that is increased on the 26th to 20 mg twice daily. So that is the prescription that is commenced and at the same time Dr Barton prescribes 80-160 mg of diamorphine, coupled with 40-80 mg of midazolam. Do you have your reports in front of you?

A I do.

Q We are looking at paragraph 11 of your report. We all know now the conversion rate. At this level I think it would be one-third normally rather than one half?

A Correct.

Q And so a normal conversion, if one was attempting to achieve the same degree of pain relief would have been in the region of what?

A 15 mg approximately; 13 mg if one is being precise with a third.

Q What do you say about the prescription that allows for between 80-160 mg of diamorphine to be given and 40-80 mg of midazolam?
A It is not indicated or justified, and it is a very high dose. It is a four to five or sixfold increase, and if that had been commenced it would be highly likely to cause major adverse effects which is respiratory depression and coma, particularly with the co-prescription of midazolam at the dose range prescribed.

Q Does that apply to the lowest dose?
A It applies to the lowest dose of 80 mg.

Q So it follows that anything above that is going to have a worse effect?
A If one was concerned that this lady was going to become unable to swallow and take the opiates which were controlling her pain, one could have written either PRN doses of subcutaneous morphine, as we discussed yesterday, which can be given four hourly, or one could have written, if one wanted to, a subcutaneous equivalent dose but I cannot see any justification for prescribing such a greatly increased dose. That is unsafe practice.

Q You mentioned there the possibility of coma which is obviously a hazard. What is the difference between unconsciousness and coma? What is a coma?
A Coma is generally used to describe a deeper level of being unconscious, but a coma is just the lowest form of conscious level. That is all. Depressed conscious level is a better way – it describes the fact that that is a common adverse effect of excessive doses of opiates when first starting.

Q If we come back, please, to the chronology, that particular prescription was not administered except in so far as the MST, and we can see on page 11 of the chronology that the MST was administered 20 mg twice daily. Then over the page we can see that the patient is still complaining of pain in her shoulders on movement but refusing medication. It took a while to persuade her to take them. Then on 2 March there is a comment about slight pain in shoulders. On 4 March the patient is complaining of pain and having extra analgesia "PRM" – is that meant to be "PRN"?
A I think that is meant to be PRN.

Q "MST dose increased to 30 mg ... by Dr Barton." At this stage, if the patient is continuing to have pain, is an increase in the dose of the MST the appropriate approach in your view?
A I think at some point one would have wanted to see an assessment of cause of the pain, whether it was earlier at the beginning or now. The problem is, one would assume it was being treated as arthritis or musculoskeletal pain but in the context of somebody having had a major fall, I think one would have wanted to review what the cause of the pain was. It may not have responded well to opiates if it was neuropathic pain, for example, relating to nerve entrapment. There are a number of different approaches one might have taken, depending what the cause of the pain was.

Q If one was in the position at this stage, that the doctor still does not have the x-ray from the previous hospital, or at least an x-ray report, what steps in your view could the doctor properly have taken?
A The start would be to examine the patient and see if there are any obvious signs of injury or particular problems. There is no record of that. I think it is not unreasonable to

increase analgesia but the problem is, we do not at this point have a clear diagnosis of exactly what is thought is being treated – at least recorded in the medical records.

Q If we go to 5 March, page 13 of the chronology,

"Reviewed by Dr Barton
Has deteriorated over last few days. In some pain therefore start sc [subcutaneous] analgesia. Let family know."

Then there is a nursing note:

"Patient's pain uncontrolled. Very poor night. Syringe driver commenced...".

Just pausing for a moment, this patient by this stage, I think, is on a total of slow release morphine of 60 mg daily?
A Yes.

Q That is being taken orally and so according to the BNF certainly the equivalent dose would be 20, and one could of course increase it from that starting point?
A Yes.

MR JENKINS: Forgive me. Can I just interject? Look at page 975. We have left out one line that perhaps should be included: "Not eating or drinking".

MR KARK: I am grateful.

MR JENKINS: That is in Dr Barton's note.

MR KARK: Very well.

MR JENKINS: On the chronology it should come after "Has reviewed over last few days. Not eating or drinking". Page 975.

MR KARK: I think it is probably worth adding that to our chronology. I see it now. It is the second line. If we go to 975, it is the second line down on that entry. It is under the words "Has deteriorated over last few days. Not eating or drinking." I think the time has come, probably, when we need to stop sending these back for reprints, perhaps, and just make annotations as needed.

THE CHAIRMAN: I agree, Mr Kark.

MR KARK: The patient is then prescribed a variable dose by Dr Barton of between 100-200 ml of diamorphine and 40 mg of midazolam. That is begun at 9.30 on 5 March. What, if anything, do you say about that starting dose of diamorphine? I am looking at your paragraphs 12 and 13 of your report?
A Just to discuss the deterioration first, the first issue is why is this lady deteriorating at this stage. It should not be related to her stroke per se. It is possible it was an adverse effect of the opiates. It is difficult to tell from the information in the medical and nursing notes, but it is not clear to me why this lady at this point is not eating or drinking, but that could be related to her opiates. Also you have the issue again of what is the cause of this continuing

pain. That said, she is taking 60 mg of oral morphine, which is the equivalent of 20 mg prescription of subcutaneous infusion of 100 mg, is five times higher than the current equivalent she is taking. That, again, is – like the first prescription – not justified. It is an excessive increase. One would want to give the equivalent and possibly a little bit more of, say, 30 or 50 per cent. That would take it to the equivalent of around 30 mg over 24 hours. Again, I would judge that prescription to be very risky and likely to lead to, as the first prescription if it had been administered, adverse effects, with particular concerns about depression of respiration and conscious level.

Q In the middle of that sentence you said "likely to lead to". Was it likely to lead to the respiratory depression?
A Yes.

Q And depression of conscious level?
A In a lady of this age that increase in dose would be expected to be very likely to cause significant adverse effects.

Q We see from the chronology there is a review by Dr Barton on 6 March. The day after that has started, the syringe driver has started. There is a comment:

> "Further deterioration. SC [subcutaneous] analgesia commenced. Comfortable and peaceful."

What is the state of this patient with that amount of diamorphine and midazolam going through her?
A There is not a formal assessment of conscious level in this lady but I would be very surprised if this lady had not had significant depression of conscious level, and that was why she was peaceful, because the drugs had significantly depressed her conscious level.

Q If we stay with the chronology on 6 March, that analgesia at that level having commenced, we can see from page 15 that death is actually recorded at 9.28 on the evening of the 6th. The cause of death is given as a CVA and diabetes mellitus. Have you formed any view as to what may have led to this patient's death?
A Because I do not think she had a stroke, obviously I do not think the stroke, referred to as a CVA, is a cause of her death. The timing of deterioration in this lady with her death – I need to work out the exact time the final prescription was administered. Within 24 hours – would suggest there temporarily that drugs are very likely to have contributed to her death. In my view she may have died from other causes. She was an older, frail lady who was very dependent, so she could have developed a pulmonary embolus; she could well have developed a pneumonia but of course drugs had induced respiratory depression. You would also often see broncho-pneumonia. I think one of the issues with any older patient with multiple pathologies is they can die suddenly, particularly if in hospital, so it is very difficult to prove beyond all doubt that one cause is the definite cause of death, but I think it was highly likely that drugs contributed to this lady's death.

Q And if the drugs did contribute to her death, what is the system? What are the drugs doing which actually cause her to stop breathing and her heart stop?
A They are suppressing the central respiratory drive so you eventually stop breathing. You die from hypoxia, low blood oxygen levels.

Q And does the heart stop first or does the breathing stop first?
A The breathing would stop first with a drug-induced respiratory arrest.

MR KARK: That is all I am going to ask you about Patient B. Sir, we are going to move on to Patient C. Mr Fitzgerald has just provided me with page 244 which indeed is the second page of the letter. I think for the sake of completeness it is probably sensible to put it in just so that we do not raise this again in three weeks' time when we have all forgotten what that page is.

THE CHAIRMAN: We can do that comfortably because it is only a single document. (Page 244 distributed)

MR LANGDALE: May I just indicate while the Panel are going to be inserting this extra page that page 242, the one that immediately precedes it – and Professor Ford can hear me saying this because I may need to ask him about it – perhaps the Panel would care to note that in the first paragraph of the letter at page 242, half way through the first paragraph:

"She tells me she's had her neck and chest x-rayed."

I will be drawing Professor Ford's attention to that as to whether there was or was not an x-ray. It may be convenient to note it now.

MR KARK: Once we have inserted that, the time has come to move on to Patient C. You will need your reading time again. We are getting through the patients a bit more quickly because the reading is being done and because we spent quite a long time yesterday dealing with the basis, as it were. Even so, you will no doubt require your 20-30 minutes, perhaps a bit longer if you are doing two.

THE CHAIRMAN: I think what we have found is, it is 30 minutes in combination because, of course, we will be looking at Dr Barton's statement as well. The two together seems to work in about 30 minutes. Ladies and gentlemen, we will formally break now so that the Panel can spend the next 30 minutes reading Dr Barton's statement in respect of Patient C and also looking at the updated chronology for Patient C.

MR LANGDALE: May I inquire with regard to Patient C, I have not received an updated chronology.

MR KARK: You should have done, Mr Langdale.

THE CHAIRMAN: I am afraid we have not received it either.

MR KARK: I am sorry. It is sitting behind me. I have it but nobody else has, so apologies. That will be sent round. (So done)

THE CHAIRMAN: I am told also that there is no statement in respect of this patient, and therefore we can reduce the amount of time that we are going to need to read. We will therefore take that down to 20 minutes, please.

MR KARK: Very well.

THE CHAIRMAN: We will re-start at 10.30, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Kark, before you resume, I should tell you the Panel have taken the opportunity to read through the new chronology and cross-reference it with the Patient C bundle. In that regard, page 272 of the bundle has what might very well be one of the replacement photocopy pages. It is certainly remarkably clear insofar as it has been photocopied, but the left-hand margins have been cut off and so, for example, we are unable to read the date of the prescriptions for diamorphine referred to in the upper part. Similarly, parts of the boxes on the lower part to the left are also missing. Could we either have copies that do show all or, failing that, we would be content to have a look at the original. In fact, we probably have that, do we not, in the bundle?

MR KARK: No, I do not think you will, sir, because this is Patient C and the originals do not start until D. I am afraid for A, B and C, we are relying on microfiche copies. We will see if we can get a better copy of this.

THE CHAIRMAN: If it is possible, we would be grateful.

MR KARK: There is also something else we need to do on the chronology, but we will come to that. (To the witness) Let us start, please, Professor Ford. This patient was plainly very ill when she came into the GWMH.

A Yes.

Q She had been admitted to the Queen Alexandra Hospital on 6 February 1998 and it looks like she had a carcinoma.

A Yes. There is not a tissue diagnosis, but one would not usually pursue that in a patient of this age and frailty and she had appearance on her chest x-ray from the reports which was entirely consistent with a lung cancer: a carcinoma of the bronchus. I think that is very clear that that was the underlying problem.

Q We see from our chronology the references to general deterioration, nausea, decreased appetite and feeling depressed. This is all on page 1. Could I suggest we may wish to add one matter to the chronology? If we go to page 299 of the patient notes, this is an entry at the top which actually is a continuation from the previous page of 12 February 1996. It is a review by a doctor and the last words are:

> "In view of advanced age, aim in the management should be palliative care. Charles Ward is suitable. Not for CPR."

That may be an important reference in this patient's notes. It is plain that this patient was, at her age, destined, as it were, for palliative care.

A Yes, and she would not be expected to survive for very long.

Q If the members of the Panel want to make a note in their chronology: 12 February 1998, reference page 299:

> "In view of her advanced age, aim in the management should be palliative care."

MR LANGDALE: Sir, I am sorry to interrupt, but while we are on a page, it will save me coming back to it in cross-examination of Professor Ford. Might we also note on that same page – this is mentioned in Professor Ford's report – with regard to the last paragraph on that page, "Son agrees not suitable for invasive treatment." That is three lines up from the bottom. Professor Ford at paragraph 6.2 says that that says, "Son agrees not suitable for invasive treatment."

MR KARK: I have no objection at all to Mr Langdale indicating what his additions are. I think it is helpful.

THE WITNESS: May I comment? I read that to be "investigation". I do not think it makes a substantive difference, but it is just a comment.

MR KARK: On any view, this patient was not going to be operated on at her age and she was not going to survive this cancer.
A Yes. Any intervention would have been inappropriate in terms of further investigation or treatment of the carcinoma of the bronchus.

Q She was reviewed on 25 February by Dr Lord and said to be confused with agitation and frightened, perhaps not surprisingly, although she says, "not sure why". She tends to scream at night, although she is not in pain and there is the suggestion, "Try thioridazine". You have mentioned thioridazine yesterday. Can you just remind us about that, please?
A It is an anti-psychotic drug that was used quite extensively before 2000, when there were cautions against its use because of toxicity. It was used quite extensively in older people for sedation and treatment of agitation.

Q Is that the one that was taken off the market?
A It is the one that was taken off the market, but its prescription at this time- point was appropriate and very frequent.

Q Then we can see that the patient was transferred to Dryad Ward. There is a note by Dr Barton at page 304. I am not going to go through all of that. It is in our chronology at the bottom of page 4 that the patient needed help with eating and drinking. There is a diagnosis of a carcinoma of the bronchus and:

> "Plan: Get to know. Family seen and well aware of prognosis. Opiates commenced. Happy for nursing staff to confirm death."

We have seen that note, or we will see that note, in relation to other patients. In relation to this patient, was that in your view appropriate?
A Entirely reasonable and appropriate. Are you referring to confirming death or to the use of opiates?

Q Both.
A The rationale for prescribing opiates was not clearly described and I think some palliative care specialists might say if she was not in pain, opiates would not be the first choice, but I think it was a reasonable prescription. Many geriatricians and general physicians in this patient, who was showing signs of distress, even if it was not clear they were in pain, if they had end stage carcinoma, would consider the use of opiates. So yes, I think it was reasonable.

Q In terms of "Happy" or whatever words one uses – there may be more felicitous ways of expressing it – but the fact that nursing staff could confirm death in this patient?
A Yes. We have not discussed that. I think it depends what the general policy of the unit was for confirmation of death in patients. One would prefer to have a policy for a unit rather than it being done on individual patients necessarily. But that is a general comment.

Q From the drug charts, if we go to page 5 of our chronology, we can see that on the day of her transfer she was written up by 2.5 to 5 ml (5 to 10 mg) of Oramorph, thioridazine and then various other drugs such as digoxin and frusemide. I do not think you have any substantial criticism of those drugs.
A No.

Q She is described on 28 February and being "very distressed" and calling for help. The patient was given drugs, but they unfortunately did not relieve her. There is a reference on page 7 in the chronology to 1 March 1998, when the patient was described as:

> "Slept well but calling+. Shouting from approx 05.30. Spat out all medication."

You are nodding. We have not dealt with that in any detail, but if a patient is unable to take medicine orally or is spitting out medication and requires medication, what is the appropriate route?
A You have a number of choices. One is to give drugs by the intramuscular or subcutaneous route or potentially intravenous, but that would not be a route one would use in this setting. Or, as we will go on to discuss, there are some drugs, a few, that can be given through the skin, through a transdermal patch.

Q Let us look at that. If we go to page 8 of the chronology, this is dealing with 2 March. The clinical note is at page 305, which reveals:

> "No improvement on major tranquilliser. I suggest adequate opiates to control fear and pain. Son to be seen by Dr Lord today."

Then over to the top of page 8 of the chronology, there is a reference to spitting out thioridazine and:

> "Quieter on prn ... diamorphine. Fentanyl patch started today."

If we go to the following page, we can see that the drugs which were prescribed first of all was fentanyl 25 – that should be a microgram patch, should it?
A Yes.

Q "x 3 days." So that would be one patch lasting - ?
A The patch is recommended to be in place for three days and then removed and a new patch put on.

Q We have looked at this yesterday in the BNF. The equivalent dose of a fentanyl 25, my recollection is that it was about 135 mg.

A I think it was up to 135. I think 90 mg was the standard conversion. It certainly is now. I think the 135 – I cannot remember if that was the Wessex protocol we were looking at. I think the BNF says 90 mg.

Q Just looking at this prescription, this was administered at eight o'clock that morning. So that means it would be put on the skin of the patient – where are these patches normally placed?

B A Well, in somebody who is agitated and might be pulling things off or pushing them away, you might put it on their back, so that they were less able to get it, or typically it is put on the abdomen or the chest wall.

Q I want to pause for a moment on the fentanyl patch. You dealt with this first of all in your report that you made for the police at paragraph 6.12. Do you have that?

A I do, yes. I have it open at that section.

C

Q Tell us, please, your view first of all about the appropriateness of prescribing and administering this patch in these circumstances?

A The first approach that had been taken was to give intramuscular diamorphine and the nursing notes or medical notes report that there was some improvement on that. I think two doses were given and, although it was not clear on the prescription chart that was referred to earlier, I think it became clear from the nursing notes that that was the day and these two

D doses were given at eight o'clock and three o'clock. I think that was a reasonable approach. I think the decision to use fentanyl is reasonable; I can understand the rationale for that. You have somebody who may be difficult to manage and you want to avoid having to keep repeat injections. I think using the fentanyl patch is not an unreasonable thing to do, but I think the issue, as we talked about earlier, is that it is quite a high dose of opiate that one is administering. So one has to be aware that there is a risk of adverse effects in this age group, because it is a large dose of opiate. I think it was reasonable, because the notes suggest that

E there was quite a lot of difficulty giving medication to this lady. We do not know how difficult it was to give the intramuscular drugs, but I think this was a reasonable approach to try in a patient where you have difficulty administering drugs.

Q This was a lady who was, as you have revealed, inevitably dying of her carcinoma.

A Yes. I think again you are trying to achieve palliation in somebody who is nearing the end of life and, in that context, it is not unreasonable to take some risk to achieve palliation.

F Because there was not a smaller fentanyl patch at that time, they had to use the 25 mcg patch.

Q 25 being at that time the minimum dose; it has now changed.

A Yes.

Q I want to come back to what you just said about the use of diamorphine, because I do not think it appears in our chronology and it could certainly be relevant. Your understanding

G was that this patient had received injections of diamorphine prior to the fentanyl being put on.

A Yes. It is listed at the top of page 9: 5 mg administered at 0800 and 1500 hours.

Q If we go back to page 272 of the notes, the point the Chairman raised, sir, we do not have a better copy of this, but the chronology reveals that that was in fact prescribed on 2 March. So far as the use of diamorphine, those are injections of diamorphine, are they?

A Yes, they are.

H

Q 5 mg each, one given at eight o'clock in the morning and one given at three o'clock in the afternoon. I should have dealt with those in passing. Do you have any criticisms of that use?
A No. She settled on diamorphine and there are no obvious adverse effects at that point. I think they were reasonable and appropriate. Obviously it is in the context of the transdermal patch of fentanyl is increasing the concentration of fentanyl in this lady.

Q Can we come back to the fentanyl and what happens thereafter? The potency of that fentanyl patch is going to reach its peak when?
A It is not going to be – we would say five half lives and, in someone like this, that is going to be at least 24 hours before you are going to see the maximum effect and possibly longer.

Q So the patch is administered at eight o'clock, it would seem, in the morning of 2 March. On 2 March, Dr Barton appears to have written out a prescription – it is either the 2nd or the 3rd, but our chronology shows it is undated – for between 20 and 200 mg of diamorphine and 20 to 80 mg of midazolam. If we look to 3 March on our chronology, we can see that the diamorphine and the midazolam at the rate of 20 mg each were administered from 10.50.
A Yes.

Q At this time, first of all, is there any indication in the notes, unless something is pointed out to you later perhaps, that the fentanyl patch has been removed?
A I could not find any indication in the notes that the fentanyl patch had been removed.

Q So what you say I think about this, it follows from that assumption, is that the fentanyl patch is still there?
A On the information in the notes, that is the assumption I drew.

Q Even if it had been removed, would the effect of the fentanyl continue for some time thereafter?
A It would. If we recollect, we looked at the British National Formulary yesterday which talked about 17 hours before the concentration would have halved.

Q In that context – I am referring to your report at paragraph 6.13 – what do you say about the prescription first of all and also the administration of the diamorphine; prescription first, between 20-200 mgs of diamorphine?
A The first thing to say is that the notes record there is a deterioration but it is not very well described what the deterioration in Mrs Page was at this point. There is mention in the nursing notes of right-sided – no, neck and left side of body rigid, right side flaccid, a suggestion that she might have had a stroke.

Q We will find that, if anybody wants to look at it, I am relying on the chronology at page 170 which is the note of the significant events.
A I could not find a clear indication that she was in pain and she deteriorated. There was also, because of the potency of the fentanyl, the possibility that the deterioration could itself be due to the opiates which would need to be considered. Equally, we have a description but we do not have a more detailed medical examination recorded, of weakness down the right-hand side, so she could have had a stroke, she possibly could have a cerebral

A metastases which had suddenly got swelling around it. There are a number of possibilities for a deterioration.

Q If we look at the note, which I think we should because there is an amendment we ought to make to the chronology. If we look at the note on page 170, we can see at the bottom that there is a note:

B "Rapid deterioration in condition this morning. Neck and left side of body rigid, right side flaccid."

As you have indicated, that could be caused by a number of factors. Could fentanyl be a feature of that or not?
A You would not normally expect the fentanyl or opiate intoxication to produce focal neurological signs. We do not have a detailed examination. All we have is that description, C but you would expect it to produce a depressed conscious level. It looks like this lady has a depressed conscious level, but there is no formal assessment of it, so again it is very difficult to assess from reviewing the notes.

Q Then the note reads, "syringe driver", and my reading of this is "commenced at". In our chronology we have "recommenced at", which would not make sense because there is no evidence that the patient had been on a syringe driver prior to this point. I am looking at D page 10 of the chronology. You see it in the last line of the first entry:

"Syringe driver recommenced at 10.50".

I think that should be "commenced". Could I suggest an amendment to that. This patient has fentanyl in her body. She is described as having a rapid deterioration, her neck and left side of body of rigid. What justification, in your view, is there for adding diamorphine and E midazolam?
A Diamorphine is primarily to treat pain. We have no information presented that this lady is in pain. She could have been but it is not recorded in the notes. One would treat someone who has a stroke or weakness due to cerebral metastases with morphine, but that does not require opiates in itself. Similarly, midazolam is, in this context, for treatment of terminal restlessness, but we do not have any description that she is restless but, in particular, when she already has a lot of opiate that she has received, I cannot understand the rationale F for starting in addition to that a diamorphine infusion.

Q Can we try and look at the rate of increase. It is difficult perhaps, it is harder than normal because we are dealing with a fentanyl patch. Let us take it at its lowest level, the fentanyl patch is the equivalent of 90 mgs of oral morphine?
A Over 24 hours.

G Q To that is added a syringe driver of 20 mgs diamorphine and 20 mgs midazolam?
A I do not wish to over complicate it, but it is more complicated because the half life of fentanyl is longer, so it is the equivalent but it is taking longer to get up to the equivalent steady state. I am sorry to make this a bit complicated. She is not going to be at the full effect at 24 hours, and it is just slightly complicated, that is all. As you continue it, you are going to get increasing effects as the drug accumulates.

H

Q Is this combination of drugs going to have an effect on the respiratory and circulatory systems?
A Obviously, in broad terms, what she is now receiving from the combined prescription, we understand she still has the fentanyl patch on, she has 90 mgs over 24 hours from the fentanyl patch and 60 mgs equivalent of the diamorphine so she is having 150 mgs morphine equivalent over 24 hours at this point which is obviously a very high dose.

Q In your view is that consistent with *Good Medical Practice* or not?
A Only if there was a clear indication that she had pain and required further opiate treatment, but it is a very, very rapid escalation, the introduction of opiates in a patient who was opiate naïve until when she was she receiving oral morphine, a much lower dose of oral morphine, so it is a very large increase.

Q The patient's death was recorded the same evening at 21.30, The cause of death is given as carcinomatosis and carcinoma of the bronchus. Do you have any comment to make about the likely cause of death in this case?
A I think in this lady the underlying cancer was the cause of death and the drugs may have had a contributory factor, but you could say nothing more than that because she was so ill with advanced cancer.

MR KARK: That is all I am going to ask about this patient and we are moving on to Patient D. I have a new chronology to pass up.

MR LANGDALE: Perhaps the Panel would just note that there is not an account from Dr Barton with regard to this patient.

THE CHAIRMAN: What I am going to do is some quick mental arithmetic. The Panel will take time to match up the new chronology with the Patient D bundle. We do not need to give time for reading of a non existent statement, but it is now 11 o'clock and we do need to take a break for the Panel, if not, for others. I am going to say that you should all return at 11.40 am and the Panel will return at 11.20 am.

(The Panel adjourned for a short while)

THE CHAIRMAN: Welcome back. Mr Kark, the Panel have taken the opportunity to work their way through the new chronology for Patient D and cross referred it to the Patient D bundle.

MR KARK: Can I also mention in relation to the last patient we were dealing with, Mrs Page, that Mrs Page's son is present in the room and he has very kindly provided us with some better copy medical notes. We have had those copied up and they are being renumbered at the moment. Once those are finished, we will provide them you, perhaps in the next break.

THE CHAIRMAN: Mr Langdale has seen those, has he?

MR KARK: He has not yet, no. I am sorry, they are still being copied.

MR LANGDALE: There is no problem, we can sort it.

MR KARK: Turning to Patient D, Alice Wilkie, again a very brief review in relation to her. She had been admitted at the very end of July to the QAH with an unresolved urinary tract infection. She is described as having as having dementia and she was catheterised due to incontinence of urine. We can see all of that from page 1. Page 2 of our chronology reveals that she is an 81-year old lady with advanced dementia. Could I take you to page 3. She is still on a catheter which is said to be draining:

"Needs plenty of encouragement with food and fluids."

Then we see that there is a QAH prescription by a Dr Wilson for a drug called haloperidol. Is that a variable dose prescription?
A Yes, from 2.5-10 mgs and would have been to control her behavioural disturbance and agitation.

Q We have looked at a number of prescriptions written by Dr Barton for variable doses and I want to compare those with this. This is for a range between 2.5-10 mgs and a maximum is stated. Is that in your view an acceptable way to write a variable dose or would you have criticism of that?
A No, I think it is useful to put in a maximum dose. It is often done with simple drugs like paracetamol, for example, "no more than 4 grams a day", so it is helpful to put in the maximum.

Q The range that has been specified, 2.5-10 mgs of haloperidol?
A It is reasonable; that is quite a large dose for an older person.

Q We can see that on 6 August, if we go to page 5 of our chronology, that the patient is transferred to Daedalus Ward. If you go back to 4 August:

"Reviewed by Dr Lord."

This is when she is still at the QAH:

"Usually quiet and withdrawn."

She is catheterised.

"CXR and ECG – NAD."

Is that "nothing abnormal detected"?
A Yes, the chest x-ray and ECG.

Q

"Plan: continue oral augmentin. SC [sub cut] fluids. Overall prognosis is poor +."

Does that mean very poor?
A I think, yes, I think one would interpret it as that.

A Q "...too dependent to return to Addenbrookes. Transfer to Daedalus continuing care."

A That may simply mean and is too dependent to transfers because of poor prognosis.

Q "—› for 4-6/52 observation + then decide on placement. Keep bed at Addenbrookes."

B A Yes.

Q "DNR", do not resuscitate?
A Yes.

Q Then she is indeed transferred to Daedalus on 6 August. The very bottom entry on our chronology page 5 I think belongs at the top of the page:

C "Slept very well Sub/cut fluids continued. For Dryad Ward Gosport today. Assisted with washing and dressing. Catheter draining poor."

That is plainly a note made at the QAH and it may be important because at that time she was receiving subcutaneous fluids. Is that an indication that she is being hydrated, the bottom of the chronology on page 5?

D A Yes. She is obviously not drinking very well and is on subcutaneous fluids at that time.

Q She is clerked in and seen by Dr Peters. There is a referral letter. I am not going through that, the Panel have read it. If we turn to page 6 of our chronology, she is described as having dementia and being withdrawn. Her appetite is described as poor:

E "Does have pain at times, unable to ascertain where."

And there is another reference underneath that:

"Withdrawn – does not communicate well. Can be agitated at times. Does have pain occasionally but cannot advise us where."

F A Can I make a comment on that. In patients with advanced dementia who cannot communicate, it is actually quite difficult to tell whether they have pain. One of the aspects one would be interested in is what was it that the patient was exhibiting in terms of their behaviour that made the nursing staff think that the patient was in pain, because there are other causes of screaming and behavioural disturbance which are not secondary to pain, so it can be quite difficult to conclude that someone one is in pain.

G Q We can see that this patient still appears to have had, there is mention there, a urinary tract infection. I do not know if that had resolved by this stage. Would a urinary tract infection of itself cause pain?
A Not usually. It can do if it involves the kidney, but usually you get frequency and some burning but not usually severe pain.

Q We do see that the patient was catheterised?

H A Yes.

Q If the catheter was not working, as we have seen with other patients, can that cause a problem?
A It can be uncomfortable and patients with dementia can be aware of them and you can get secondary problems related to that.

Q If we turn to 10 August, I am deliberately not stopping on every entry because we know the Panel have read these, at the top of page 7, so we are still on the 6th, I have the nursing notes.

> "Daughter was also there.
> Alice has a Barthel of 1 at present. Alice did require haloperidol @ QAH for the 1st few days there. I will contact ward in 3-4 weeks time."

Then she is reviewed on 10 August by Dr Lord where she has a Barthel of 2 and she is said to be eating and drinking better:

> "Confused and slow. Give up place at Addenbrookes."

So "R/W" is?
A "Residential", I would assume the "R" stands for. Usually it is "residential home" we would say. I am afraid I cannot interpret the "W".

Q And "In 1/12" means in one month's time?
A Yes.

Q "... if no specialist medical or nursing problems ... to a N/Home."
A So Dr Lord was recommending she move to a higher level of care because of her increased dependency.

Q If we go then to about a week later, top of page 8, we can see a deterioration has been recorded.

> "Condition generally deteriorated over the weekend. ... Daughter seen – aware that [I think it should be] mum's condition is worsening, agrees active treatment not appropriate & to use of syringe driver if Mrs Wilkie is in pain."

It appears that that day she was written up with diamorphine at a dose between 20-200 mg and midazolam 20 - 80 mg. At this stage do we regard this patient as opiate naïve or not?
A She is opiate naïve, unless my understanding of what she had received is incorrect.

Q If we look at what happened on 20 August, bottom of page 8 of the chronology, she started on a syringe driver at 13.50, diamorphine 30 mg and midazolam 20 mg?
A Yes.

Q And we can see that there is a note by Dr Barton, page 99B:

> "Marked deterioration over last few days.
> SC [subcutaneous] analgesia commenced yesterday.
> Family aware and happy."

Perhaps we ought to look at that note which we have in our documents for this patient, page 99B.
A Yes.

Q The last entry prior to Dr Barton's entry on 21 August – unfortunately our hole punch has gone straight through the date, but I have written underneath it is 21 August 1998 and that is right on the chronology, and I see Mr Langdale nodding. The last entry is on 10 August, the one that we looked at from Dr Lord. Dr Barton writes, as we see:

"Marked deterioration over last few days."

Any indication that you have seen in these notes, apart from the two that we have referred to rather earlier, on pain?
A No. There is no record I could find on the medical notes or the nursing notes to indicate whether the patient was having pain at this point, or the nature of it, and what one would expect to see is an assessment of the patient to understand what the cause of the pain might be, to initiate appropriate treatment.

Q How would you expect that assessment to appear in the notes?
A By the record of a medical assessment which might be a combination recording nursing observations and observations of the doctors themselves. And then if there was pain, and you still were not sure of the source of the pain, I would be critical of going straight to opiates, to strong opiates. I think one could have tried mild opiates, paracetamol and codeine or non-steroidal anti-inflammatory drugs if she was able to swallow.

Q I am sorry – can you keep your voice up. It is a bit difficult to hear you even for me.
A I am sorry. I will start again. If, having assessed the patient, it still was not clear what the cause of their pain was or there was no treatable cause in terms of another intervention one could take, a reasonable approach would have been to start mid-way, or half way up the analgesic ladder.

Q Which would be what?
A Say with paracetamol and codeine, for example, if she was able to swallow at this point. Failing that, if the pain was thought to be very severe – and we do not have any assessments which give a clear indication in the notes of how this lady was – again I think a reasonable approach might have been to consider a one off oral dose or a small subcutaneous dose of morphine orally or morphine subcutaneously, but I think to start with such a high dose of a powerful opioid in an opioid naïve patient without a clearer justification is not good practice.

Q When you speak about a "low oral dose" as a start, what would you mean by a low oral dose?
A Five milligrams.

Q Five milligrams?
A For example, of morphine.

Q The equivalent of the dose that this patient was started on was 90 mg?
A 90 mg every 24 hours, yes, and that is a very high dose and in an opioid naïve, frail older patient one would expect there would be a high probability of adverse effects occurring.

Q And such adverse effects would be?
A Again, as we have discussed before the major important ones would be respiratory depression, depression of conscious level and that is why one would want to start cautiously with a small dose.

Q The lowest dose that we have seen Dr Barton prescribe for a syringe driver anywhere, I think, in these records is 20 mg. Is it possible to give less than 20 mg?
A Yes. You very definitely can give less than that, and it is often given.

Q Sorry? And it is ---
A It is given – 10 mg or even less.

Q If a syringe driver is necessary one could have started at a lower dose?
A Yes, but we go back to the point that the preferable way of starting opiates is by single doses first of all and you assess the patient's response rather than putting somebody straight on to an infusion, a continuous infusion.

Q Do we have to bear in mind, first of all, that all of these patients are elderly and we have looked at that previously. I am not going to go back through it. I think this lady is described as frail and elderly. Is that significant in relation to the starting dose?
A When we talk about how the elderly respond differently, we are talking about literature which has mostly studied relatively healthy older people. In general there is not much published scientific literature about the effect of frailty on drugs, but general clinical experience is that frail older people with comorbidities are even more sensitive to drugs where there is an aging effect.

Q This syringe driver is started, according to the records, on 20 August at ten to two in the afternoon. The diamorphine is coupled with midazolam. I am not going to ask you again to repeat your comments about that, but can we take it that they pertain to this case?
A They both potentially have profound depressant effects on conscious level and respiration and I think you would be surprised not to see such effects using this dose of diamorphine and midazolam in a patient like this.

Q And we can see that the next note that is made on 99B, on 21 August, after Dr Barton's note is:

"Pulse & Breathing absent.
No heart sounds
Pupils fixed
...
Family present."

And then the note, "For cremation" and that is at 6.30 that evening.
A Yes.

Q I just want to ask you a little, please, about the notes that we have here. The last note before Dr Barton's note on the 21st is 10 August, and then the next note is 21 August, which reveals that the subcutaneous analgesia is commenced. Do you have any comment to make on the quality of the note-making in this case?

A It is infrequent. Clearly one would not expect the extent of note entry in a patient in a continuing care or rehabilitation ward such as this, as one would see in a hospital unit where one would expect to see entries in the notes every day or two. An important issue is, there should be entries in the notes when there was a significant change in the patient's condition. I think the nursing notes referred to deterioration before the 21st so that should have prompted an assessment. Whether the nursing staff asked.... I just have to remind myself whether the nursing staff pointed out deterioration to Dr Barton or any other medical staff before that.

Q On 17 August there is a reference to "Condition generally deteriorated over the weekend"?

A Yes. This was not a lady where there was going to be an aggressive intervention policy pursued, but it still is important to medically assess if there is significant decline in a patient.

Q We have covered this and I do not want to spend long on it now, but before a decision is made to start a syringe driver with opiates in it with this lady, would you expect a note to be made as to why that is happening?

A I think absolutely. We care for many people, older people with dementia, who die from complications and become very frail. It is not common practice to use combined diamorphine and midazolam, or similar drugs, in infusion towards the end of their life, so one would want to see the rationale for that. It is not only a matter of it not being common practice; these are potent, powerful drugs and there should be a clear indication recorded in the notes as to why they were prescribed.

Q And are you able to say now whether these drugs appear to have, or may have contributed towards death or not?

A I think they contributed to deterioration but the note-keeping is not in sufficient detail. We do not have nursing observations of her respiratory rate or conscious level to be able to conclude the exact effect of the drugs. I think they may have but, again, this was an old frail lady with advanced dementia who was going to die in the near future, so I do not think once could say that drugs definitely contributed to death.

MR KARK: Thank you very much. That is all that I ask you about Alice Wilkie, and we are going to move on now to Gladys Richards.

We are moving through, if I can give the Panel some light. It is a long procedure but I am afraid it obviously has to be. It will take you a little while, I think, to read the chronology for Gladys Richards, although this is one of those patients who may well be in the front of your minds, as it were, and slightly out of the ordinary compared to the others but you will no doubt need 20-30 minutes. Can I pass up the new chronologies.

MR LANGDALE: There is, of course, a statement from Dr Barton for this patient.

THE CHAIRMAN: We will start on the basis that we will be looking for a 30-minute period but if that looks untenable we will let you know. Potentially we might bid for another ten minutes, but we will work on the basis at the moment that it will be thirty.

MR KARK: Thank you.

(The Panel adjourned for short time)

THE CHAIRMAN: Welcome back, everybody. The Panel have read the chronology for Patient E and have cross-referenced it to the Patient E bundle and, of course, we have read Dr Barton's statement in respect of that patient, so we are ready to proceed.

MR KARK: I am very grateful. Just before we do, can we do a bit of house-keeping in relation to what I think are definitely better copies in the Eva Page bundle, Patient C. Can I hand those out, please, to the Panel. I am sorry, I still have not given these to Mr Langdale, but I know that will not cause him any difficulty. These are replacement pages. Please take up bundle C – I am sorry, Professor Ford to interrupt your evidence – these are replacement pages for 272, 274, 276 and 278. They still, I am afraid, on 272 do not quite give us the full date.

THE CHAIRMAN: You have a bit more there.

MR KARK: It has a bit more there. I think generally they are certainly clearer copies.

THE CHAIRMAN: That is very helpful. We are most grateful for the addition. Thank you very much.

MR KARK: Once that task has been completed could we put away those notes for Mrs Page and take up bundle E for Mrs Richards and starting at least with our chronology, Professor Ford, we can see that on 4 February 1998 this patient was assessed by Dr Banks, I am going to ask the Panel on this occasion to turn up the letter at page 108. Mr Langdale has invited an addition to the chronology with which I entirely agree. The chronology reveals that Dr Banks found the patient had severe dementia. She had deteriorated since Christmas. She –

> "Does not seem over-sedated, but spends significant part of the day asleep. At times quite agitated and distressed during the day. Mobile and able to wander. Try regular haloperidol."

If we go to page 110, under the heading in bold "Impression" it says:

> "This is a lady with severe dementia with, I think N stage illness..."

We think it should be "end stage illness". I suspect this was a dictated letter.

THE CHAIRMAN: Yes. We have noted this on a previous occasion.

MR KARK: I am grateful.

> "... and as a result it is not surprising that she does spend considerable periods of the day asleep. She obviously needs some help to relieve the distress that she experiences when she is awake.

A

Management Suggestions

In the first instance, I think it is extremely important to try the regular Haloperidol"

Is that 5 mg?
A I think it is 0.5 mg.

B

Q It is 0.5 mg. Is that three times a day?
A Yes.

Q I think the suggestion is that one should just add a note in our chronology to remind the Panel of the comment about end stage illness. One can always go back to the original notes in the bundle to remind us of that. Then we see that there is a review on 2 March by
C Dr Banks.

"More settled. Conversation, although very minimal, is more coherent."

Then I am going to move on to 29 July 1998 at the bottom of page 2 of our chronology:

"Taken to A&E, Royal Hospital Haslar, after fall in nursing home, fracturing right
D neck of femur.
Fall onto right hip. Pain on movement of right leg. Quality of life has decreased markedly [since] last [six months]. For admission, operation, PRN analgesia."

Then at the top of page 3:

"Admitted from A&E, Royal Hospital Haslar. Undergoes operation – right hip hemi-
E arthroplasty."

There are notes in relation to the drugs that this lady was on. Could I just ask the Panel to note particularly page 243 of the drug charts? The operation takes place on 30 July and we can see that on 30 July she was on morphine for four days: 30 and 31 July, 1 August and 2 August. We can see that she is on regular haloperidol as suggested and she was also on co-codamol from 1 August and I think that continued to 7 August, according to this chart at
F page 243.
A Yes, that is correct.

Q Can you just help us, please, Professor Ford, about co-codamol? It is a tablet, is it?
A Correct. It is a tablet, a combination of paracetamol and codeine.

Q Are you able to tell us in what form it comes?
G A I think if you see next to the co-codamol it says "eff", which I would take to stand for effervescent. So you can take it either as a tablet or there are tablets that dissolve in water, which are easier to take if people are having trouble swallowing tablets.

Q What dosage is co-codamol?
A Each tablet contains 500 mg of paracetamol and I am pretty sure it is 8 mg of codeine. So it is a small dose.

H

A Q Paracetamol we know about. What about codeine?
A Is a mild opiate.

Q It is a mild opiate. Your report details with this entry on 30 July and I am afraid I foolishly had not identified where it is in the notes, but I think there is a note which may also be relevant by Surgeon Commander Malcolm Pott dated 30 July. I suspect this is in the clinical notes, but I will have a look in a moment, stating:

B

> "After discussion with the patient's daughters, in the event of this patient having a cardiac arrest, she is not for cardiopulmonary resuscitation. However she is to be kept pain free, hydrated and nourished."

We will find that if we go to the bottom of page 174, which is a horrible copy, and slightly clearer at the top of page 175. We can certainly read the words at the top of page 175 C "cardiopulmonary resuscitation" I think it is, and:

> "However she is to be kept pain free, hydrated and nourished."

I think you pick that up in your report.
A Yes.

D Q We have dealt with this. The fact that a patient is not for resuscitation in the event of a cardiac arrest is no reflection upon the rest of her medical care.
A No. That is a very specific decision about a very specific clinical event that might happen.

Q Then if we go back to the chronology at page 3, she is reviewed on a ward round after her operation and she is described as being "up and eating". Then at page 4 of the E chronology, on 3 August 1998:

> "All well on ward round. Sitting out. Has nursing home place but family not happy for her to return."

We heard something about that.

F

> "To GWMH."

Then:

> "Reviewed by Dr Reid.
> Confused, but pleasant and co-operative. Able to move left leg freely. A little discomfort on passive movement of right hip. Sitting out in chair. Should be given G opportunity to try to re-mobilise. Will arrange transfer to GWMH."

A Yes.

Q She was reviewed by a house officer on 8 August:

> "Quite distressed first thing, but settled after haloperidol. Little breakfast taken, but H ate well at lunchtime."

A

So we have an indication there that she is taking food and drink orally. On 10 August:

> "Referred to GWMH.
> Now fully weight bearing, walking with the aid of two nurses and a zimmer frame. Needs total care with washing and dressing, eating and drinking. Soft diet. Enjoys a cup of tea. Continent. When becomes fidgety and agitated means she wants toilet.
B Occasionally incontinent at night. Occasionally says recognisable words. Wound healed, clean and dry. Pressure areas all intact."

Then the following day she is transferred to Daedalus Ward. Can we then look at Dr Barton's clinical note?

> "[On examination] frail demented lady. Not obviously in pain. Transfers with hoist.
C Usually continent. Needs help with ADL [activities of daily living]. Barthel 2. Happy for nursing staff to confirm death."

Just pausing there for a moment, we have seen that phrase elsewhere in the notes and we commented on it in relation to the last patient. Is it appropriate in these circumstances to make that sort of notation in your view?
A I do not think the nursing staff confirming death is necessarily inappropriate in a
D patient with advanced dementia. I think what is lacking in this note is a summary of what the plan with this lady is.

Q What would you expect to see?
A A reiteration of the previous plan to improve mobility with a view to discharging back to the nursing home.

E Q If that plan had for any reason changed or if the patient's condition had deteriorated between the two hospitals, would you expect any note to be made of that?
A Yes. Clearly this lady was making quite good progress. Given her dementia and having had a hip replacement, she had achieved some mobility, albeit needing a lot of assistance with walking with a zimmer frame and the assistance of two nurses. So if there is any major change in that, which there appears to have been, but it would depend on when Dr Barton had assessed the patient, whether they had had a full nursing and physiotherapy
F assessment at the time Dr Barton wrote that note. They would not have seen the physiotherapist, I would not have thought, at that point. The "transfer with hoist" may be the initial nursing plan as to how they were going to manage the patient until a physiotherapy assessment. Obviously I am speculating in this respect.

Q We had better not do that. Can we look at the drugs which were written up upon admission? We have those on page 6 of our chronology. Oramorph was prescribed prn – and
G I am going to stick to the milligrams, because it makes it simpler – between 5 and 10 mg. The higher of that dose was administered twice on the day of admission, it would appear, at 1415 and 1145. Diamorphine was written up, between 20 and 200 mg; hyoscine was written up; midazolam was written up, between 20 and 80 mg, and haloperidol was continued, because she had been on haloperidol before. Is that right?
A Yes, she had. She had been taking haloperidol regularly at the previous hospital.

H

Q And lactulose, which we are not going to be concerned about for the moment. Can we deal with the Oramorph first? You have dealt with this in your report at various points. In fact, I think in your police report you dealt with it at paragraphs 219, 220 and 221. Focusing first on the Oramorph for this patient, do you have any commendation or criticism of first of all the prescription and secondly the administration of that drug?
A On the information available in the medical and nursing notes, there is no rationale presented for prescribing morphine at this point. This lady was mobilising a few days before at the Royal Hospital Haslar and taking regular co-codamol. So that would be the appropriate analgesic to continue, unless there had been a major change in her situation. In fact, I am not sure whether we know she was still taking co-codamol after 7 August, between the 7th and the 11th, but even if she had stopped it or was still taking it, the appropriate prescription for analgesia would be to continue the co-codamol in my view. That could have been written up either as a prn or a regular prescription. Either would be reasonable and appropriate, I think. But to move to prescribing morphine, when obviously there is the potential for significant adverse effects, without a clear description of there being a change in the pain severity or lack of control on other painkillers, means the prescription has no justification.

Q If there had been a significant change in the patient's condition, quite apart from making a note about it, which you have discussed, what else would you expect the doctor to do about it?
A I would expect a description of the change in the patient's function and then an examination of the patient to determine again why they were in more severe pain.

Q It follows from that, as I think you have revealed before, and it is in the Wessex protocol as well, you need to identify what the source of the pain is.
A Yes. I think it would be very expected that for any patient of any age being prescribed morphine, there would be a clear indication recorded in the notes for that.

Q Let us look at the rest of the prescription that was written up on the same day but not administered. I am not going to ask in relation to every patient for your comments about the wide range of drugs, unless your view for any particular patient is different. If you think it is justified, then you will no doubt reveal that. Prescribing diamorphine for this patient on the day of her admission, starting at 20 mg with a variable dose going up to 200, with midazolam. What view, if any, do you have about that?
A I cannot find any information in the medical and nursing notes that would provide any justification for that prescription. This is a lady who, having had a major change in her level of function, against a background of slow deterioration, is now improving from a major surgical procedure. She has been referred for further rehabilitation in an attempt to improve her mobility, with a recognition that that may not be possible, to get her back to her previous level of functioning. So there is no information which would justify why this patient would potentially need nursing staff to commence infusions of diamorphine and midazolam. The notes do not say at this point that this patient is deteriorating and has symptoms which require those drugs.

Q If at this stage the nurses had taken it upon themselves to decide, because, for instanace, the patient was screaming and they had not appreciated that she might need the lavatory, if the nurses had taken it upon themselves in fact to act upon this prescription and administer it, would that potentially have had any adverse effect upon the patient?

A Again, the doses, without going through them, are high starting doses in what is at this point essentially an opiate naïve patient. She has not yet received any of the oral morphine and there is a high risk of serious adverse events again.

Q You said opiate naïve. What about the codeine?
A That is a very mild opiate. We tend not to – it does not induce significant tolerance, so you are essentially dealing with a patient who is opiate naïve.

Q Can we continue with the chronology, please? At the top of page 7, we see:

> "Reviewed by nursing team.
> Requires assistance to settle and sleep at night. Nursing action: Night sedation if required. Observe for pain. 23:30: Haloperidol given as woke from sleep very agitated. Did not seem to be in pain."

Then the next day, we can see that Oramorph was administered at 0615. Then it was prescribed I think at a different rate, 5 mg four times daily and 10 mg nocte. That prescription again was not administered, but do you see any justification for such a prescription?
A What the notes are telling us is that this lady is agitated and dementia is the likely underlying main cause of that. There is no record that she is in pain. In fact, to the contrary: we have an entry which says she does not seem to be in pain. So opiates are not an appropriate treatment for agitation and confusion in patients who are pain-free.

Q The last time that Oramorph seems to have been given is the 10 mg administered at 0615 on 12 August. Then the following day, at 1.30 p.m., the patient appears to have been found on the floor and she is hoisted into a safer chair. It is plain from that that she has been able, with assistance no doubt, to remove herself from the bed and into a chair. By 1330 on 13 August, would you expect the Oramorph to be having any effect, the Oramorph given the day before in the morning?
A I am just checking exactly when she had the last dose. She had a dose at 6.15, more than 24 hours ago. So, no.

Q We can see that although – and I am just going back to the drug chart – Oramorph had been written up, there are a number of crosses against where the time when the prescription would normally have been given. So we take it that those prescriptions were not given. In any event, the unfortunate patient was found on the floor, no injury was apparent, but she had pain in her right hip and Dr Reid advised an x-ray and analgesia for that pain.
A Yes.

Q Was that an appropriate course to take?
A I think someone should have come and examined her. An x-ray is the right thing to do, to examine the leg if it is shorter, to see if there is evidence, clinical evidence, of a dislocation or other problem.

Q We can see that Oramorph was administered at ten to nine that evening and the following day she was reviewed by Dr Barton. We can see this note:

> "Sedation/pain relief a problem. Screaming not controlled by haloperidol but very sensitive to Oramorph."

How should we read those words, how should we interpret that annotation, "very sensitive to Oramorph"?
A I think that relates to a comment from when she had received morphine at the previous hospital, if I remember correctly. I think I mentioned that in my report, unless it related to her observations of her response to the morphine she had received on the ward.

Q The patient was in fact x-rayed and the notes reveal that she had indeed dislocated her hip. No doubt that would be a very painful occurrence for her?
A Yes.

Q She is taken back to the Haslar?
A Can I say at this point, clearly she is in a lot of pain and it is appropriate for her to have more powerful analgesia.

Q She is taken back to the Haslar and the dislocation is reduced. She then remains at the Haslar until 17 August. I want you to see page 286 to pages 291 of the drug charts at the Haslar. If we turn to page 291, we can see that Oramorph is written up but not given?
A Yes.

Q That is on 14 August. Is that haloperidol?
A Yes.

Q It is given on 16 August and then co-codamol and that appears to have been given on 15 August. If you go back to page 286, I think the Panel have the file of the original prescription sheets. Could we retain it while we are going through this exercise so that Mr Fitzgerald can dig out any relevant prescriptions. I am going to see if we can find the sheet which is our page 286. We are going to have to make some enquiries because this file contains the GWMH prescription sheets and not the Haslar prescription sheets. We will look at that and see if we can identify when that was given. We know that the patient was transferred back to Daedalus Ward on 17 August when she was reviewed again and we have a note from Dr Barton on page 31. There is a note that she remained unresponsive for some hours. That means after the surgery presumably?
A Yes, I would assume that was after the sedation which was given to replace the hip – sorry, to correct the dislocation not replace.

Q
"Now appears peaceful continue. Plan: Continue haloperidol. Only give Oramorph if in severe pain. See daughter again."

That annotation "Only give Oramorph if in severe pain", would you have any criticism of that?
A No, I think that is a very appropriate comment and the expectation would be that now the hip has been relocated, it should not be as painful but it clearly might be sore for some days afterwards and there might be a need for analgesia.

Q At some stage, certainly that day, the patient does appear to be distressed.
A Yes.

A Q Something has obviously occurred with that patient and it may be to do somehow with her transfer?
A Yes. There was a lot of discussion in the notes and some statements about the way she was transferred back to the ward when she came back from the Royal Hospital Haslar.

Q We heard from one of her daughters about finding her mother in a very uncomfortable position in the bed and having to obtain assistance to put her legs straight?
B A Yes.

Q From here on in, there are notes that this patient was in pain?
A Yes, that seems very clear, she was in severe pain.

MR KARK: I am very grateful. We have found that note in relation to the drugs and it may be worth briefly going back to it. It is the Haslar drug charts which are 286 to 291. If we
C turn to the 14 August – I am sorry I cannot find the document we were looking at before with the midazolam. It is page 286. Can I invite you to add on page 286 that the date for that midazolam is 14 August 1998. Professor Ford, just going back to the 14th momentarily, the patient having suffered a dislocation, she is taken back to the Haslar on the 14th, she is given midazolam and it looks like 2 mg.
A Yes, I would agree, I believe it is 2 mg.

D Q Is that an appropriate dose?
A It is slightly out of my area of expertise because that is an anaesthetic pre-med, so I would not really like to comment, but it seems to me to be a sort of induction sedation dose that is used.

Q Coming back to the GWMH, page 12 of our chronology:

E "Reviewed by Dr Barton.
Still in great pain. Nursing a problem. I suggest [sub/cut] diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable."

We can see from page 13 that on that day Oramorph is administered 10 mg twice, said to be in the early hours. Do you have page 13 of the chronology?
F A Yes.

Q Then Dr Barton prescribes diamorphine, 40-200 mg, 40 mg is administered at 11.45 together with midazolam of 20 mg?
A Yes.

Q That midazolam appears to be being administered on the basis of Dr Barton's original
G prescription?
A Yes.

Q Because there is no fresh prescription for the midazolam?
A Yes.

Q What do you say at this stage about the diamorphine being administered at this point
H and then with the addition of midazolam?

A A Mrs Richards had been receiving oral morphine at this point and I think over the previous 24 hours had received, I have recorded, 45 mg in a series of 5 mg and 10 mg doses. In the notes I could not find a clear reason why there was a need to switch to the subcutaneous route. It seems the patient was still in pain, so one could have increased the dose that was being given orally, but if there was difficulty swallowing or difficulty getting the patient to take it, it would be not unreasonable to switch to a subcutaneous dose. The dose that was prescribed is high in terms of equivalent terms. If we take the 45 mg of
B morphine, that equates to 15 mg of diamorphine. If one uses the half conversion, which has been used rightly or wrongly by some doctors, that would be 23 mg. If you wanted to increase a further 50 per cent, say, the usual guidelines, that would take you up to about 35 mg, so the 40 mg that is given is high but it is not completely unreasonable. It is high, but I would not be overly critical of that so long as the patient was being monitored.

Q What about the addition of the midazolam to that?
C A That is not clearly indicated. The haloperidol is appropriate because she has been receiving that for a long time and if she cannot swallow the haloperidol, it is appropriate to continue giving her that because of her agitation. One has not at this point seen a response to the diamorphine and if she is comfortable with the haloperidol, would that control her symptoms?
A Given we know she is very sensitive to a single 2 mg dose she has had, the 20 mg – which is as we have said before a high dose to start with in an older person – would be, again,
D very likely to produce adverse effects when it is started at the same time as a significant increase in the opiates.

Q It is the combination again?
A It is the combination, but even without the opiates, that dose of midazolam on the basis of her prolonged sedation after the 2 mg, might be expected to produce profound depression of conscious level.

E

Q Are you saying effectively that the note, which I think Dr Barton has recognised in her clinical note, in relation to the patient's reaction after the operation is a flag?
A Yes, if that is what was being referred to, if this happened in another hospital, but it was an important piece of information if it was in your mind as a prescriber.

MR KARK: I am going to continue. I am aware of the time, but I would prefer, if the Panel
F can bear it, to finish this patient. (The Panel concurred) (To the witness) Can we continue with the drug administration. On 19 August the same drugs are administered then together with hyoscine, and hyoscine will be the result of secretions potentially produced by the other drugs?
A Yes. I would perhaps give some context. I think at this point the clinical situation of this lady has changed quite dramatically. The hip is a problem again. It is not dislocated and there is nothing obviously remediable, and in a lady with severe dementia this paints a very
G gloomy picture for the future and she is unlikely to improve and is likely to have a deteriorating course from here on.

Q In terms of the cause of this patient's pain, would you expect any assessment, or has sufficient assessment been done, to try to find out what has gone wrong?
A You would expect an examination of the hip. I am trying to look back at what was written in the notes at that point about whether there was any shortening or any other obvious
H problem in the hip. An x-ray was performed, that was appropriate. You could say that since

A the hip seems a problem, best practice might be to discuss yet again with the orthopaedic team was there anything to be done, but I would not be critical of that particularly because there would be limited interventions that could be done here I think.

Q The clinical notes you will find at page 31, and we can see that there is an entry on 17 August. It looks like the 12th, but it is the 17 August, "Readmission to Daedalus". That is the note we looked at earlier. After that, 18 August:

B

> "Still in great pain. Nursing a problem. I suggest sub/cut diamorphine/haloperidol/midazolam. Will see daughters today."

That I think is the only note about that that we have from Dr Barton?
A I think ideally one would want to see a record of observation of the hip and whether movement of the hip, particularly rotation, gave rise to pain. All the indication is that the
C pain is from her hip from what we have heard, but there is no detailed examination recorded. The x-ray was done, which was the most important thing in terms of identifying a problem that was likely to be potentially correctable.

Q Then the drugs hereafter continue, on 21 August she is described by Dr Barton as being:

D

> "Much more peaceful. Needs hyoscine for rattly chest."

"Much more peaceful" indicating that she does not seem any longer to be in pain, but we do not know whether she is conscious or not?
A We do not have any formal observations of conscious level by the nursing staff at this time.

E Q On the same day we see:

> "Condition very poor."

And in the same line:

> "Pronounced dead at 21.20."

F

This patient's death certificate revealed that she died of bronchopneumonia. We will see this cause of death given again and again. Can you give the Panel a little assistance about that?
A I think the predominant cause of death here was dementia and the hip fracture, I think that is what has led to the deterioration of problems. Bronchopneumonia is a common preterminal/terminal event in any mobile patient and also if you have drugs which suppress respiratory function, that will also often show signs of bronchopneumonia.

G

Q So the diamorphine and midazolam can themselves lead to the inability to ---
A Yes, because they depress respiration and you get less clearance of chest secretions.

MR KARK: Sir, I think that is all that I want to ask about this patient, and I would welcome the opportunity of just reviewing the notes very briefly. Perhaps we could then treat that as the end of dealing with Mrs Richards and we could move on to reading the chronology for
H Patient F. I think you already have them.

THE CHAIRMAN: No.

MR KARK: We have to hand that one out. We will hand out the notes for Patient F. We will make sure, Professor Ford, you get a copy before we break. (Document distributed)

Perhaps we can break there for the moment.

THE CHAIRMAN: Yes. We shall break now for lunch and the Panel will then go straight into the reading of these documents for Patient F. If when we come back you do have anything else on Patient E, we will deal with that first.

I think we shall come back, then, please at 2.50.

(Luncheon adjournment)

THE CHAIRMAN: I see that not absolutely everybody is back in the room. However we shall start but I have to make an immediate confession to you. The Panel have not used all of the time that they intended for the purpose expressed because another matter has come up, which is of general time-tabling. It concerns as much as anything, as I understand it, the administration of the overall GMC operation here.

The Panel have been told of the circumstances and we have given a preliminary view. I understand that the Panel Secretary at the end of the day will discuss what we have just been told further with the parties. This undoubtedly will have some effect on the way in which we all look at where we are going in terms of timescale. At any event we were going to begin with our return this afternoon by asking you if you were able to assist the Panel with a little crystal ball-gazing in terms of how the next few days are going to pan out.

As it had been left, we have all known that, for administration reasons, tomorrow would not be available to us as a sitting day because the room is required although the Panel have been able to make arrangements to do independent reading elsewhere.

There was then the issue of the following day. We had been told that Professor Ford would not be available and we were asked for an update on that and then, of course, as to canvassing his availability for next week. It was an update on that that we first sought from you.

MR KARK: When I last spoke to Professor Ford – and I have not spoken to him about this for a day or two – so far as Thursday is concerned, that is an inextricable engagement. He is, I believe, speaking at a conference and it is his event, as it were, and he has not been able to extricate himself from it. He will no doubt explain in a moment to you. I have not sought to disturb that because I gather it really is one of those professional commitments that he is unable to escape from.

We therefore have Friday. I certainly hope that I would finish examination in chief on Friday morning. We are going slowly – and that is no fault, I hope, of anybody's – there is material to get through and the Panel have to acquaint themselves with the material before you hear the evidence from Professor Ford. That is actually making his evidence much shorter than it might otherwise be. He is not referring to letters and notes that are in the chronology that he might otherwise have to refer to.

Professor Ford is available on Monday. He was meant to be starting, I believe, his family holiday on the Tuesday but he is understanding as far as anybody in those circumstances can be that he is likely to have to be here Tuesday. Beyond that we have not really got.

THE CHAIRMAN: I think we probably need now to spend a couple of minutes looking at that, starting with observations from Mr Langdale and his team, because you seem to be suggesting that if you were to finish your examination in chief during the course of Friday, that would not give a great deal of time for the rest of the process. Do you, Mr Langdale, have any sense of the sort of time that you would be wishing to have? It is difficult in advance.

MR LANGDALE: This is the question one always dreads and I am as bad as anybody at the Bar can possibly be in estimating how long I am going to take to do anything, but I can say this in the presence of Professor Ford: a certain amount of time has been taken by Professor Ford in explaining what I am going to call basics with regard to what is in the books and general matters with regards to analgesia, patient care, opiates and so on. It is not going to be a case of my taking issue with him as to what those precepts are. I will have to ask him some questions about the general approach in the context of this case. I hope that will not take too long. I find it impossible to say now quite how long that part of it will take.

With the individual patients, obviously one speeds up a great deal in terms of the Panel not having to read material. The issues have become narrowed down and the actual issues which have to be explored with Professor Ford on the individual patients are not that wide ranging because a lot of his criticism is directed in certain aspects which, though no patient is identical, repeat themselves in the context of patients. I doubt if it is going to take as much time as it otherwise would. I will have to draw his attention to certain other aspects and so on.

I would have thought, and this can be no more than a guess, I am bound to take the equivalent of a day, and I think it would be wiser to think I might be as long as a day and a half. I hope that is being over-pessimistic, but I cannot really say. It remains a bit of a guess. I shall do my best, of course, to keep matters within the confines of my own duty, and endeavour to keep matters as brief as I can.

THE CHAIRMAN: Taking that on board, and recognising there is then the matter of re-examination from Mr Kark, inevitably a substantial period of time with questions from the Panel and then counsel's own questions arising out of those of the Panel.

It would appear at best to be tough but do-able by the end of Tuesday.

MR LANGDALE: I was just going to say, that would be my best guess.

THE CHAIRMAN: If it is tough but do-able we need to have in place a Plan B or a longstop in case it remains tough but no do-able.

MR KARK: The Plan B, I am afraid, has to be to ask Professor Ford to give us another day. That is the reality.

THE CHAIRMAN: Or possible day.

PROFESSOR FORD: I already planned to revise my plans, to be available for all of Tuesday. I have changed my holiday plans accordingly. I would be very reluctant to have to come back later in the week because that is the remainder of the time I am spending with my family. I am, however, then on holiday for a further week but at home. If needs must I could come on the Monday or another day that week, although obviously I would prefer not to, but I recognise that may be necessary.

THE CHAIRMAN: The following week we would be, presumably, into the defence case so we would not be able to then revert to the GMC case. We have to finish the GMC case before we can go on.

PROFESSOR FORD: I could ask whether I could make myself available on the Wednesday. It is really not something I would like to do.

THE CHAIRMAN: I think if we can at this stage agree on that. I think it is clear that none of us would wish to put you in a position where we would need to be asking you to come back on the Wednesday. There are some things we can all do to try to assist with the days, in terms of the times at which we sit. But within all of that there is an overriding obligation to the doctor to make sure that the Panel remains sharp and receptive. A Panel that is hearing evidence when it is so tired that it is not able to take it on board properly is not doing the doctor any favours at all.

MR LANGDALE: I fully appreciate that point. Thank you for mentioning it. I think in terms of the cross-examination of individual patients, it is not going to be such tough going from anybody's point of view because we have all been through it, at least in chief, with Professor Ford and it is not as if I need to review each aspect of the patient history, or anything of that kind. I would hope that the concentration problem may not be – who knows – as bad as might otherwise appear.

THE CHAIRMAN: What I am going to say then, Mr Kark, is this. We are going to get on now. The fact that we have not had all the time that we would have wished on this patient is regrettable but it is by no means the end of the world. We can make that up.

We do have the advantage of two days coming up when the Panel can do a certain amount of pre-preparation. One of the things that we can undertake to do is to ensure that for Friday, Monday and the rest of the time in which we may be receiving evidence in chief, that we will not require therefore any further time for pre-reading because we will have done it.

MR KARK: That would make a very significant difference. I would ask the Panel also to consider whether we might sit earlier on Friday. I suggest that with reluctance, but the reality is that a half hour here and a half hour there does really make a difference.

THE CHAIRMAN: They do indeed. All I have to do is remember that I must also balance the need to keep a Panel sharp and fresh.

MR KARK: Of course.

THE CHAIRMAN: In principle, I do not see a problem with that. We might as well say now, then, that on Friday, Professor, we will start half an hour earlier and we will see what other savings might be made, if that is convenient to you.

PROFESSOR FORD: It is. I am on call for the stroke service in Newcastle on Thursday evening, so I cannot stay here, but if I get the six o'clock train which arrives in at nine o'clock for a 9.30 start – assuming there are no travel delays – that will be fine for me.

MR KARK: We were looking at a nine o'clock start, but you were here at 9.15. You cannot make it for nine o'clock?

PROFESSOR FORD: I cannot release myself. I cannot leave that early in the morning to get here before that. I am sorry.

MR KARK: Fair enough.

THE CHAIRMAN: We will start at the normal time, but we will be looking to get a half hour here and there in the remainder of the time to make it less likely that we do have to put the thumbscrews on you for the Wednesday. If we possibly can, I think we are all agreed, we are going to be aiming for the end of Tuesday but nobody can commit themselves at this stage.

MR KARK: I am grateful for all that. Let us move on. (To the witness) We are now going to turn to Ruby Lake, Patient F. Do you have the chronology in front of you?
A Yes, I do.

Q This lady, as we can see from page 2 of our chronology, was admitted to the Royal Haslar on 5 August of 1998. She had had a fall which fractured the left neck of her femur. She underwent surgery. Prior to that it is revealed that she was walking 100 yards and then had to stop because of arthritis. She had lived alone, but she was mobile, independent and self-caring. The plan was, as we see at the top of page 3, after the operation:

> "For X-ray and bloods tomorrow morning and then to mobilise when comfortable."

She is reviewed by a physiotherapist on the 6th and further reviewed on the 7th. Then on 8 August, at the bottom of page 5, we see a nursing note:

> "All care given. ... Remains very breathless. ... Sacrum broken in sacral crease. ... Sat out for half an hour. Mobility poor. Unable to tolerate nursing on side. Poor fluid intake. Paracetamol given for pyrexia."

So she had a slight fever of some sort. Does that mean a raised temperature?
A Yes. Yes, pyrexia does mean that.

Q

> "Agitated at time."

Then it says "Cyclizine given". I do not think we have come across Cyclizine?
A It is an anti-emetic.

MR LANGDALE: I am sorry to interrupt but can we just take note in the history. I am not objecting to the speed at which this is being done. Can we take note of the entry on 6 August, the bottom part of that with regard to "LVF". It is page 3, 6 August, just that little last thing.

MR KARK: I am sorry.

"Fluid overload – LVF"

Is that left ventricle failure?
A Left ventricular failure, yes.

Q And then –

"Infection."

A Yes.

Q What is the correlation between fluid overload and LVF, if any?
A When you have heart failure, you develop pulmonary oedema, fluid on the lungs. The different diagnosis that the doctors are thinking of there is either the patient has a chest infection or that they have pulmonary oedema due to heart failure.

Q And "Stop ivi". Is that intravenous fluid?
A Yes. They are thinking that the intravenous fluid the patient has been given post-operatively may have precipitated the fluid on the lungs in the context of impaired heart function.

Q Moving on then, bottom of page 5, we have dealt with. On 9 August she walked around the bed but her mobility is described as poor. She walked round the bed with a zimmer frame and assistance. She sat out for an hour. She was unable to tolerate nursing on side, always rolling onto her back. On 10 August, physio revealed:

"*Appears unwell today. ?MI*"

Myocardial infarction?
A Yes, that would be what "MI" stands for.

Q And "?chest infection", so those are the differential diagnoses?
A Yes.

Q "*R/V* [review] *mane.*" Then, underneath that:

"*Patient unwell. Vomiting/diarrhoea, drowsy, denies pain, orientated. Apyrexial.*"

So the temperature has gone?
A Has come down to normal, yes.

Q "*Chest clear.*" Underneath that:

"*14.30: Much improved, alert, bright and orientated.*

A *CXR ...*"

Is that a chest X-ray?
A Yes.

Q "*... chest infection. On augmentin.*"

B

A Yes. An antibiotic.

Q Does that necessarily reveal that that was, in fact, the cause of her chest problems, or may there still have been an infarction?
A Their conclusion is that was what they thought at this time the diagnosis was; that there had been a chest infection. It is not absolutely certain that she seems to have got better
C on the antibiotics, so the temperature has come down. That would be a reasonable

Q At the bottom of that page of the chronology, could I just suggest adding one note which comes from page 511, which you have picked up, I think, in your report, Professor Ford. It comes from 10 August 1998, so the day that we are looking at, and there is a Surgeon Captain Farquharson-Roberts?
A Yes.

D

Q He states:

"For all necessary treatments and resuscitation..."

A Yes.

E

Q And then there is a word that, I am afraid, I cannot read. Or "... and resuscitate...", and then there is a word. This is in the middle of page 68 of the notes.
A Yes. I could not read that word either.

Q Whereas with some patients, as we have seen, there is the notation "Not for 555" or "Not for resuscitation" certainly at that stage of the patient's treatment on 10 August she seems to be noted "For resuscitation"?
F A Yes.

THE CHAIRMAN: Could you repeat that?

MR KARK: It is quite difficult to read. It is "511" right in the middle of a page. It has a large "68" – it is right in the middle of the page, 10 August 1998, and I think you can see:

G "For all necessary treatment and resuscitate [something]."

Can we go on to the top of the chronology, the top of page 7. This lady is obviously having problems with diarrhoea and her skin appears to be having problems.

"Ate small amount of ice cream. Ulcers need redressing – both legs."

H

She had an unsettled night and she was incontinent of faeces, and her sacral area remained red. That would be uncomfortable for her, no doubt?
A Yes, it would.

Q Or painful. On 11 August she is seen by a physiotherapist. She remarks that she remains unwell.

"L base remains quiet."

A That would most likely be referring to the left base of the lung. The physiotherapist probably listened with a stethoscope herself and would be possibly indicating there was still residual infection.

Q Then over the page of the chronology, I am just trying to stick with the chronology for the moment, she feels nauseous and she has abdominal pain.

"Later: Much improved, apyrexial, good urine output.
Chest: Good expansion R = L."

Would that be the lungs as well?
A Yes, that would be the lungs.

Q

"Plan: Switch to oral augmentin...".

Augmentin is used for what?
A It is an antibiotic commonly used to treat chest infections.

Q

"... encourage fluids" and then "Ensure."

Ensure is ---?
A Is a dietary supplement to help maintain nutrition.

Q Then urine output is down and the plan is to stop IV fluids. Later, we see she is given a full wash, her bottom and sacral area is very red and breaking down in the cleft. She is described at 1930 as:

"Remains very sleepy. To encourage oral fluids. Urine output satisfactory."

Then on the 12th she is described as "much improved", she has sat out, but she is developing sacral bed sores. Over the page – and again, I am not referring to every part of every entry – on 13 August she is seen by Dr Lord and at the end of that, which seems to be her conclusions, she is still dehydrated. Hypokalaemic is?
A Low potassium in the blood.

Q And normachromic?
A It is a certain type of anaemia, often seen in chronic disease, rather than iron deficiency anaemias or other vitamin deficiency anaemias.

Q Then:

"Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at the present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement."

MR LANGDALE: Might we just know what she said about ECGs and ischemic heart disease in that section?

MR KARK: Certainly.

"Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease and LVF have been problems recently."

A Atrial fibrillation is irregular heart beat. That puts patients at risk of having a stroke.

Q We can see that the physio notes underneath that:

"Unable to mobilise at present due to chest pain."

So that does not seem entirely to have resolved itself.

A No, it does not. She was still really quite medically unstable at this stage.

Q The following entry at the top of page 11, we can see she has had an unsettled night, she is still complaining of central chest pain and she is given a GTN spray. A GTN spray would be given to relieve any heart ...

A To relieve angina. It is a nitrate.

Q Then:

"Comfortable afternoon. Oral fluids taken. No [complaining of] chest pain. For transfer to GWMH next week."

Then on 14 August she is described by the physio as:

"Brighter today. Sitting out. Walked short distance with frame ... To gradually [increase] distance ..."

Over the page to page 12, she is reviewed and again it is recorded that unfortunately she has chest pain in her ribs through to her back since being manhandled. The ECG reveals nil change and no effect with GTN. What does that indicate to you, if anything?

A The doctor assessing her would be looking to see if there was evidence of any acute myocardial ischaemia, whether she was having a heart attack, or a prolonged period of angina at rest. The ECG was normal, there was no relief with GTN, which would be a sign often that it was a cardiac pain, so her differential diagnosis has become muscular-skeletal pain or alternatively pulmonary embolus, which is a clot to the lung; she has been dependent, so she is at risk of that, and he or she is still considering angina.

Q The patient is given codeine phosphate. Then at 0700:

A

"Some pain due to arthritis in left shoulder overnight. Had paracetamol to good effect."

We can all see what follows after that. Then I am going to take you through 17 August. She is described as sitting out in a chair. Then at 2015:

B

" ... Seemed confused this afternoon, reluctant to move herself from bed. ... paracetamol given."

Then on 18 August:

"Reviewed by SHO at Royal Hospital Haslar.
Well, comfortable and happy. Last pm spike temp, now 37.3°. Mobilising well. [To]
C GWMH today."

Again, "spike temp"?
A That means the temperature was elevated the previous afternoon on the 17th, which relates to that recorded temperature of 38.8°.

Q Now 37.3°?
D A Which is normal.

Q At two o'clock in the morning, there is a note that she has increased shortness of breath and oxygen therapy is recommended. She is then transferred, it appears, to Dryad Ward. We can see the transfer letter. I am not going to go through that, but can you have a look at the clinical note made by Dr Barton?

E

"Reviewed by Dr Barton
Transfer to Dryad Ward continuing care."

Her history reveals she has had a fracture of the left neck of femur on 5 August 1998, she has had angina and CCF. What is CCF?
A Is congested cardiac failure, again, indicating heart failure.

F Q Then:

"Catheterised. Transfers with 2. Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death."

Are you able to comment, having looked at that whole background, on the state of this patient at this point of transfer?
G A Yes. In my report I commented that it was reasonable to transfer this patient when they were medically stable for rehabilitation and that was the plan, but she had had a really very medically unstable course and had multiple medical problems. I think certainly in retrospect one can say she was not really fit and stable to be transferred. So in retrospect, one would have perhaps said it would have been better for her not to be transferred. Dr Barton's note also suggests there has been quite a change in her mobility, in that the notes say she was mobilising well the previous day. So again, there is a difference in mobility recorded. The
H "happy for nursing staff to confirm death", again, this is a lady with multiple medical

problems who could die. I do not think there is a problem with that in itself. I think the issue is whether that is interpreted or seen to indicate an approach to treatment of any active problems that develop. This was a lady who has had infection treated, she has been assessed for angina, they were going to investigate if she had a pulmonary embolus and I cannot comment whether that statement is an indication that there has been a change in approach to this patient in terms of investigation and active treatment of any other problems.

Q I wanted to ask you about that. You deal with the quality of the medical assessment by Dr Barton at paragraph 8 of your report.
A I comment there, I think particularly in a patient like this, where there has been a change in function, they are no longer mobile and they have been quite medically unstable, that it would be good practice to have baseline observations and an examination of, for example, the chest and heart. It would be helpful to have a baseline as to what the patient's condition was at the time of transfer and arrival at Dryad Ward.

Q What are the fundamentals of a baseline observation assessment? What are you looking for in the notes, if you are looking to know where you are starting from?
A One is the patient's level of function, and that is described. We have a description of the mobility. The second is some basic observations which are usually done by nursing staff, which would be pulse, blood pressure, temperature and often oxygen saturation. I think in this patient, who has had an elevated temperature, who has had problems with their heart, those I think are assessments that should have been undertaken. As I say, I would normally expect those to be done by nursing staff on admission. Then I think an examination of the patient's chest, respiratory rate and listening to the heart would be a reasonable baseline set of physical examinations.

Q Who would you expect to perform such an examination?
A I would expect the assessing doctor, who in this case was Dr Barton.

Q If we go over the page momentarily – we will have to come back to where we were – we can see that Dr Barton has prescribed Oramorph, between 5 and 10 mg prn, and temazepam. I am going to ignore the rest for the moment. Do we also see underneath temazepam that bumetanide is prescribed?
A Bumetanide, which is a diuretic drug.

Q And allopurinol?
A Allopurinol is a drug to treat gout and lower uric acid levels in the blood.

Q How are those taken?
A Orally usually. I think they were prescribed orally. Allopurinol only comes as an oral preparation. Bumetanide comes as tablets or an injection.

Q So all of those drugs, the Oramorph, the temazepam, the digoxin, Slow K, bumetanide and allopurinol, all of those would be orally administered?
A Yes, they are.

Q Can we deal, before we move on to the box below, with Oramorph? You deal with this at paragraph 9 of your report.

A Yes. I could not find in the notes a clear indication or rationale for prescribing Oramorph. This lady had not been on regular analgesia, if I am correct, and there is not a description of what the Oramorph is for.

Q In terms of the analgesic ladder, you have described Oramorph as being the third level. Where should Dr Barton have started, in your view?
A It depends what is being treated. If it is pain from the sacral sore, paracetamol and codeine would be reasonable drugs to start with.

Q What about the chest pain?
A I think this is more complicated. For any patient with ischaemic heart disease, it is often standard, because they often take nitrates themselves, to write up GTN to take if the patient gets angina type pain. This patient was a bit more unstable than that. There were concerns whether she was having a myocardial infarct at one stage and you would not write up prn morphine for a patient who you were concerned might have severe coronary pain due to a myocardial infarction or acute coronary syndrome. That would not be good practice, the reason being that the patient needs an assessment as to the cause of the pain.

Q Can we move on, please? First of all, that Oramorph that was written up was in fact administered, 5 mg was given at 2.15 in the afternoon. Does what you say about the prescription apply with equal force, as it were, to the administration of it?
A I thought the administration was not appropriate. It was given for anxiety and distress in the absence of any pain. That would not be an appropriate use of morphine.

Q Can we have a look at the basis of that? If we go to page 15 of the chronology, we can see that she settled and slept well from 10.00 p.m. until midnight. Then:

> "Woke very distress and anxious, says she needs someone with her. Oramorph 10mg given 00.145 with little effect. Very anxious during the night. Confused at times."

If that were the basis for giving this lady Oramorph, what do you say about it?
A I think it can be criticised. The patient is anxious, they have come to a new environment, they have been quite unwell, they are saying they want someone to sit with them. The first response would be for a nurse to sit with the patient. Nurses would not necessarily be able to sit with her all night, but you would expect, unless there were major staffing problems or other problems on that unit, a nurse to be able to sit with the patient for 20 or 30 minutes. If they were no better at the end of that, I think it would be perfectly reasonable to give either a hypnotic, temazepam, which I think she was written up for, or an antipsychotic drug such as thioridazine or haloperidol, but not morphine.

Q This appears to have been given at quarter past midnight, so I think we can take it that it has to be a nurse deciding to give that.
A Yes.

Q Does that reveal anything about the nurse's understanding of how these drugs were meant to be used?
A I think it did raise to me concerns that the nurses had interpreted that prescription of morphine to be used to treat anxiety or agitation in older people, in the absence of pain. I think most nurses would look at morphine being used to treat pain. So I thought that was potentially a confusion or maybe that was the general understanding of nurses, that morphine

was to be used for either pain or anxiety and I think that would not be an appropriate use in the majority of patients.

Q Can we look on to the prescription that was written at the same time at the bottom of page 16? At the same time as Oramorph was written up, Dr Barton has also prescribed her a variable dose of between 20 and 200 mg of diamorphine and 20 to 80 mg of midazolam. Can you just help us, please? I appreciate you have dealt with this on a number of occasions, but with this particular patient, is she to be regarded as opiate naïve?

A Yes. When that was written up, she had not received – well, it depends on the exact timing of that, but assuming this was written up on the day of admission, she was opiate naïve and there was not a clear indication recorded as to why she might require diamorphine and midazolam as a continuous infusion.

Q I do not want to waste time by asking you again about what that increase in dose would be. I think we have your evidence about that and your comments about the wide dose range applied to this patient and this prescription.

A Yes, they do. The comments I have made before for other patients apply.

Q Can we go, please, to the top of page 17 of the chronology? We there see a note made by Nurse Hallman:

> "[Complaining of] chest pain, not radiating down arm – no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg given. Doctor notified. Pain only relieved for short period – very anxious. Diamorphine 20mg midazolam 20mg commenced in syringe driver."

We are going to have to chop this up, I am afraid. First of all, "complaining of chest pain, not radiating down arm", is that an indication of whether this patient was in heart failure?

A Well, it would not be heart failure. The concern is that this lady has had chest pain before and there have been concerns that that might be due to a pulmonary embolus, that it might be due to coronary ischaemia. She is looking unwell. She looks too unwell for this to be likely to be muscular skeletal pain and you would expect a medical assessment. Obviously contact was made with whoever was the on-call doctor at that time.

Q Does any assessment appear to in fact have been done?

A I did not find a record of any assessment in the medical records.

Q We can see that at this stage the diamorphine which had been written up – I say "at this stage"; essentially in the afternoon at 4.00 p.m. – and the midazolam which had been written up were both started at 20 mg over a 24-hour period.

A Yes.

Q What do you say about the appropriateness or otherwise of that administration of the drug?

A I would consider it inappropriate. There has not been a diagnosis made. There were a number of assessments which needed to be done, as were done on previous occasions on this lady: an ECG, a heart recording, was obtained, you would want to know the oxygen saturations, the respiratory rate, listen to the chest, possibly get a chest x-ray, think about whether she was having a pulmonary embolus, all of which would have very different treatments. What has happened is that there has been a symptomatic response, in that the

A patient's chest pain is being treated now with a continuous infusion of diamorphine, which I would say is excessive both in dose and also in the decision to use diamorphine in the absence of a more detailed assessment, a working diagnosis, and there is no clear indication for midazolam, which has been started again at a high dose.

Q We can see that the next entry is 20 August at 12.15:

B "Condition appears to have deteriorated overnight. Driver recharged at 10.10. Family informed of condition."

Then there is a note:

"Night: General condition continues to deteriorate. Very bubbly. Suction attempted without success. Position changed frequently. Ruby rousable and distressed when C moved. Syringe driver recharged at 07.35 ..."

A patient being distressed in these circumstances can be the result of what; are you able to assist us?
A It could be the result of a number of problems. She may still be in chest pain, she may be confused, she may be hypoxic.

D Q What would be causing her hypoxia?
A She could have a chest infection or pulmonary oedema, or her respiratory rate could be being depressed by the midazolam and diamorphine. There are a large number of possibilities and in the absence of any more detailed nursing or medical assessments it is difficult to know what was the definite cause of deterioration at this point.

Q By this stage, would the syringe driver which had been started at 4 o'clock the E afternoon before, be having any significant effect on her respiratory rate?
A I would expect it to with that dose and, her being essentially opiate naïve, she would not have developed tolerance. It is a reasonably large dose and the midazolam dose is a large dose.

Q Can we look at what happens thereafter. Over the page we are still on 20 August, the driver is recharged it seems at 09.15 and then the rate of the diamorphine is doubled to 40 mg F and the midazolam is also doubled. That appears to be over, effectively, a 12-hour period. Looking at it globally, if we looked at 21 September, at 07.35 the diamorphine is put up to 60 mg and the midazolam is up to 60 mg, so over a 24-hour period, if you look at it from 9.15 on the 20th to 7.35 on the 1st, it appears to be a tripling of the dose.
A Yes, it is.

Q How should we be looking at these increases. We know that you have told the Panel G that you can increase at increments.
A One would want to see clear rationale for these large increases. The increases are greater than those which are recommended in the Wessex protocols and other guidelines, which would be a 50 per cent increase. One would generally increase one drug at a time to treat a specific symptom, but the escalation of doses over that period in an older patient like this would be expected to cause very marked sedation.

H

Q The patient dies at 6.25 that evening. In your view, would the administration of the syringe driver potentially have a significant effect on that event?
A I was of the view that the doses administered over the period would very likely contribute to her death, yes, but again, because she had a lot of other medical problems, you cannot conclude that the drugs were the cause of her death.

Q I understand.
A I think the issue is, at this point, clearly she was being treated as somebody at the end of life. If there were clear justification to palliate symptoms and that was the agreed management plan, that might be acceptable and appropriate, but that information was not available in the notes to justify the escalation of the diamorphine and midazolam.

Q On 18 August, three days earlier than this, she is described as:

"Well, comfortable and happy and mobilising well."

If there was this sort of significant change in her health, would you expect a clear note to be made about it?
A Yes. This lady had been very actively treated right up to the day of transfer and was being assessed. If there was a deterioration, you would expect there to be a medical assessment and if there was a chest infection for that to be treated, if there was a pulmonary embolus for that to be treated. That, to me, would be appropriate unless you are accepting that it was entirely appropriate that she was being quite medically unstable and at the point of transfer to Dryad Ward there is a complete change in approach to management and that that was appropriate, but that is not clearly laid out in either Dr Lord's letter or justified in any other correspondence. There is a comment "gentle rehabilitation", so even on that initial admission to Dryad Ward, that was the plan which was reasonable and appropriate.

Q Going back to that note at page 78, which is the clinical record made by Dr Barton, the last note she makes is:

"Get to know. Gentle rehabilitation. I am happy for nursing staff to notify death."

The next note records Mrs Lake's death. If there were any reassessments, would you expect them to be noted?
A If there was a reassessment I would expect it to be entered in the notes. With a lady like this I think you would have to consider it relates to what I described yesterday, that sometimes patients are transferred over when in retrospect they should not have been. She was very medically unstable and I would expect there to have been at least a discussion as to whether it was appropriate to transfer her back for further care because it was going to be very difficult in this setting if the agreed plan was still for active treatment.

MR KARK: That is all I ask about Mrs Lake. Again, perhaps that would be a convenient moment to pause for some reading.

THE CHAIRMAN: Yes, indeed. The new chronology for Patient G is just about to find its way to us.

MR KARK: I think we were going to suggest we hand out all the chronologies now to make sure we do not forget to do that at the end of the day.

THE CHAIRMAN: That is probably very wise, then we definitely have them for the next patients.

MR KARK: I will just ask for that to be done. (Copies distributed)

THE CHAIRMAN: Miss K, the Panel already have the new chronology for. There is a replacement Patient A.

MR KARK: We are trying to remember now what we have added, but I know it was something crucial.

MR LANGDALE: 9 January.

MR KARK: I think L has been transmitted, but it is being produced at the moment.

THE CHAIRMAN: I understand it is with the print room and we hope to have it by the end of today. As far as Patient G is concerned, we have now received both updated chronology and we note that within the file of Dr Barton's statements there is a statement in respect of G.

MR KARK: About 20 minutes/half an hour?

THE CHAIRMAN: I think we will take a short break and combine that with some reading efforts. It is coming up to ten to four. If we say quarter past four, that will give everybody a chance for a quick break and give the Panel a chance to dip their toe into the paper.

MR KARK: Thank you.

(The Panel adjourned for a short while)

THE CHAIRMAN: Welcome back everybody.

MR KARK: The chronology in relation to Mr Cunningham is fairly extensive. I expect you have been reading it again over the last few minutes. I am not going to spend any time going through all the early entries. The Panel have read them all and they reflect this patient's state on of health. There is reference to him suffering from Parkinson's and being a difficult man to manage; him losing weight. He was reviewed on occasions by Dr Lord. In July he found himself on Mulberry Ward, which we heard was the elderly psychiatric ward, or the ward for the elderly. Reviewed in September, and this was the first reference to infection, to sores being diagnosed, his weight being mentioned. This is page 7 of the chronology. His weight is recorded as 68.6 kg:

> "Not eating too badly, sleeping reasonably."

On 21 September he is reviewed again by Dr Lord at the Dolphin Day Hospital in respect of a sacral ulcer and he is admitted to Dryad Ward.

Can we look at page 8 of the chronology first. We can see that on 21 September when he is reviewed, he is shown to have a large necrotic sacral ulcer:

"Extremely offensive. Some grazing of the skin around the necrotic area, also reddened area with black centre on left lateral malleolus. Parkinson's no worse. Mentally less depressed but continues to be frail. Admitted to Dryad Ward with a view to more aggressive treatment on the sacral ulcer as I feel this will now need aserbine in the first instance."

Pausing there, this gentleman is being seen at the Dolphin Day Hospital?
A Yes.

Q It is being suggested he be admitted to Dryad Ward for treatment?
A Yes.

Q What sort of treatment can be applied to this sacral ulcer?
A Essentially it is nursing care which is at a level which you cannot achieve in patients in the community. Admitting to a rehabilitation unit allows you to do more intensive nursing care, more regular dressings with staff that may be more experienced and would be more available than would be the case if he stayed in the community. Getting large pressure sores to heal in patients who are in the community is very difficult, so admitting them is an appropriate practice that is done.

Q If there is a necrotic area, with a reddened area with a black centre, would that indicate debridement?
A You would often consider debridement and various ways to do that.

Q Is it aserbine?
A Yes, I am not particularly familiar with that. It is a type of dressing to clean ulcers, I believe.

Q If we go to the top of page 9, the patient is described as:

"Very frail. Tablets found in mouth some hours after they are given. Offensive large necrotic sacral ulcer."

I will not go through the rest of that. Can we look at the diagnosis first.

"Sacral sore.
PD."

A Parkinson's disease:

Q
"Old back injury. Depression and element of dementia. Diabetes mellitus - diet."

In other words it is diet controlled diabetes.

"Catheter for retention",

so he is suffering from urinary retention?
A Yes.

A Q "Plan: Stop codanthramer"?

A Which is a laxative, and metronidazole which is an antibiotic which he was probably on because of the inflammation and offensive nature of the pressure sore.

B Q "Dryad today, aserbine for sacral ulcer, nurse on site, high protein diet."

A Yes, because if you improve nutrition, one of the problems with achieving tissue healing is if you have poor nutrition you do not get good tissue healing, so, again, admission and ensuring patients take a good diet with high protein to help ulcer healing.

C Q "Oramorph PRN if pain. Nursing home to keep bed open for next 3/52 at least. Patient informed of admission."

So that is admission to the hospital:

"Inform nursing home, Dr Banks + social worker. Prognosis poor."

D What is this gentleman's biggest problem, as it were?
A He obviously has lots of problem, but the main problem at the moment is the sacral sore. If that is not improved, he is likely to get infection and become more unwell and frail from the sacral sore itself.

Q The suggestion of PRN Oramorph, is that a reasonable suggestion at that stage?
A Yes, one would expect this to be painful. I cannot see what other medication he was
E on at this point, but if he has not responded to codeine or paracetamol, it would be an appropriate analgesic, yes.

Q Because he was not at that stage actually in hospital, he was visiting a day hospital, I do not think we know what pain killers he had previously been on.
A I think you should go up the analgesic ladder with someone like this, but if it is very severe some people would consider starting Oramorph. The other rationale for that might
F have been, I think it is mentioned, some of the concerns about swallowing tablets, so slightly easier to swallow syrup, but that in itself is not a strong indication to go to Oramorph.

Q At the bottom of page 9:

G "Seen by Dr Lord. Pressure sore looks worse although NH [nursing home] felt it had improved. Plan: Admit Dryad Ward for treatment of pressure area. Ask Thalassa to keep bed for 2/3 weeks at least. Plan of care for ward written in med [medical] notes by Dr Lord."

MR LANGDALE: I am sorry. It is my fault, maybe I missed it, did you mention "Prognosis poor".

MR KARK: Yes.

H

MR LANGDALE: I am sorry, my mistake.

MR KARK: That is the plan for this gentleman, to treat his sores and he is being admitted to Dryad for that purpose.
A Hopefully, with the intent that after two or three weeks this sore will have improved enough that he can be discharged back to the nursing home.

Q He is reviewed the same day by Dr Barton and we have her note at page 647. This is the one where we have the note at 644 which is pre-transfer on 21 September and then the note from Dr Barton on page 647 at the time of transfer. We apparently have a photograph which we cannot see, but it is in the notes if anybody wants to look at it. 21 September Dr Barton writes:

> "Transfer to Dryad Ward
> Make comfortable
> Give adequate analgesia
> I am happy for nursing staff to confirm death."

In terms of assessment and plan, how do you regard that note.
A I think it has to be looked in the context that he has already had a detailed assessment by Dr Lord, so one would not expect that to be repeated. I do not think anyone would have any particular problems with any of that. There is a clear instruction about the type of approach to analgesia from Dr Lord. They are happy for the nursing staff to confirm death we have discussed before. In itself, this is a sick, frail man with many problems and he could die suddenly. That is not the issue. It is whether that has connotations around other aspects of his management.

Q I was going to ask you about that note and also the note "make comfortable". We have heard, as you appreciate having read the transcripts, quite a lot of evidence about that being a euphemism for a particular route.
A It can be a euphemism, but it can be exactly what it says. I would not like to speculate about what the specific meaning. I would acknowledge that it can be interpreted in different ways.

Q It is a question of how the nursing staff would interpret the note?
A Yes.

Q Back to the chronology, please. We will find the drug charts, or the chronology dealing with the drug charts, at page 12. On the day of his admission, Dr Lord has prescribed a PRN dose of Oramorph which we looked at earlier from 2.5 up to 10 mg of Oramorph.
A Yes.

Q And you commented on that already. Dr Barton then prescribes 20-200 mg of diamorphine. We are dealing with the prescriptions first before we actually deal with their deployment, and 20-80 mg of midazolam and hyoscine. In terms of this patient, at this stage of his life, how do you regard those prescriptions?
A I will not go through; the prescriptions are too wide and hazardous for that, but, yet again, I do not see a clear indication as to why he needs to be written up for continuous infusions. In previous discussions of this I indicated the benefits in somebody who might have difficulty swallowing, and there were some suggestions that he might well have

A difficulty swallowing, of having an alternate route which could be for PRN. Oramorph itself is subcutaneous or could be written as separate subcutaneous diamorphine. That would be appropriate, but not to put a high starting dose of diamorphine and midazolam when one has not established his response to morphine to begin with.

Q I am sorry. I just wanted to ensure I had not misheard you. Did you say that Oramorph could be given subcutaneously?
B A Sorry. Oramorph cannot. Morphine can be. Sorry. Thank you for correcting me on that. Morphine can be given subcutaneously but diamorphine is generally used, so what I am saying is, it would be appropriate and good practice if one was concerned about his ability to swallow to have alternate PRN opiates to give which would say, "Administer if unable to take Oramorph".

Q Before we come back to the actual administration of those drugs, I think we need to
C go to page 13, which reveals a note from the evening before so the day that that prescription is written out, we then see this note, which is made the following day:

> *"Mr Farthing has telephoned, Explained that syringe driver commenced yesterday evening for pain relief and to allay his anxiety following episode when Arthur tried to wipe sputum on a nurse saying he had HIV and was going to give it to her. Also tried to remove catheter and episiotomy the bag and removed sacral dressing throwing it*
> D *across the room, finally he took off his covers and exposed himself."*

That in any setting, I suppose, is challenging – what is nowadays described as challenging behaviour?
A Yes. One does come across older people who are confused and agitated, or can occasionally be difficult, of course. The history suggests there were difficulties with his behaviour in other settings.

E

Q Then, if we now go back to page 12 of the chronology, do we see that night, at ten minutes past eleven, the diamorphine and the midazolam which Dr Barton had prescribed, is started? Sorry – you are nodding?
A Yes. I do apologise.

Q That is all right, but it has to go on the transcript. Unless Dr Barton was attending the
F hospital that time it appears that that was or may have been a nurse-led decision?
A Yes. It appears in my initial report to Hampshire Police; I indicated it might raise concerns that the midazolam and diamorphine infusions were commenced to control his behaviour and sedate him.

Q And how appropriate or inappropriate would that be?
A He is taking Oramorph, so he is getting morphine to control the pain, so there is no
G need to change that unless he is refusing to take medication, which this note does not say. Midazolam is not a treatment for behavioural difficulties and agitation in older people. It is, to remind ourselves of the Wessex protocols, a treatment for terminal restlessness, so it would be quite reasonable if one was going to use pharmacological measures to control his behaviour – one does not always have to resort to that – to look at a dose of haloperidol or thioridazine. One would start with an antipsychotic as a rule for these sorts of symptoms. One might consider a benzodiazepine but for this sort of agitation and behavioural difficulty
H most geriatricians would not choose a short-acting benzodiazepine but you would not choose

to give midazolam or some continuous infusion when that is recommended for use with the management of terminal restlessness.

Q This was a patient who, it appears, was able to swallow his Oramorph, at least because we know that was being administered. Is there any other indication as to whether this gentleman needed a syringe driver as opposed to any other form of delivery?
A I am trying to find it. There is a record that he swallowed a drink of milk, if I have it correctly.

Q There is. I think he took two glasses of milk. It is page 10, the bottom of page 10.

> "Driver commenced at 23.10 containing diamorphine 20 mg and midazolam 20 mg. Slept soundly following. BS at 23.20. 2 glasses of milk taken when awake. Much calmer this [morning]."

Can we look at how this administration went on. First, if the nurses had started diamorphine and midazolam inappropriately and the doctor treating this patient comes across that, what in your view could or should the doctor have done?
A At this point, the first thing is there was a recognition that the patient should have pain treated, so the first thing to assess is are they in pain, and do they have any adverse effects from the diamorphine that they are now receiving, recognising that because you started a continuous infusion it is going to be some time before the maximum effects of that infusion will occur. It might be up to 24 hours. That might likely require adjustment or conversion back to oral morphine, in the sense he is able to swallow. I really would be very critical about the continuation of midazolam because this is highly likely at this dose, if one continues it, to produce marked sedation, particularly in the context of giving a large dose, starting dose, of the 20mg or 60 mg of oral morphine equivalent.

Q If we go on in our chronology please ---
A Sorry, can I just add a comment to that?

Q Yes.
A Partly that is because behavioural disturbances often are intermittent and people have behavioural problems and agitation for a short period. You treat that and then you withdraw the drugs. The trials which have looked at behavioural disturbances in patients with dementia and psychotropics show, for example, a very high response rate in the placebo group, the group in a trial who do not receive any active treatment, about 40 per cent, and 60 per cent with treatment. That is a broad generalisation. You would always review drug management for agitation and behavioural problems unless, obviously, we are now in a position where it has been decided he is dying and for terminal care. This again does not seem to be explicitly articulated. It does not seem to be the reason it was started by the nursing staff. It seems to follow his behavioural problems and it is trying to palliate those symptoms, but it is not clear that there was an intent that he was for terminal care.

Q We can see on page 13 that the driver continues. Over to page 14, at the top, it continues on the 22nd and is administered at twenty past eight in the evening, or re-started at twenty past eight in the evening. Then, on the morning of 23 September, he is reviewed by Dr Barton. This comes from the significant events in the nursing plan. There is no note, I do not think, made on the 23rd of any review by Dr Barton, but we have one on the 24th at page

645 of the file notes. Can we just look at the bottom of page 14 before we go to that. In relation to 23 September:

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

I do not think we have food or fluid charts for this patient?
A No, no.

Q The only entry we have is the two glasses of milk that we have looked at?
A At this point my interpretation of the notes was that he was not receiving any hydration or nutrition.

Q And the comment "syringe driver boosted with effect": can you just help us with this. The syringe driver can be boosted, I think, with a button on the side?
A I interpret this to mean the infusion rate was increased. That is my interpretation.

Q Let us have a look at the top of page 15. We can see that in the morning of 23 September, at 9.25, the 20 mg dose of diamorphine is continued and then re-administered but at the same dose at 8 p.m. The midazolam appears to start at 20 mg and then there appears to be a three-fold increase?
A Yes. And I think that is what the term "boosted" means, so it is a threefold increase in the infusion rate of midazolam. That is a very high dose for this man and a very, very large increase.

Q It may be obvious but what effect is that going to have in terms of sedation?
A This dose would be definitely expected to produce very marked sedation in a man of this age.

Q We heard evidence from Mr Stewart-Farthing – Day 6/8 – that on the 23rd, the day that this boost took place, he found him (he called him Brian) unconscious and unrousable. He says he went berserk, got very angry and he demanded to see the people responsible in the hospital, and he had a row with Sister Hamblin. He asked for the syringe driver to be removed so that he could speak to Brian. Now, obviously one does not have to follow, I suppose – you have indicated yesterday – the wishes of relatives.
A Yes. And that is in the best interests of the patient. One of the problems of using sedation therapy is exactly this. It sedates people and they are unable to communicate at the end of life, and that is why, irrespective of any effects it may have on shortening life, it has to be weighed up very carefully if you introduce sedation therapy because it means you have somebody dying who is no longer alert who might otherwise be. Good quality end of life experience for many people might be to be alert and to be able to hold a loved one's hand. These are the potential problems with using sedation therapy. It is not just the risk of respiratory depression. It is that you are rendered less conscious which, by definition, is what sedation therapy does.

Q If he is described as unconscious and unrousable on 23 September, first of all is that a state that the patient should be in?
A It would be a state that he would be in if he had a clear indication and his symptoms were uncontrollable through any other means except by going to that level of sedation; but

A this was a very large dose, a very large increase, and there was no attempt to titrate or adjust it. What could have been done was to reduce the midazolam at this point, and see what happened. He was variable in his agitation and, of course, we had the problem that it possibly was the diamorphine and its metabolites that might be worsening his agitation. It is a very difficult situation. The good palliation at the end of life, you try and adjust and optimise drug therapy, so you minimise side effects. You keep a patient's symptoms in control, but you keep them as alert as possible. The aim is not to render patients unconscious B through high doses of sedation therapy.

Q Even if you do not feel that the nursing staff, or the doctor does not feel it appropriate to remove the syringe driver completely the dose could be reduced?
A Yes. If you have somebody who is over-sedated, or has excessive amounts, and that is your judgment, of opiates or sedatives, it is best to initially stop for a few hours and then see what happens to the patient, and then re-start the infusion at a lower rate. That is best C practice if someone is clearly overly treated. It is reasonable if they are not in an immediately life-threatening situation to reduce the infusion.

Q If we have a look at Dr Barton's note on 24 September – it is page 645 if anybody wants to turn it up but it is revealed in our chronology at page 15:

> *"Remains unwell. Son has visited again today and is aware of how unwell he is: sc* D *analgesia is controlled pain just. Happy for nursing staff to confirm death."*

And over the page, at the top of page 16, Sister Hamblin:

> *"Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees. Syringe driver renewed at 10.55 with diamorphine 50 mg, midazolam 80 mg and hyoscine 800 microgram. ... Mr Farthing* E *seen by Dr Barton this afternoon and is fully aware of Brian's condition."*

Can we just look at the drug charts set out at the bottom of page 16 of the chronology:

> "Diamorphine: 40 mg/24 hrs administered at 10.55"

This is all on 24 September. Then, on the same day:

F

> "... increased to 60 mg/24 administered...".

A Yes.

Q So within a 24 hour period, unless I am misreading it, just looking back at page 15, on the 23rd he had been on 20 mg diamorphine and by the end of the 24th he was on 60 mg of G diamorphine?
A Yes.

Q The midazolam, he had been on 20 mg on the 23rd, and we have already looked at that – there was that threefold increase.
A Can I comment? I find it difficult to know how the nurses could assess the pain was in his knees at this point. He had a very marked depressed conscious level so I find that H comment slightly surprising. I would have thought it would be difficult for them to gain an

idea where his pain was. I can only assume when he was being moved he was making noises which led nursing staff to believe he was in pain.

Q Can we carry on, please, we see at the bottom of page 16 that the syringe driver continues. Over the page, now on 25 September, we can see that the driver is recharged with 60 mg of diamorphine and 80 mg of midazolam. At the bottom of the page, Dr Barton has re-prescribed the diamorphine, this time with a higher starting dose, of 40 – 200 mg. Midazolam is prescribed again, as is hyoscine. The diamorphine continues to be given at 60 and the midazolam at 80. Over the page, at page 18, we are on to the 26th, the note is:

> "*Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. ... Driver recharged ...*"

and, again, it has gone up to 80 mg of diamorphine and 100 mg of midazolam. If we go back to the notes at page 647, we can see that there is a note on 25 September by, I think, Dr Brook?

A Yes.

Q

> "Remains very poorly on syringe driver
> For TLC."

By this stage, what sort of condition is the patient going to be in?

A He is dying. With those doses of midazolam in particular and diamorphine, he is bound to be deeply unconscious. It is a very high dose of a potent sedative drug.

Q This patient, I think we all understand, is not being hydrated.

A Yes. At this point, the decision has clearly been made that he is dying; he is not for hydration or nutrition. He is moved into this at that early period. Once he has a depression of his consciousness level, it would seem he is on at that point an end of life pathway.

Q So from the point on 21 September, after his agitation, he is put on the syringe driver and it is increased either with diamorphine or midazolam on I think a daily basis. By this stage on 26 September, in your view is he going to be saying anything, is he going to be rousable?

A No, he is not. I just think it is an unusual approach to managing the problem. I think most geriatricians faced with this type of problem would have carried on with intermittent prn morphine at this stage and would have given a prn variable dose of an antipsychotic, such as haloperidol or thioridazine would have been used, and one would have observed the response. One would not have started an infusion at this point.

Q We can see that the patient died at 11.15 p.m. on 26 September. In your view, would these drugs have had any significant effect on that event?

A I actually think it would be difficult to conclude that the drugs did not play some part in his death through causing deep sedation and respiratory depression, but equally the literature is unclear about people who are clearly having palliative care – this is often cancer patients – as to whether sedation therapy significantly shortens life. But in this patient, who was not initially in that setting, I think the fact that he became unconscious, it is very likely that drugs contributed to respiratory depression and him getting bronchial pneumonia. But he

was at high risk of getting bronchial pneumonia and dying anyway, so again you cannot conclude that the drugs definitely caused his death.

Q At the time that he was transferred on 21 September, he was supposedly destined by Dr Lord for a high protein diet.
A Yes.

Q Does any of that plan in fact appear to have been put into action once he had got to the GWMH?
A No. The plan appears to have been changed by the behavioural problems and the institution of the diamorphine and midazolam infusions at that point. When he was admitted, Dr Barton's note still indicates there was a plan to try and improve this man's function and his pressure sore.

MR KARK: That is all that I ask about this patient. I suspect that would be a convenient moment to break.

THE CHAIRMAN: Yes, particularly as there will be a need for certainly the Panel and I guess yourselves to be organising those papers which you need to take out of the room tonight, since it will not be available to us tomorrow. Thank you. We will resume on Friday at 9.30.

(The Panel adjourned until 9.30 a.m. on Friday 10 July 2009)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 10 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWENTY-TWO)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

INDEX

THE CHAIRMAN: Welcome back, everyone. I hope everyone has been able to get their files back to the position they were in before we had to break. I know there were some concerns that some pieces of paper had migrated, but on our side we are now all back firmly as we should be. Over to you, Mr Kark.

GARY ASHLEY FORD, Recalled
Examined by MR FORD, Continued

Q Professor Ford, we were just going to move on to deal with the case of Robert Wilson, Patient H. You are still on oath of course.
A Yes.

Q I think everybody has received the new chronology for this patient. So far as Mr Wilson is concerned, this is the gentleman who had been diagnosed with alcoholic liver disease.
A Yes, correct.

Q We will look at that in more detail in due course, but you revealed to us when you began giving evidence that that may have an effect on the use of opiates.
A Yes. Two reasons. One is that a reduced dose is recommended in patients with cirrhosis established damage to the liver, because there may be less metabolism of the opiate drugs by the liver. Secondly, patients with liver disease can develop confusion due to hepatic encephalopathy and opiates can precipitate that. So for those two reasons, it is mentioned as a reason to proceed cautiously in terms of using opiates in patients with liver disease.

Q This gentleman we know had a fall. He fractured his left humerus on 21 September 1998 and he went into the Queen Alexandra. As we see on 22 September, an x-ray revealed some displacement of the fragment, but he was not keen to undergo surgical intervention. Indeed, that is what happened: he never had that arm fixed?
A Clearly I am not an expert in this areas, but it is a fracture that is not always surgically repaired, but my understanding was that in his case it was thought desirable to repair it to obtain a better healing result and to reduce pain, which was significant.

Q We see with this gentleman, as time went on, that in fact it did cause him pain when he banged it or moved.
A Yes.

Q On 24 September we see that he was given diamorphine for his pain at a rate of 2.5 mg. So that would be a single injection, would it?
A It would.

Q Then he was given a further 2.5 mg, a total of 5 mg, he was given codeine phosphate and then from then on, as we look through the chronology from 26 September 1998 onwards, he is in general given co-dydramol and then moving on to paracetamol. There are occasions when he refuses the paracetamol. On 31 October we see there is an entry on page 12 of the chronology, "Discomfort continues on movement". And there is reference there to a pressure area to the sacral, red but still intact. He is boarded, which presumably means prescribed, morphine.
A Yes.

Q 2.5 mg for his painful arm, because oral analgesia was refused. On 5 October there is a remark that he had knocked his left arm, that he was not very alert am, but in the afternoon he was very alert, his speech was clear, he was in some discomfort but he was still refusing paracetamol.

MR LANGDALE: (Speaking off microphone, in audible)

THE CHAIRMAN: Please use the microphone, Mr Langdale. I should say that I have noted there are one or two occasions where the transcript reads "Inaudible" as a result of somebody from the other side of the room speaking without the microphone. It really is useful if we can have the words recorded.

MR KARK: I think Mr Langdale was just trying to give me a prompt.

MR LANGDALE: It is my fault mostly I think. Might I just invite my learned friend to draw attention to the fact that on 4 October there is morphine? He had moved on to the 5th. That is all.

MR KARK: There are occasional references throughout I think to him being given morphine on occasions when he had pain.

A Yes.

Q The amount of morphine that he was given on 4 October was 2.5 mg. Then we can see he was given 2.5 mg on 5 October. Again, I am trying to skip through it quite quickly. There are comments about his left arm being bruised and sore and he is still being given paracetamol. Then on 8 October, he was reviewed by Dr Luznat and we heard from her.

> "Had impaired rental function, active alcoholic hepatitis and hypothyroidism. Was treated with IV fluids and gradually improved. Now eating and drinking well, appears much brighter in mood."

Then towards the end of that entry we see:

> "Left hand grossly swollen and bruised. Marked oedema of both legs. Mobility remains poor. May have developed early dementia. Might be early Alzheimer's Disease of vascular type dementia. Also depression."

At the bottom of the next entry, we can see – this is page 17 – there is a nursing note:

> "No longer requiring acute bed. At risk of self injury, hand very oedematous + at risk of breakdown due to low albumen."

Then three lines down:

> "Very chatty and funny ... Sacral cleft quite red .... "

Then right at the bottom, we can see:

A

"Communicating quite well although varies according to mood. Asked doctor to consider stronger analgesia. Now prescribed codeine phosphate .."

We can see that that was administered together with paracetamol. Over the page, at the bottom of the page, codeine phosphate and paracetamol were administered. That continues. On 13 October we see that his weight was up to 114 kilos, which by my reckoning is about 17½ stone. Then we can see at the bottom of page 23, he is on codeine phosphate 30 mg and
B paracetamol, and he is then transferred to Dryad Ward for continuing care.
A Yes.

Q I am not going to turn them up, but we have the clinical notes of Dr Barton at page 180, when he was reviewed. "HPC", is that history of presenting complaint?
A Yes.

C Q

"Fractured humerus ..."

Then there is a date –

"[Past medical history]: alcohol problems, recurrent oedema."

D

What is CCF?
A Congested cardiac failing.

Q Then:

"Needs help with activities of daily living. Hoisting. Continent. Barthel 7. Lives
E with wife Sarisbury Green. Plan gentle mobilisation."

So there is a reference there to alcohol problems. We do not know if the notes were with her at that time or not, but she was plainly aware of an alcoholic background.
A Yes. That might mean alcohol problems in terms of abuse and the effect on his mood and depression or it could obviously also mean alcohol problems in terms of liver complications or indeed both.

F

Q We can see, if we go to pages 24 and 25 that Dr Barton prescribed Oramorph 5 to 10 mg four hourly. We can see that there is a nursing reference on page 24 in the middle of the page:

"Restless at time. Used urinal with assistance as he wanted to stand. Oramorph 10 mg given for pain control."

G

So this is on the day of his admission to Dryad.
A Yes.

Q His last morphine by my reckoning was on 5 October, when he had had 2.5 mg. Now he is given 10 mg for pain control on the basis of Dr Barton's prescription. Can we have a look at that prescription at page 25 of the chronology? She has written him up for 2.5 to 5
H mls (5-10 mg) four hourly as required, but it is actually given to him twice on the day of his

admission at a rate of 10 mg. So 20 mg on the day of his admission. Just pausing there for a moment, I think you dealt with this both in your police report at page 5.11 and also in your GMC report at paragraph 11. What is your view, please, about the appropriateness of that prescription at that time or Oramorph?

A I think it would have been preferable to establish him on regular moderate opioid analgesia with paracetamol. He had been getting, if I have interpreted the prescribing correctly, intermittent doses of codeine at 30 mg and I think it would have been most appropriate to continue paracetamol regularly and increase the dose of codeine to say 60 mg four times a day. He had not had that level of regular moderate opioid dosing prior to his admission to Dryad Ward as far as I could tell. The dose is a large increase on what he had been having before of intermittent doses of 2.5, so I think it would have been reasonable, if one had decided he was unlikely to be controlled or had not been controlled on the moderate opioid, to start with a more cautious dose of 2.5 to 5 mg, given his liver disease and given that is what had been given before. But I think best practice would have been to go through the analgesic ladder through a moderate opioid to begin with, with paracetamol, and then add in prn available the morphine. So I think the 10 mg is in my view an excessive dose, given his age and liver disease.

Q Does it make any difference that this is to a one-off dose, as it were? It is 10 mg four hourly.

A Yes, because he has only had intermittent doses, much lower doses, so far, so there is a high risk that 10 mg four hourly is likely to potentially produce problems in terms of the adverse effects we have talked about before.

Q I will not ask you to go through them again. In addition to that prescription, as we can see from the chronology at page 25, Dr Barton wrote up a prescription for 20 to 200 mg of diamorphine, 200 to 800 mcg of hyoscine and midazolam of 20 to 80 mg. Just dealing with the diamorphine – again, I am not going to ask you to deal with the range – does what you have said previously in relation to the range apply equally or with more to this particular patient?

A It applies with I think more force for this particular patient because of the risk of precipitating an encephalopathy in a patient with established chronic liver disease.

Q In relation to midazolam?

A Again, patients with cirrhosis are at risk of developing hepatic encephalopathy, liver failure, from benzodiazepine drugs, including midazolam.

Q On the day after his admission, 15 October, if we turn over to page 26, we can see that he was commenced on Oramorph 10 mg four times daily. Oramorph 20 mg was given to him at midnight with what is described as "good effect". Then the note – I take this to be the morning of 15 October – Oramorph 10 mg was given at six o'clock. Then:

> "Condition deteriorated overnight. Very chesty + difficulty swallowing medication. Incontinent urine ++"

Do you have any view as to what may be causing this patient's deterioration overnight?

A I think one would have to consider that it was due to the opiates, because he has just been commenced on those and he has deteriorated after a few doses of morphine at a higher level than he has received before. So that would be the key concern, the most likely cause of deterioration. Clearly there could be other causes: he could have developed an infection or

A other problems, but one would have to consider the opiates as in my view the most likely cause of his deterioration overnight.

Q We can see at the bottom of page 26 that in fact on 15 October, he was given what I think is a total of 50 mg of oramorphine, the maximum dose he had been on at the previous hospital had been 5 mg daily.
A Yes.

B

Q At the top of page 27, he was reviewed by Dr Knapman. We have this in our clinical notes again. This is a Friday, 16 October 1998:

"Declined overnight with ..."

Is that shortness of breath?
C A Yes. I would interpret it as that.

Q Then:

"[On examination] bubbling. Weak pulse. Unresponsive to spoken orders."

Although this patient had been in pain previously from his arm when he had knocked it on
D occasions at the previous hospital, this is the first time we have seen this sort of note about this patient.
A In terms of his - ?

Q Unresponsiveness.
A Yes, that is my understanding. At no point before has he been described as unresponsive that I could see.

E

Q Then there is a significant event raised by a nurse:

"Seen by Dr Knapman am as deteriorated overnight. Increased frusemide to 80 mg daily."

Frusemide is not going to be having a sedative effect, or is it?
F A No. It should not do. Again, diuretics can sometimes precipitate encephalopathy in patients with liver disease, but ---

Q Encephalopathy. Can you just explain that?
A This is liver failure. The liver normally rids the body of breakdown waste products and if you have damaged liver, these accumulate and they can cause a confusion and drowsiness because they are not eliminated from the bloodstream. But I think frusemide
G would not be likely to be a precipitating factor in this patient.

Q Then we can see that the decision is taken apparently by a nurse, but this may have been in conjunction with a doctor:

"Syringe driver commenced. Wife informed ..."

H Can you see any basis here for commencing a syringe driver with this patient?

A A No. I could not see a basis for prescribing the initial as required infusions of diamorphine and midazolam and I am critical of the assessment by Dr Knapman in not perhaps considering the role of opiates and undertaking more investigation. Whether he or she considered this patient was not for active treatment and investigation beyond giving frusemide is not entirely clear.

B Q The note we see by the doctor following "Seen by Dr Knapman" is "For ANC". All nursing care. Then the syringe driver is started. The syringe driver was started, as we can see over the page at the top of page 28, following 30 mg of Oramorph having been given to the patient up until two o'clock that afternoon. Then at 4.10 the syringe driver is started apparently with 20 mg. That is the lowest dose possible, as it were, on Dr Barton's prescription.
A Yes.

C Q But, as you have told us, I think it is actually equivalent to the 60 mg dose of ---
A On the usual conversion, yes.

Q Then we can see the next entry is a review by Dr Peters, from whom we heard:

"Comfortable but rapid deterioration. N/S to verify death if necessary."

D We have heard about that. Then the syringe driver is renewed, this time by Nurse Hamblin. We can see at the bottom of page 28:

"Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver renewed at 15.50 with diamorphine 40 mg midazolam 20 mg ...."

E So that perhaps obviously is a doubling of the diamorphine and now midazolam is added. Can you see any basis for this?
A I could not. The notes - both medical notes do not provide any description of the symptoms and whether he is in pain, and the nursing notes do not either, so on the basis of the information in the medical notes there is no clear justification for the escalation and increase in doses.

F Q In fact, the note by Nurse Hamblin is "slow deterioration in already poor condition".
A Yes. I think none of the doctors who saw Mr Wilson or the nursing staff appeared, on the basis of the information that is available in the notes, to have considered that the drugs he had been started on could, in fact, be the cause of his deterioration. Instead it was assumed to be heart failure or other problems not described, and that he required more palliation from these drugs.

G Q On page 29 we can see the record of the dose being increased, and then the following day, 18 October, Nurse Hamblin records:

"Further deterioration in already poor condition. ... Syringe driver renewed ..."

This time with 60 mgs of diamorphine and 40 mgs of midazolam. We have seen the addition of midazolam earlier, but what would be the purpose of adding midazolam?

H

A Well, as described in the Wessex protocols it is for the treatment of terminal restlessness. I think it is important to emphasise that a patient may be deteriorating but that does not in itself act as an indication to increase doses of opiates or sedative drugs. Those should be increased for specific control of pain or terminal restlessness, not because a patient is slowly deteriorating in itself.

Q Then moving on to the following page, page 30, we can see that that syringe driver was recharged. It is administered at 1450 at the higher dose of 60 mgs diamorphine, and a doctor at the same time has prescribed 1200 micrograms. That is to deal with secretions?
A Yes.

Q And the midazolam has also been administered and then that evening, eight hours later, the patient dies.
A Yes.

Q The cause of death is given as congestive cardiac failure, renal failure and liver failure. In your view what contribution, if any, would diamorphine and midazolam appear to have made to this patient's death?
A Well, in my view, I considered the drugs had led to his deterioration and contributed to his death. Clearly he had other serious comorbidities, including liver disease and clinically evidence of heart failure, so one cannot say that the drugs were the only cause of his death, but in my view they were most likely a contributory factor.

Q As this patient deteriorated, in your view, certainly potentially because of the drugs he was being given, if there had been concern about what was causing that deterioration, what could Dr Barton have done? Or what should Dr Barton have done?
A Obviously, if drugs are considered to be a cause of deterioration one discontinues them and observes if you see a response, and you also examine the patient for signs of toxicity due to the drugs, so one could examine for signs of encephalopathy, although he may not have been well enough at this point to see if he had a liver flap, which is where the hands shake due to the accumulation of breakdown substances. Clearly there were opportunities; a number of times he was seen to look at this, the first time by Dr Barton and also I think particularly the second time when Dr Knapman saw him.

Q That is all I am going to ask you about that patient. We are going to move on, please, to the case of Enid Spurgin. This patient we see was born in February 1907 and was admitted to the Royal Haslar on 19 March 1999. She had had a fall and she had fractured her right hip. She had had a fall because she had been walking her dog, it would appear, and had been pulled over by her dog. She is described on page one of the chronologies as living alone, self-caring and independent. On examination at the hospital she was "well alert + orientated". I do not know if that means "and orientated" or ---
A It means "and". "Alert and orientated".

Q "Abraded right forearm/elbow", so it looked like she had grazed her elbow in the fall.

> "Plan: Admit... Takes no drugs and has no other health problems. Non smoker. Has a brandy and ginger every morning at eleven."

Indeed, later I think we see that actually prescribed at the hospital, which is rather a nice touch, but in any event she had no difficulty breathing, a small appetite, loved to walk her

dog and do the garden, slept a lot, always falling asleep in the chair, and is described as alert and understands everything, although a little deaf. She is given diclofenac and paracetamol. Diclofenac is?
A A potent non steroidal anti inflammatory drug.

Q And she is operated upon. She was given morphine and at the bottom of page 2 we can see that she seemed to have reacted to that by having hallucinations. There is a note "therefore nil further opiates". We know, in fact, she was given opiates at that same hospital later on.
A Yes.

Q But hallucinations from morphine, is that a fairly well-recognised side effect?
A Yes. It is one of the manifestations of confusion produced by opiates in some older people.

Q We can see that at page 3, the patient was complaining of discomfort in leg and pain on palpation, otherwise nil else. We can see that she was given paracetamol and 2 mgs of morphine and then 5 mgs administered twice. On 21 March Enid is described as being able to get into a chair. "Please give her morphine before moving" because "there is a lot of pain on movement. Push fluids as much as possible ... urine output poor", but then it is described as improving. Then she is reviewed late in the evening by Dr Woods. "Urine output abysmal but patient not complaining of thirst", and then this:

"Clinically this lady is slightly dry but not excessively so but when UO" ---

Is that --- ?
A I would determine that to be "urine output".

Q "Taken into account she is in acute pre renal failure. Urgent U + Es requested."

Acute pre renal failure. What is the significance of that?
A It means the clinical assessment is that she is dehydrated, she has reduced blood volume, this obviously is a common problem following surgery, and the kidneys are not being adequately perfused so they are not doing their job as well as usual, and the urea count may be increasing, so the treatment for pre renal failure, renal failure in the early stages, is to correct the hypovolaemia and to give the patient more fluids.

Q "Note: right hip painful +++ no ooze but thigh enlarged."

Ooze would be an indication of infection?
A I do not wish to comment outside my area of expertise. Blood leaking through the wound I would have thought would be the reference here, the concern that she is bleeding, and the ooze would be a reflection of blood coming out of the wound, perhaps suggesting she is bleeding into the wound would be how I would interpret this as a non orthopaedics specialist.

Q And we can see the thigh is large: "Possible bleed into thigh but no evidence of hypovolaemia."
A There is a slight contradiction there. The clinical impression by Dr Woods is that she may be in pre renal failure due to hypovolaemia, and then his assessment appears to be that

A there is no hypovolaemia. I think he would be making that judgment but the blood pressure chart, would be my impression.

Q She is given paracetamol and morphine again, and we can see the following day: "Poor oral fluid intake".

> "Sat out by physios. Drinking and eating much better today. Oral fluids pushed. ... Urine output monitored. One hourly measurements satisfactory. ... large amount of ooze. Paracetamol."

Page 6: She removed her catheter. "Patient has difficulty and pain ++ with mobility." She can wash her face and upper torso. "Redressed ulcer on right leg, "Transferral and mobilising not well. No ooze on wound". I think she was reviewed by Dr Reed on that day but I will not go to that for the moment. Paracetamol administered, and then over the page we see she is referred to Dr Lord and reviewed by Dr Reid, where we can see in the first row: "Has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult. [Her] quality of skin, especially lower legs, is poor, and at great risk of breaking down."

And then in the next entry:

> "Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful",

and he described to us how what that meant was simply lifting the leg without the patient putting pressure on it herself. That would cause the patient pain?
A Yes.

Q And then Dr Reid writes at the top of page 8 of that chronology:

> "Still in a lot of pain, which is main barrier to mobilisation ... could her analgesia be reviewed?"

She is given paracetamol. At the bottom of the page in the chronology:

> "Skin tissue-paper thin + very fragile. Haematoma developed + broken down".

Paracetamol again, and then we can see on page 9 on 26 March she is transferred to Dryad Ward, and the transfer letter revealed that,

> "She is now mobile from bed to chair with two nurses and can walk short distances with a zimmer frame. No urinary catheter. Sometimes incontinent at night. Skin on lower legs paper thin. Right lower leg very swollen and has a small break on the posterior aspect. Needs encouragement eating and drinking but can manage independently. Her only medication is analgesia (paracetamol) PRN".

She is then reviewed on arrival at Dryad by Dr Barton.

A "[History of presenting complaint]. Fractured [neck of] femur [right] 19 March 1999. [Past medical history]: Nil of significance. No weight bearing. Tissue paper skin. Not continent. Plan sort out analgesia."

We can see that there is a nursing note.

B "... complained of a lot of pain for which she is receiving Oramorph regularly now, with effect."

And we will look at the prescription written out by Dr Barton but while we are on this page at the bottom we can see: "Requires much assistance with mobility ... Oramorph given 10 mgs at 23.15 + 5 mg [the following morning] at 06.50".

C If we now look to the prescription, page 11, Dr Barton prescribed 2.5-5 ml (5-10 mgs) "PRN subcutaneously". I do not think that can be right, can it?
A It may be as a - it probably would be - let me just check. I had it recorded as "subcutaneous" when I reviewed the notes.

MR LANGDALE: I do not think it is "subcutaneous", in fact.

D MR KARK: Can you just help us with that? "Oramorph subcutaneously". I think you have mentioned that previously but can you just help us ---
A Well, Oramorph is oral morphine, it is the trade name for oral morphine, so it cannot be given subcutaneously, so I suspect that was a prescribing error by Dr Barton. But obviously that would be my assumption, unless the intention was to prescribe morphine subcutaneously, in which case one would just write "morphine".

MR LANGDALE: If we look at page 160 I think, I may be wrong, that is the prescription.

E MR KARK: We are just trying to get the original so we can read it better.

MR LANGDALE: The hole punch of mine is obscuring what I think may be "oral", but we will see.

F MR KARK: Can I pass it to the witness so he can give us some evidence about it?
A Looking at this I think it is "oral", re-looking at it, and I think I have misread that because it is not entirely clear if it is "subcut", but as I have indicated certainly page 160 is "oral", I think.

Q The other document you have been given is our copy of page 164, which starts with Oramorph at the top.
A As I say, I am sure that is correct, because one would not prescribe Oramorph subcutaneously. So I think I must have misread that, because it was slightly unclear in the copy I have.

G Q Can I suggest for the moment we put a bracket round "subcutaneously"? We will hear evidence about it in due course.

MR LANGDALE: May I suggest we just put a line through it, because it is not subcutaneous.

H

MR KARK: I agree. It is simply I heard Mr Langdale said it was subcutaneously so I presumed those were his instructions. We can put a line through it. (To the witness) Let us stay with that prescription now for the moment. Bearing in mind the previous opiates that this lady had received – she had been on paracetamol for the days leading up to her admission – it is right to say that there had been that comment by Dr Reid, "Please review analgesia".
A Yes.

Q Just staying with this for a moment, Oramorph 5 to 10 mg as required and a regular prescription of 5 mg four times daily and 5 mls at night, or 10 mls at night. An appropriate prescription in your view for this lady, or not?
A Again, if she is in pain, one would want to try regular analgesia with a moderate opioid to begin with, such as codeine or similar opioid drugs. As was discussed in some of the previous evidence, there is a conflict or a change between her description of how she is at her preceding hospital, where she is apparently mobilising without pain, although Dr Reid had noted there was pain on moving her hip, and then on arrival at Dryad Ward, where she is not mobilising and reported to be in pain.

Q Would that require a review by Dr Barton or a doctor as to the reasons for that change?
A I state in my report that I could not see a record of a physical examination of the hip and that would be the first thing one would do if there has been a change in function and pain has increased, to examine the hip and see if there is any evidence of a change in the hip function.

Q We have seen previously that there have been examinations of the hip, there have been references to it "not oozing, but it is swollen", et cetera, et cetera. How long would such an examination take?
A If a patient is lying on the bed, one would examine – the patient would need to be undressed of course – you would examine the leg and see if it was shortened or externally rotate it of course and one would then generally see if the patient could move their leg voluntarily and then one would lift the leg oneself and you would see if lifting up the leg, bending the knee and doing internal/external rotation would elicit any pain or symptoms and one would expect the wound, because there had been a concern about infection, one would ask the nurses to check the temperature. It would not take particularly long. Often, the delays in examining patients in this setting are if they are not in bed and you need to ask the nursing staff to come along and get the patient ready and undressed and onto the bed. That actually can often take longer than undertaking the examination itself.

Q We can see on page 11 that three doses of 5 mg are administered and one dose of 10 mg. That is 25 mg given apparently on the day of her arrival. How significant an increase is that compared to what she had been receiving?
A She had only received – sorry, I am looking to where I referred to this in my report.

Q I think it is paragraphs 9 and 10 of your GMC report and.
A We are referring now to the prescription on - ?

Q On the day of arrival, 26 March, and the fact that she is actually administered 25 mg on that day.

A A It is a high dose to start with. She is very elderly and one would start with 2.5 to 5 mg. That is what one would wish to start with.

Q Can you see what happened the next day? If you go to the top of page 12 of the chronology, the drug chart indicates 2.5 mg was administered or Oramorph and then discontinued. Then Dr Barton re-prescribes and this time it is 10 mg four times daily, plus 10 ml, meaning 20 mg, at night. So that is actually a prescription for 60 mg on the second day.
B What is administered to the patient is two 10 mg doses and a 20 mg dose, I think we can presume that was at night. So she is given 40 mg on day 2.
A A lot would depend on her clinical state and whether she had had any response to the previous doses of morphine and if this was a lady who was in pain, severe pain, and it was not controlled by those previous doses, it would be reasonable to increase the dose, but the notes do not contain a clear description of her pain control.

C Q There is a comment we see in the middle page 12:

"Having regular Oramorph but still in pain. Used commode, passed urine. In some pain, needs two nurses to transfer."

A I think I have commented it is appropriate, even if the original dose might not be what
D was recommended, if she is in pain and she has not had any major adverse effects from that, it is reasonable to increase it, but one needs to monitor any response to the increased dose.

Q To what extent does there have to be a set-off between the sort of pain that a patient is willing to undergo to deal with in order to mobilise and making the patient completely pain free? What is one's aim?
A One's aim is to achieve analgesia and pain control without producing adverse effects
E which produce other problems. If you make a patient drowsy or confused from opiates, they are not going to mobilise because of the confusion or drowsiness. So there is a balance that has to be struck.

Q We can see at the bottom of page 12 that Oramorph was continued, but then over the page, we see a reference to this patient having vomited Oramorph. I suppose that might be consistent with the patient's adverse reaction.
F A Yes. Nausea and vomiting are common and the usual response to that in the first instance is to prescribe anti-emetics to control nausea or vomiting.

Q What Dr Barton actually did was to prescribe metoclopramide. That is - ?
A That is an anti-emetic.

Q So that is to deal with the vomiting?
G A Yes, and that is an appropriate response.

Q Then we can see that in fact the next day she is brought down, as it were, to using co-dydramol.
A Again, I think that is an appropriate response. It was really what I was indicating would have been the preferable response initially, but I think where there has been adverse symptoms secondary to the morphine, that is exactly the correct approach to take: to re-
H evaluate and try and see if you can get pain control on a milder opioid.

Q Then on page 14, we see that she has a small area near the top of her wound which is oozing, she is sat out in a chair for assisted washing and dressing. Then we can see on 31 March that she is back on the Oramorph, a small amount of oramorphine, co-dydramol and then MST is prescribed. Those are the slow-release tablets.
A Yes.

Q Because they are slow release, they act over what, a 12-hour period?
A A 12-hour period usually, yes.

Q Is there a period where they are building up to their effectiveness, or do they have an immediate effect?
A As I explained before, because they release it more slowly, you would not want to treat somebody in acute pain or start with sustained release morphine, but of course this lady has had intermittent doses of opiate, or Oramorph. There has been an assessment of her response to that and so that is a reasonable approach.

Q Then we can see at the top of page 15:

"Walked with physiotherapist this am but in a lot of pain. Physio demonstrated ...

I suspect to the nurses –

" ... how to get Enid from chair onto zimmer frame."

Then there is further reference to having pain on movement in the penultimate entry. She then remains on MST. I am not going to go through these in any detail until we get to page 18 and 7 April.

MR LANGDALE: Perhaps we can just note any complaints of pain on page 16 and any others.

MR KARK: She is still complaining of pain on movement on 3 April.
A I think the key issue in this lady at this point was that one would not expect her to be having severe pain after surgery at this time point. So the treatment of the pain is appropriate, but the question should be being asked is why she has severe pain. One should not be requiring strong, potent opioid analgesia this long after hip surgery.

Q Her surgery was back on 20 March.
A Yes.

Q So we are almost three weeks on.
A Yes. So the concern is that there is a complication and a problem, as has been discussed previously.

Q Which should lead to what?
A To an evaluation, x-ray and discussion with the orthopaedic team.

Q Can we have a look at page 18 of the chronology? This patient is seen by Dr Barton on 7 April and reviewed by Dr Reid. Dr Reid notes:

A

"Still in a lot of pain and very apprehensive. MST [increased] 20mg [twice a day] yesterday"

So that is up to 40 mg of painkiller?
A Yes.

B Q Then it says, "Try adding flupenthixol."
A This is an antipsychotic drug. It is actually a depo preparation, so if you give it, it will have sustained effects for probably at least two weeks.

Q Then there is this note:

"For x-ray [right] hip as movement still quite painful – also, about 2" shortening C [right] leg."

Is that a significant note?
A Yes. Obviously Dr Reid had reviewed the hip, because of the continuing pain and the shortening suggests there may be a problem in terms of dislocation or fracture or, as was discussed by him, problems with infection and destruction of the head of the femur or acetabulum?

D

Q So the purpose obviously is to find out what is causing this patient's pain and see if it can be fixed?
A Yes. Absolutely.

Q On 8 April, we see the MST continued, this time we are now up to 40 mg daily, on 9 April there is a note:

E

"To remain on bed rest until Dr Reid sees x-ray of hip ..."

Obviously if there is a disintegration of the hip or there is a collapse of the operation for any reason, presumably they would not want her mobilising.
A No. There would have to be a discussion with the orthopaedic team as to what the appropriate future management would be.

F

Q At page 20 we have the note "Appears to be leaning to left". As we will see later on, there seems to have been an inference drawn from that, perhaps among other indications, I do not know, that she has had a CVA.
A A stroke, yes. As a stroke specialist, we would not say that was specific enough to give a high possibility or even moderate possibility of a patient having a stroke. One needs to have a neurological examination performed to see if there are any focal neurological G deficits to support the impression that there may be a stroke diagnosis. But there are many other reasons why she might have been unsteady on her feet, of which one might be the opiates she is receiving at this point.

Q We can see on page 20 underneath that:

"Does not appear to be as well and experiencing difficulty in swallowing. Stitchline H inflamed and hard area. [Complaining of] pain on movement ..."

Does "stitchline inflamed" indicate potentially a stitchline infection?
A I would take it – again, not as an orthopaedic expert – to indicate signs of a wound infection.

Q At page 21 of the chronology:

"Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way. Did settle for long periods.

... In pain on movement. Oramorph 5mg given."

Then there is a review by Dr Barton on that day. This is noted not I think in the clinical record, but it is noted in the significant events by a nurse:

"Nephew telephoned at 19.10, as Enid's condition has deteriorated during this afternoon. She is very drowsy – unrousable at times. Refusing food and drink and asking to be left alone. Site round wound ... inflamed ... Enid denies pain when left along, but complaining when moved at all. Syringe driver possibility discussed ..."

She is reviewed by Dr Barton. There does not appear to be any note about whether the x-ray has been taken.
A Yes.

Q What are Dr Barton's duties, if any, at this stage?
A As the doctor responsible for day to day care of the patient, that would include responsibility for ensuring the x-ray had happened and finding out the results of that x-ray.

Q We can see that a syringe driver is now being discussed. We can see that she is given I think a total of 45 mg of morphine, 5 mg by way of Oramorph and then two 20 mg doses. She is reviewed by Dr Reid:

"Now very drowsy (diamorphine infusion established)"

Let jus just pause for a moment and go to page 23. What appears to have happened is that prior to Dr Reid seeing her, Dr Barton has prescribed, following the discussion about a syringe driver, a variable dose of between 20 to 200 mg by subcutaneous infusion together with hyoscine, together with midazolam at 20 to 80 mg and the syringe driver has in fact been started at 80 mg administered at eight o'clock in the morning together with midazolam at 20 mg. That is the starting dose.
A Yes.

Q What do you say about that as a starting dose via a syringe driver?
A Just before I comment on that, obviously this patient has a number of problems. She is drowsy, almost certainly due to the opiates that she is on, and there is evidence that she is in pain when she moves. So you have adverse effects and you also have evidence that she is still in pain. So this is a very difficult position, because it is clear if you are going to increase her opiates to try to control her pain, she is going to be – a depression and conscious level is going to be even more depressed. So one would first of all want to have a clear agreement about what the management plan is: is there any attempt to investigate further what the

A underlying problem is and treat that? Has a decision been made that there is no further effective treatment and one is in the end of life palliative stage? But one would want to be particularly cautious about increasing the opiates. So one would want to only do the 30 to 50 per cent increase and hope tolerance came to the drowsiness in a patient who is experiencing the probable adverse effects and the opiates are the most likely cause. So reviewing the notes at this point, she has had 45 mg of oral morphine a day. I think that is 20 and 20 and the 5, which is equivalent to 50 mg of diamorphine, over 24 hours. So if one increases that by a B third or a half, on the basis she has some pain, one would reasonably give 20 to maybe 25 mg of diamorphine over 24 hours. So the commencement of 80 mg is clearly much, much greater than one would administer if one were going by the guidelines. In this patient, because she has evidence of adverse effects already, I think one would have to have very good reason not to follow the generally accepted guidelines of a 30 to 50 per cent increase.

Q You mean you would go less?
C A Certainly less. As I say, a reasonably appropriate dose to give to control would be somewhere between 20 and 25 mg of diamorphine over 24 hours in the first instance and then review response.

Q What would be the likely effect of this, which is I think a four to five-fold increase?
A That she would become very drowsy and it could suppress respiratory function.

D Q That prescription is in fact reduced by Dr Reid. It is administered via a syringe driver between eight o'clock and 1640. Then at 1640, that is discarded and he has halved it down to 40, but that is still above what you thought would be an appropriate dose in any event.
A Yes, it is. My view was that that reduction probably was not sufficient to prevent the toxicity she was experiencing at this point in terms of having a depressed conscious level. She is described as very drowsy and unrousable at times.

E Q The midazolam. Can we deal with that for a moment? It is originally prescribed at 20 to 80 mg. Again, I have not asked you about the variable range; I do not want to take more time doing that. She is administered 20 mg of midazolam coupled with the 80 mg of diamorphine. Dealing with that first of all, from what you have told us already, that is going to have an effect on her sedation.
A Yes, it is. Whilst there is an indication that she is clearly in pain and requires analgesia, again, going back to the indication for midazolam, it is for terminal restlessness F and it will clearly depress conscious level. It is a large starting dose for a very old lady.

Q Dr Reid having reduced the diamorphine, what appears to have happened is that a nurse has followed his directions on the diamorphine, but for one reason or another has increased the midazolam, doubled it.
A Yes. Again, without the notes clearly describing the rationale for doing that or a clear protocol or consideration of the potential consequences of that, looking at this, one assumes G at this point that the staff are considering she is at the end of life and these drugs are being given to palliate, but there is still a need to document the symptoms one is palliating and to justify particularly the use of very high doses of drugs for patients of this age.

Q Dr Reid described that increase as "astonishing".
A Well, it is. It is a huge dose for an older person. It will induce deep sedation and coma.
H

Q The nurse of course is allowed to do that because of the prescription that has been written.
A There is a prescription that has been written. Yes, it is open to interpretation. In the lack of any clear policy or application of guidance, there does not seem to have been – there is reference to the Wessex protocols, but they do not seem to have been implemented in what they recommend and the notes do not record the assessment and the thinking of the nurse in the decision to start this very high increase.

Q Death is recorded for this lady at 0115 the following morning. In your view, to what degree, if any, have the infusions of diamorphine and midazolam and hyoscine had an effect upon that?
A I think it is very difficult to conclude that that combination of the diamorphine and midazolam did not contribute to her death through sedation and respiratory depression. As I discussed, there clearly was an indication for the opiates and the dose was excessive, but there were clear indications for the opiate infusion. The issue is, was the dose appropriate? But I did not find recorded in the notes a clear indication for the use of midazolam and certainly the doses given were very excessive in my view and there was not a clear justification that there were symptoms that required the very early use of a very high dose.

Q We see that the cause of death is written on the certificate by Dr Barton as being "cerebrovascular accident". What basis, if any, does there appear to be for that?
A This is an elderly lady, she was unwell, she could have had a stroke, but I would say there is no clear documentation or assessment to support the diagnosis. There was not an examination showing focal neurological signs, which is the cardinal finding to support a diagnosis of stroke, and there are other causes for her being unsteady on her feet. It could have been a general infection, sepsis. Most likely in my view was the opiates she was receiving at that point. But in the absence of a detailed physical examination, one obviously is limited in the conclusions one can draw.

Q If in fact the doctor's view were that the cause of death were over-sedation by opiates, would that ever be written on a death certificate and, if it were, what would the reaction of ---
A Of course, in people who are dying, for example, the doctrine of double effect is well accepted. If there is a clear indication to give the opiates at the doses that were given and they may have contributed you would not – I think most doctors would not – consider putting that on the death certificate. The issue of course is if the drugs were not indicated and were thought to contribute to death. In that case, there would be a need to discuss the case with the coroner and not issue a death certificate.

MR KARK: Would that be a convenient moment to break?

THE CHAIRMAN: Yes, certainly. We have come to the end of this patient.

MR KARK: Sir, there is a matter I need to raise with you in camera very briefly.

THE CHAIRMAN: Thank you, Professor Ford. You can go and take a break and we will take a break shortly thereafter. We will say we will be back at 11 o'clock, please.

(See separate transcript for proceedings held in private.)

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Kark?

MR KARK: Can we move on, please, to the case of Geoffrey Packman, Patient J. Again, I am going to concentrate entirely on the chronology, and we may not need to go to the notes. This was the unfortunate gentleman who was very obese indeed and effectively got stuck in his bathroom on the lavatory. That was on 6 August and as a result he had been admitted to the Queen Alexandra Hospital. He is described as having multiple medical problems and not for CPR in the event of arrest. If we go to page 4 of the chronology, there is a comment that the wife was very stressed because she had her own medical problems unfortunately.

> "Discussed that Mick" - as he was known - "would probably need rehabilitation/long-term care. He is on antibiotics for his cellulitis",

Ad at the bottom of page 6, we see he has leg ulcers and pressure areas on his lower back. If we go to page 7, he has continuing leakage of serous fluid, and there is a reference to "slight leakage" of serous fluid from his "sacral sores". And no question, his sacral sores would have been painful to him?

A Yes, absolutely.

Q At the bottom of page 7, "All dressings changed. Slough +++." Is that dead skin?

A Dead tissue and secretions coming off an ulcer.

Q "and necrotic areas observed. Malodorous and exuding from all areas of skin breakdown".

So clearly he was having very significant problems from his sacral sores?

A Yes.

Q Page 8, 18 August 1999:

> "Reviewed by registrar. Wounds look better. Stop antibiotics from tomorrow".

Then he is reviewed by Dr Tandy. "P sores"?

A Pressure sores.

Q Thank you. "Extensive", and then "Feeds himself. Not mobilising. Black stool overnight", and then "nil today". Now, a single event of a black stool might be an indication of what?

A It could be that there has been an onset of what is called melena, which is blood in the gastrointestinal tract turns black and turns the stool black, so that would be the concern and why she would have recommended examining his abdomen and checked if he had abdominal pain and checked his haemoglobin to see if there had been a fall in his haemoglobin.

Q Then on page 10 of the chronology we have a review by Dr Ravindrane, and I think we most probably have noted that was a review by Dr Ravindrane actually on Dryad Ward, once he has been transferred to the Gosport War Memorial, and Dr Ravindrane has set out his problems as being:

"Obesity, arthritis [bilateral in his knees, immobility, pressure sores. [He is] On high protein diet. MTS" --- ?

A Mental test score.

Q --- "very good. No pain. Better in himself: Legs [Unclear], chronic skin change. Ulcers dressed yesterday. Need review later this week."

We have heard from Dr Ravindrane that that followed an examination of the patient, and is that the sort of examination you would normally expect?
A As we have discussed before, it is good practice to examine somebody if you have not assessed them personally yourself beforehand when they come to a new environment.

Q Now, if we go to page 11, the drugs that Dr Ravindrane prescribed, and I am not going to go through them all, included Clexane. I do not think we have included it in the chronology but there is certainly reference to this patient having been on clexane at the Queen Alexandra Hospital for some time.
A Yes.

Q And that we know is an anticoagulant?
A It is a heparin drug, an oxypurine, which is given in low dose to reduce the risk of developing deep vein thrombosis and pulmonary embolae, and he would have been at high risk because of his obesity and immobility.

MR JENKINS: Can I just add the reference that has just been referred to is page 182.

MR KARK: And provided his signs and symptoms are watched, no reason not to give this patient clexane at the beginning?
A On the contrary, guidelines now strongly recommend the use of low dose heparin to prevent pulmonary embolae, so it is entirely appropriate that he received it.

Q But as we will see there comes a point where there is reference to blood per rectum and the clexane was stopped and that also would be an appropriate response?
A Yes, if you have bleeding you would stop any anticoagulant drug or antiplatelet drug such as aspirin.

Q And just focusing at the moment on his pain and his analgesia, this patient no doubt would have been in a degree of pain from his sacral sores but up until this point I think the most he had been on was paracetamol and we heard from his wife that he did not really tend to take analgesia in normal life, but he was on paracetamol and, or rather he was prescribed paracetamol by Dr Ravindrane. Is that an appropriate step?
A It is very reasonable. Paracetamol would be, again, at the bottom of the analgesic ladder, and would be an initial starting point.

Q Right. We can see that Dr Barton the next week, 24 August, prescribed temazepam. We have all heard of temazepam. Is that a hypnotic?
A Yes, a hypnotic to help people sleep.

Q And we can see that there is a note at the bottom of page 11 to the patient passing fresh blood which we have looked at; Dr Beasley says to withhold clexane, and that was absolutely the right thing to do.
A Yes, correct. Sorry, can I comment there? Obviously withholding clexane is the right thing to do, but in a patient where there has been a concern about possible gastrointestinal bleeding one might have wanted a more detailed assessment. That I think would be best practice.

Q I was going to take you on to the following day, the 26 August. We know that there is a review by Dr Barton, and we have actually to look at page 56 of the clinical notes for that.

> "Review by Dr Barton. Called to see male. Clammy, unwell. Suggest ? MI [myocardial infarction]. Treat stat diamorph and Oramorph overnight. Alternative possibility GI bleed but no hematemesis. Not well enough to transfer to acute unit. Keep comfortable. Happy for nursing staff to confirm death".

Can you take us through, please, what is happening with this patient and what should have happened, if anything different?
A He is clearly unwell, and Dr Barton's notes indicates that was her assessment, and he is clammy which can suggest a number of problems, and certainly a myocardial infarction might be one. In the context of previous concerns that he might have had a gastrointestinal bleed one would also be concerned that he might be clammy because he has had a gastrointestinal bleed, and again that was considered by Dr Barton in her notes. So, the assessment describes a man who is unwell.

I would have expected some other observations in this context, certainly a blood pressure and heart rate recorded by nursing staff in somebody who may have had a myocardial infarction or gastrointestinal bleed. I would have expected more details of a physical examination, such as abdominal examination, and whether the patient looked anaemic, and best practice would say to also do a rectal examination to be sure there was no altered blood in the rectum, but given he is clearly unwell and at this stage there is no suggestion in the notes from what is recorded that he is for end of life care, certainly I would have expected the appropriate response was to contact the acute hospital, either the on-call medical doctor depending on the structure, medical registrar or the coronary care unit if one thought that the main problem was a myocardial infarct.

If there was an ECG machine available on the ward I would have expected an ECG to have been obtained by the nursing staff as well, and for him to be transferred back for further active management. He is clearly unwell and one cannot treat as effectively complications of a myocardial infarct, if that is what he has got, and one certainly cannot adequately treat him if he is having a gastrointestinal bleed on a Dryad Ward environment.

Q What this note says is "Not well enough to transfer to an acute unit"?
A I cannot really follow the logic of that. It indicates he is very unwell and that is even more of a reason why he needs to be in an acute hospital. One would have to ask obviously Dr Barton what her meaning was by that. The only situation I could see would be if you have someone who you think is highly likely to die, not for active care, and the process of transferring them could lead to them dying in transfer. We do not like to have patients dying in transfer. But this was not a man where the notes record he was not for active treatment, he is recorded as being not for resuscitation, and I consider that was reasonable because the

likelihood of success if he had had a cardiac arrest given his other problems was low, but I find it very difficult to think that he would not be considered appropriate to receive a blood transfusion, for example, if he was bleeding, or if he had a myocardial infarct and developed a ventricular fibrillation, arrhythmia, to have a defibrillator applied.

Q If this note were to reveal, and we will have to wait until we see if we hear from Dr Barton about this, but if this note were to reveal that, in fact, there was a decision here that this patient was effectively at the end of his life, that this was a palliative care route, and that is revealed by the words "not well enough to transfer, keep comfortable, happy for nursing staff to confirm death", how appropriate or inappropriate would that decision at this stage of the patient's life have been?
A The decision that he is ---

Q --- for palliative care only?
A Well, here we have a man, he has severe obesity and problematic pressure sores, he is 67, he has normal cognitive function, there is no suggestion that he has indicated he wants limits to the care he would receive. I cannot see it is an appropriate response.

Q We then need to look at the prescription, I think, that is provided. He is given 10 mgs intramuscularly. That would presumably be a response to the suggested myocardial infarction?
A Yes, one would normally give it to people complaining of chest pain with myocardial infarction but I think if that is the working clinical diagnosis, although the absence of an ECG, if that could have been obtained, there is some question over it, I would not consider that is unreasonable if that is the working diagnosis.

Q And Dr Barton then prescribes 40 mgs, four hourly 10 mgs, of Oramorph, and then 10-20 mgs, is that four times a day, QDS? And then 20 mgs nocte?
A Well, there is no record or description of him being in pain in the notes to justify commencing regular opiate analgesia, and if we were treating a patient with myocardial infarction, I do not treat this patient group now but I used to, one would not establish regular doses of opiates. Usually one gives 1 or 2 doses of diamorphine at the beginning.

Q And the level of these doses, the prescription for 10-20 mgs four times daily plus 20 mgs at night would allow at maximum, I suppose, for 100 mgs to be given?
A Working it out, yes.

Q Do you have any comment to make on the size of that sort of ---
A Well, this is a younger man, this is the youngest patient of the ones we have reviewed. He is 67. He is, one could say only, just into the older age group and he is a big man, although weight does not have necessarily a large impact on the dose required. Again, one would want to start with the usual suggested dose of I would have thought 10 mgs but not 20 mgs and observe the response, but I am not clear from the notes what the opiates are treating because he is not being described as being in pain at this point.

Q Well, he is given his intramuscular dose and then at night he is given the 20 mg dose, and then the following day he is reviewed by Dr Barton according to Sister Hamblin:

> "Some marked improvement since yesterday ... to continue with Oramorph ... same given, tolerated well. Some discomfort this afternoon, especially when dressings

A being done. Wife has visited this afternoon and is aware that condition can deteriorate again. Still remains poorly",

and that day, 27 August, by my reckoning he is given 60 mgs, depending on the four doses administered but from the day before that was, I think, 10 mgs four hourly?
A Yes. I think I was unclear what the administered dose was. I had trouble reading the prescribing chart.

B

Q Over the page, again, the same is administered the following day, and the day after that, 29 August. If you go to page 17, please, 30 August, Sister Hamblin comments:

"This mane, 30/9 [complaining of] left abdominal pain. Condition remains poor. Syringe driver commenced at 14.45. No further complaints of abdominal pain. A very small amount of diet taken, mainly puddings",

C

So he is still eating at this stage.
A Yes.

Q "Recatheterised. When possible encourage fluids. Dressings renewed".

We then need to look at the prescription. We are still on the same Oramorph, and then
D diamorphine has been prescribed at a rate of between 40, which is the lowest dose, 200 mgs and midazolam 20-80mg, and the nurses start that at 40 mgs administered at 1445. Now I am not going to ask you to go back through the maths, as it were, but do your comments apply equally to this starting dose?
A Yes, it is very high and, again, there is no - he has got abdominal pain, he seems to have been placed on an end-of-life care pathway, if one wants to use that phrase at this stage.
E His abdominal pain is being treated with high doses of opiates. It would seem, but there is really little description or clear justification for continuing the opiates, and again, going back to the indication for midazolam of terminal restlessness, there is no clear description that he had those symptoms. The fundamental issue here is that there has not been an approach, an assessment, to try and treat the underlying problem, and then there is not a clear justification for the prescriptions or the subsequent doses administered of the diamorphine and midazolam.

F Q And then on 31 August we can see a reference to the patient in the morning having passed a large amount of black faeces. You have dealt with that I think already and then at night time he is continuing to pass tarry black faeces. Is that an indication, as we have heard, of a potential GI bleed.
A I think at this point it is very clear he is having a large GI bleed and that must have been, one would have thought, the working diagnosis.

G Q For which one could do what, or one should do what at this stage?
A Well, for a gastrointestinal bleed standard management is to resuscitate the patient if they have low blood pressure by putting an intravenous line in and then starting fluids, checking the blood count, sending blood off for cross-matching blood and replacing blood with a blood transfusion, that is the initial action required, and then normally one would refer, if it was a major bleed, for an urgent endoscopy.

H

A I used to practise as a registrar in gastroenterology but I am not a gastroenterologist; there are therapeutic approaches which may or may not have been available in terms of endoscopy such as injecting adrenalin to stop a blood vessel and an ulcer bleeding if the patient has an ulcer in the stomach. Sometimes patients may be suitable for surgery to tie off a bleeding ulcer. One has to say it would be I would say extremely unlikely that a surgical team would have intervened in this man because of his obesity. Now we would also give the intravenous acid suppressant drugs, I cannot recollect when they came into use, I think they were starting
B to be used in the late 1990s, but the key issue is to provide blood replacement through transfusion ---

Q Just stopping you there for a moment, on Dryad Ward this patient is not going to be able to get blood replacement?
A No. These interventions could not be undertaken there.

C Q So what needs to happen to him?
A He should be transferred back, or at the very minimum a discussion had with the on-call medical team to accept him for management that cannot be provided and interventions on the Dryad Ward site. If there was resistance to transferring the patient back, and I cannot see why there should have been for a 67-year old man with normal cognitive function, that I would expect to be raised, if there was a consultant geriatrician rota, with the consultant geriatrician, or more likely, as I would expect, the on-call acute physician, but
D there would have to be a clear senior decision in a man like this in my view to make a decision not to undertake active intervention for his problem, be it a myocardial infarct, or, as it obviously transpired to be, very clearly a gastrointestinal bleed.

Q Let's move on to the last few days of this patient's life. On 31 August he is given diamorphine 40 mgs, and midazolam 20 mgs. On the following day on 1 September he is reviewed by Dr Reid and described as rather drowsy but comfortable. The syringe driver is
E renewed at 7.15 in the evening with 60 mgs of diamorphine and a trebling of the dose of midazolam. This patient was seen by his wife that day who described him as completely out of it, unable to talk, and unable to move. That deterioration in this patient would, in your view, be brought about by what in this case?
A The higher doses of particularly midazolam that were infused, and also the diamorphine.

F Q We can see on the following page that actually the diamorphine was also increased at 7.15, and I have dealt with that already, it went up from 40-60, and midazolam went up within the 24 hour period from 40 and then to 60 at 7.15 in the evening. Then on 2 September, bearing in mind his wife had described him as completely out of it and unable to talk, and Dr Reid had described him as rather drowsy, on 2 September the diamorphine is increased up to 90 mgs and the midazolam was increased up to 80 mgs. Is there any basis that you can see for these increases?
G A Well, again, it is like many of the other patients we have discussed, there is no clear record of symptoms and monitoring of patients, which you would expect to be in the nursing notes, which provides justification for the increase in the doses. Clearly this is a difficult area; there are concerns about the use of potent opioid drugs and sedative drugs in patients who are at the end of life if they are not being given for control of symptoms. I am not saying they were not given for control of symptoms here but I am saying the notes do not provide that information to indicate that they were appropriately increased.
H

Q And there are no notes, I do not think we have seen any notes anywhere in any of these patient files about respiratory rate, levels of consciousness, et cetera. Is that something that can be noted, if appropriate?
A It should be in good end-of-life care. As I have talked about before, the aim is to keep the patient comfortable and keep them alert. The only indication for sedating patients is if their symptoms are intolerable. When patients are at the end of life they still require appropriate monitoring and adjustment of their treatment to control their symptoms without excessive adverse effects. Because somebody is near the end of life is not a justification in itself for escalating opiate and sedative drug doses.

Q And then on the last day of this month, 2 September, we can see that the drugs that are administered are 90 mgs at 1840 of diamorphine; 8mgs of midazolam at 1840. Hyoscine was not administered, although it had been prescribed, and the patient died the following day about 22 hours after that administration had started. We do not in this case have a death certificate but, in your view, do the drugs have any contributing - are there contributing factors?
A I think there is little doubt, given we know that his haemoglobin dropped precipitously from 12 down to 7, the main cause of death in this man was his gastrointestinal bleed. I think, as that was not treated, that was – we do not have further haemoglobin levels, but that was very likely the main cause of his death, because he was passing melena after that and that blood count of 7, I think the drugs may have contributed to his death through producing respiratory depression and sedation.

Q Can we put that file away, please? I am going to move on to our penultimate patient, Elsie Devine, Patient K. This was the patient who had under the care of a Dr Cranfield, who is a consultant haematologist. She had been diagnosed with nephrotic syndrome. There was a suggestion of myeloma. At the top of page 3, Dr Cranfield found insufficient evidence of myeloma or lymphoma. That does not necessarily mean that she did not have that disease, does it?
A I interpreted it to mean she did not. There are diagnostic criteria by which one makes a diagnosis of myeloma and the appropriate investigations had been done. Again, I am not an expert in this area, but Dr Cranfield concluded that the findings did not meet the diagnostic criteria for myeloma, but there are paraprotein levels which you get secreted which are, if you like, almost pre-myeloma type states. So she has clearly had paraprotein in the blood that was not normal, but did not meet the criteria for myeloma.

Q What we do know – and we have heard a bit about this – is that her creatinine levels seem to have increased through the period of her treatment from 160, as we can see on 8 June, and then in July they go up to 192. What is that an indication of?
A That her kidneys are not working effectively, that she has a degree of renal failure. That is likely to be related to the paraprotein and other problems that were being investigated.

Q Then on 9 October she is admitted to the Queen Alexandra Hospital – this is at the bottom of page 4 of the chronology – with an episode of acute confusion. She is described as:

"Confused, aggressive and wandering. Diagnosis: multi-infarct dementia. CRF."

What is CRF?
A Chronic renal failure.

Q Can renal failure lead to an infarct in the brain? Are the two related, or are they completely separate?
A Patients with renal failure are at increased risk of developing vascular disease and that would include multi-infarct dementia, but multi-infarct dementia is generally due to the consequences of damage to the brain through hypertension and other vascular risk factors.

Q If we go to the top of page 6, we see transfer was arranged to the GWMH. She is described as:

> "Moderate chronic renal failure. Admitted with history of [urinary tract infection]. Quite alert. Can stand. Rather unsteady on walking. Chest clear. No evidence of cardiac failure. Suitable for a rehabilitation programme. Will arrange transfer to GWMH."

Two days later, on 21 October, she is transferred to Dryad Ward and Dr Barton makes a note:

> "Continuing care. [history of presenting complaint]: acute confusion. Admitted to Mulberry Ward to QA and then to Dryad. [Past medical history]: Dementia, myeloma, hypothyroidism. Transfers with one, so far continent, needs some help with [activities of daily living]. MMSE ..."

What is that?
A Mini mental state examination, which is an assessment of cognitive function.

Q The result of which was 9 out of 30. So quite low?
A Yes. She has dementia and this score would be in keeping with severe dementia.

Q Her Barthel, however, is 8, which is relatively high in comparison with some of the patients we have seen.
A Probably reflecting the fact that she has had some mobility.

Q Then:

> "Plan: Get to know. Assess rehab potential. Probably for rest home in due course."

Then over the page:

> "Needs minimal assistance with ADLs."

Then we can see the prescription she is given: thyroxine, frusemide, temazepam and Oramorph as a prn prescription, 5 to 10 mg as required. At this stage, is there any basis for that prescription?
A I could see no basis for the prescription on the information in the notes. She is not in pain. Certainly if one has agitation and confusion in a patient with dementia, in the vast majority of cases it is not due to pain. It is a common problem that one sees in patients with dementia.

Q Is Oramorph a suitable medication for confusion or dementia?
A It is not at all a suitable medication.

Q She is described by Dr Reid on 1 November, if you go to page 8, as "quite confused and disorientated". There is a note above that she is in chronic renal failure. On page 9 she is described as being:

"Confused during the night, wandering around ward. Refused night sedation."

She is given temazepam, as we can see. Then over the page, she is then given on a regular basis thioridazine, prescribed by Dr Barton. Can you help us a little bit with thioridazine?
A We have mentioned this drug before. It is an anti-psychotic. It is a very appropriate prescription in terms of this lady's problems.

Q The 10 mg that she is given is a relatively low dose.
A Yes. We do not use it now, so I am just remembering back. This is now not used, but it was an entirely appropriate prescription at this time.

Q On page 11, we can see she is seen by Dr Reid:

"Request for review by Dr Lusznat. Very aggressive at times. Very restless."

Is that a function, as it were of dementia?
A Yes. The note suggests the main problem with this lady is behavioural disturbance and restlessness due to her dementia and that was why a referral was made to Dr Luznat, who is an old age psychiatrist.

Q If we go to page 13, please, things move on. She is described on 18 November – and you deal with this in your GMC report, if that helps, at paragraph 11 – as having deteriorated and:

"... has become more restless and aggressive again. She is refusing medication and not eating well. She doesn't seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward ..."

That is the psychiatric ward for the elderly.

"Mrs Devine now at Dryad GWMH. Transferred 21.10.99. Aggressive, wandering, moving other people's clothes, refusing medication, poor appetite. Reviewed on ward. Happy, no complaints,. Waiting for her daughter. Says tablets make her mouth sore. Plan – Transfer to Mulberry C when bed available."

We can see underneath that that on that day, although I think Dr Barton has made no notes then of why, she makes a note the following day, she prescribes the patient with fentanyl. Help us, please, with your view on fentanyl. I am looking at paragraph 12 of your report.
A Again, the medical and nursing notes do not indicate that the patient is complaining of pain. There has been a decision made to transfer her to an old age psychiatry ward, which is recognising that the main issue in the management of this patient is behavioural disturbance related to her dementia. As we have discussed with other patients, a fentanyl patch is a very high dose of opioid to give in terms of its equivalence to morphine. This lady is also in significant renal failure, so she is particularly susceptible to adverse effects of opioids because of accumulation of the metabolites. There are two issues about the fentanyl

prescription in my view. One is that there is no indication, appropriate indication, recorded in the notes. If she was in pain, there is no indication that it would not have been feasible or appropriate to give either an oral or subcutaneous small dose of opiates, but I could not find any evidence she was in pain. Secondly, the use of a fentanyl patch, because of the very high dose in an elderly patient with moderate renal failure, was highly likely to result in adverse effects.

Q I just want to step back from this and try and look at the problem that the nursing staff and the medical staff had with this patient. This is a patient whose mental condition seems to be deteriorating. She wanders about, she is aggressive at times. This is not a secure ward, so they cannot presumably keep her in the ward.
A I do not know if Dryad was a ward that could be locked. Often it is necessary to lock a ward. I suspect this ward very possibly was locked at night, but obviously I do not know. You would need to really "special" the patient, because of their potential risk.

Q That is what I wanted to get to. She has not yet been transferred to Mulberry and they do not know presumably when she is going to be transferred to Mulberry.
A Yes, correct.

Q You have an aggressive, confused, wandering patient, who may not want you to inject them
A No. You would try and give more antipsychotic drugs to improve the behaviour. That would be a standard approach, either orally or by injection. You would, as an accompanying measure, try and ensure the patient was in as safe an environment was possible and have a nurse accompany them on a one to one basis.

Q Is one approach to stick a fentanyl patch on her?
A I cannot say that. I have not seen that used as a practice. It is not an indication for the drug. If you give a dose that renders a patient unconscious, that will stop them wandering around, but that is unacceptable and a dose of opiate that does not produce that is actually just as likely to make their confusion worse potentially. So opioids are not an appropriate treatment for behavioural disturbance in patients with dementia. If there was thought to be a problem of underlying pain, one would expect to see a medical assessment to support that assumption in terms of finding a problem in the patient which might be producing pain.

Q Let us look at what happened in the last few days of this patient's life. That fentanyl patch was put on her at 9.15 in the morning of 18 November. It is going to last for three days. She is reviewed the following morning, 19 November, by Dr Barton, who makes a note "Marked deterioration overnight." That is having been on fentanyl for 12 hours or whatever it is.
A Yes.

Q Then we see, "Confused, aggressive. Creatinine 360." That is a marked increase.
A Yes.

Q Then:

"Fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs [subcutaneous] analgesia with midazolam. Son seen and aware of

A condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death."

We will look at the prescription that she writes out in a moment, but "marked deterioration overnight, confused and aggressive". In your view, that may be an indication of what?
A Well, I think the most likely cause of this undoubtedly is the fentanyl patch that has been applied. As I indicated, it can make problems worse.

B

Q What about the fact that her creatinine has---
A Well, as I comment in my report, that could be because she has become dehydrated or because she has got a concurrent infection such as a urinary tract infection, but the timing is highly suggestive that a deterioration from the day before - I mean, obviously she was agitated and confused the day before, which could have been due to a urinary tract infection - the further deterioration is almost certainly in my view due to the fentanyl.

C

Q Before we go to the next entry can we look at the prescription that Dr Barton writes out, at page 15, following the day on which the fentanyl is put on to the patient. She prescribes chlorpromazine 50mg by injection administered at 8.30, and we will go back to look at why that happened; diamorphine starting off at 40 up to 80mg, effectively by syringe driver, subcutaneous infusion; and midazolam starting at 40 up to 80mg by syringe driver. Now, can we just go back then to see how that was used. Page 14:

D

"Marked deterioration over last 24 hours. Extremely aggressive this am. Refusing all help from staff. Chlorpromazine 50mg given [intramuscularly] at 08.30 – taken 2 staff to special."

If we pause there for a moment: chlorpromazine, would that have a relatively immediate---
A That is an antipsychotic and I think that is a perfectly reasonable treatment approach
E to take for the agitation, which could have been taken earlier rather than using fentanyl.

Q So that is given to her at 8.30. This is probably testing you, how long does chlorpromazine last?
A Usually you would expect it to last, and it depends on the dose and the individual patient, but certainly for 12 to 24 hours.

F Q "Syringe driver commenced at 09.25. Fentanyl patch removed. Son seen by Dr Barton at 13.00, situation explained. He will contact his sister Mrs Reeves & inform her of Elsie's poor condition ..... Daughter has visited" et cetera.

Now, the syringe driver is started at 09.25. I think we know that the fentanyl patch was not taken off until a little later, but it may not matter, because imagining even for a moment that the fentanyl patch is removed immediately, you have told us already that fentanyl is going to
G continue having an effect for quite some period.
A Correct, as listed in the BNF.

Q What do you say to the administration of 40mg of diamorphine and 40mg of midazolam for this patient; first of all, the reasoning behind it, and, secondly, the dosage itself?
A Well, again, the approach appears to being taken to increase the opiate dose to deal
H with her symptoms of agitation, behavioural disturbance, and I say that is not appropriate and

A is not an indication for opiates. There may have been a lack of appreciation about the extent to which the fentanyl effects would continue, so you have got the background fentanyl effect which is going to be there for quite some hours, and then you are adding in another 120mg equivalent of morphine. I mean, this is a very, very large opiate dose in an elderly lady with renal failure. Then, looking at the use of midazolam, so going back for the treatment of terminal restlessness, well, she is certainly restless, we know that, that is part of the problems with her dementia. Is she terminal? Well, a decision seems to have been taken that she is B now having terminal care, but even if one were to accept that that decision was appropriate and therefore she had a terminal restlessness, the dose used is extremely excessive, in that, you know, the recommendations are to start with 10mg for 24 hours in an elderly person, and this will result in profound sedation. There has been no titration up to that to see if it was appropriate, and I do not believe it was appropriate. To start at 40mg over 24 hours was a very high, excessive dose.

C Q The day before, when this patient had been reviewed by Dr Taylor, Dr Taylor was arranging for her hopefully to go to Mulberry Ward.
A So she would not have arranged that transfer if she was thought to be for terminal care at that stage.

Q If this decision has been made by Dr Barton, that this patient has changed so significantly that she is now for effectively end of life care, terminal care, would you expect D her to discuss that with anyone?
A Well, I would, but I---

Q Sorry, you would discuss it or you would expect---
A I would expect, as a responsible consultant, for it to be discussed with me, but I suppose the question would be did the consultants who Dr Barton was working with expect such, you know, change in status to be discussed with them. If they thought it was E appropriate for Dr Barton to make these decisions on her own, clearly she would then not discuss it with them, but personally I think a major change in a patient like this should be discussed. I think it certainly would be now, and I would have expected it with my patients then, but the role and responsibilities that Dr Barton was given by the consultants is clearly an issue here, and that is not something I have commented on because I have only just examined the medical notes, I have not seen statements that have really gone into that, so my statement is what I would expect to see. This is a lady who has had a major deterioration F who was expected to be transferred, and the consultant is responsible for this lady's care.

Q The Panel will have to make a decision about whether there was a particular culture on this ward in relation to whether consultants would be consulted or not, but dealing with your experience of how a normal average hospital ward runs, would you expect a doctor in Dr Barton's position to have consulted with a senior consultant?
A Well, we must not compare it to normal wards in large acute hospitals with resident G staff, and also we definitely would expect juniors, training staff, to discuss it, and I think this is the issue; the role and responsibilities of clinical assistants clinical assistant can be highly variable in the way it is set up, so I did not have a clinical assistant working in the similar hospital set up I had, and I would have expected my registrars to discuss such changes with me. I would have expected a clinical assistant to discuss such changes in a patient's status with me, within usual working hours, but, you know, I have not had a clinical assistant working in this sort of environment. I have had a clinical assistant working in a day hospital, H but not for this sort of patient group.

Q I will move on. We will look at what happens with this patient hereafter. At the bottom of page 15, 20 November, that prescription actually continues to the end of the patient's life. Sister Hamblin remarks, at the top of our page 16 of the chronology:

> "Condition remains poor ..... Skin marking. Position changed".

Again, another note in the care plan:

> "Peaceful night. Position changed ..... Skin marking. Extremities remain oedematous. Oral care given."

21 November:

> "Condition continues to deteriorate slowly ..... driver satisfactory."

This patient is not being hydrated at this stage. She has got kidney failure and she is on a, you have described it, very high dose of diamorphine.
A And midazolam, yes.

Q The deterioration---
A I think the deterioration was undoubtedly due to the drugs she received. There may have been other factors contributing, but the deterioration occurred in such close relationship to the commencement of the opioids and then the sedatives, I think it is difficult to conclude they did not contribute to her deterioration and death.

Q I was going to ask you, does the same apply to her death?
A As with these other patients, she is an elderly, frail lady with advanced dementia, and sudden death can occur in this patient group.

Q I am going to move on to Patient L. This patient, Jean Stevens, I think on any view was very unwell at the time that she was admitted to the Gosport War Memorial. She had been admitted, as we can see at the top of page 2 of our chronology, to the Royal Hospital Haslar after experiencing chest pain, collapsing at home. There is a note on a CT result of "Probable rt non-haemorrhagic infarction rt parietal lobe". Is that effectively a stroke?
A That is a stroke, yes, confirmation of brain imaging that she has had a stroke.

Q I am not going to go through a great deal of the notes. She remains in hospital for a longish time. If you go to page 7, 4 May she is described as "Still not speaking", and then on 5 May she began taking food orally, and we can see that she is referred to Dr Lord with this comment:

> "Could you give your opinion as to the best path for rehabilitation for this 73 [year old] female. She is improving slowly. Nothing more we can do for her on acute medical side."

Realistically, it is not a very bright outlook for this unfortunately lady?
A No. as I comment in my report, she has had a severe stroke, she is elderly, she has got co-morbidities, there are a lot of complications that can happen, and she has got a high risk of

A dying from complications, and certainly she will be left with significant disabilities in the long term.

Q If we go to page 8 of the chronology, there is a large nursing entry in the middle of the page: she is agitated, she is given some intravenous morphine; "unable to position her comfortably"; she is aspirating her fluids and soft diet, therefore is it "nil by mouth"?
A Yes, nil by mouth.

B

Q "[nil by mouth] until further review. Family spoken to. Aware of poor prognosis. Remains for 444". That is a notation I do not think we have come across before. You may not know---
A I assume it is a variation of 555. Different hospitals use it. It is the phone number for the resuscitation team, meaning the team have decided she is for resuscitation. I have to say I think many medical teams would have decided this lady was not for resuscitation.

C

Q Well, I can cut you short, I think, because on the following day that is exactly what happened. She is discussed with the consultant, and the decision was then made "Not for resuscitation". I suppose it may be that in the evening the nursing staff spoke to the family, and then obviously the following day there was discussion with the consultant.
A Yes. Sometimes if there is not a consultant, there is a conservatism and patients are kept for resuscitation.

D

Q She is described on 6 May as being:

> "Too unwell for transfer to GMWH. Overall prognosis poor. If [she] survives and is stable next week, happy to take her to a slow stream stroke care bed".

Over the page we see no further deterioration. Top of page 11, and this is 10 May 99:

E

> "Reviewed by Dr Tandy ..... Appeared to improve over weekend. Barthel is zero ..... Can ..... obey simple commands ..... Don't think stable enough to transfer to GWMH".

Bottom of page 12, she is now being fed through a nasogastric tube.

F

> "Spoke to Mrs Stevens' husband and daughter. Explained prognosis and rationale behind why [patient] would be allowed to die naturally".

Page 14, please:

> "No incontinence this am. Settled and slept very well without diamorphine. Feed continues as per regime."

G

She is reviewed on 18 May:

> "sitting in chair. Obs stable. Blood test results".

Then this:

H

A "Liaised with GWMH. Happy to take Mrs Stevens with above results. Tolerating [nasogastric] feeding well. Seems to have recovered from aspiration pneumo---"

A "pneumonitis" – pneumonia.

Q "Slow improvement in orientation, speech and strength. Still faecally incontinent and requires catheter".

B

If we go, please, to page 17, so this is two days after that note, she is indeed transferred to Daedalus Ward:

"Upon transfer, patient receiving aspirin, enalapril---"

A Enalapril; it is a blood pressure lowering drug.

C

Q We can see:

"PRN subcutaneous diamorphine ..... Diagnosis and treatment in hospital: Stroke. For rehab".

Then there is a nursing referral:

D

"Admitted following [right] CVA".

I am not going to go through all of that. She has got pressure areas intact, very sore, diarrhoea present. So although she has, according to the notes at least, improved to the point where she is transferred, we are still looking at a fairly sick lady?

A Yes. You want to transfer these patients when they are what we refer to as medically

E stable, so they have significant deficits and disability, but you only want to transfer patients to a ward for rehabilitation off the acute site when they have not got active ongoing problems such as pneumonia, and I work on a stroke unit where we have an off-site rehabilitation ward, and this is an important issue, that you try and ensure patients are medically stable before you transfer them to an environment where there is not the same level of medical support and investigative facilities. Sometimes one thinks a patient is stable, and they are, but then when they get to the unit they become unstable, so this can happen, but one tries to minimise that.

F

Q I am not going to read all the way through the review by Dr Barton. She sets out the history of presenting complaint. She records:

"Barthel: Needs help with ADL".

Barthel is zero. "[nasogastric] tube in situ" and she transfers with a hoist."

G

Now, you deal with this assessment by Dr Barton at paragraph 12 of your GMC report.

A Yes.

Q Is there any indication of a physical examination of the patient, first of all?

A The notes do not record there was a physical examination.

H

Q Again, on the basis of the notes, because you can only go on the basis of the notes, does there appear to have been an adequate clinical assessment in view of this patient's transfer and her poor state of health?
A Well, again, I think ideally one would – I mean, the summary of the problems is certainly adequate and describes all the main issues. I think ideally one's routine observations, which again would not be done by Dr Barton but would be done by the nursing staff, but some note of those, that they had been looked at, and it is best practice to have neurological examination to show extent of the weakness, but I would not say it is a failure of good medical practice not to do that detailed examination. I think the issue is around if this lady was complaining of pain should she have been examined, and particularly around the issue of the abdominal pain, which is referred to around this time.

Q If we have a look at page 19, I was going to take you to that, in the middle of the page we can see:

> "Requires assistance to settle and sleep at night. Oramorph 2.5mls (5mg) given. [complaining of] pain in stomach and arm. Condition poor".

Above that we can see:

> "Poor hearing in [right]. Poor vision – wears glasses most of the time. Speech slow and slurred at times. Orientated ..... Pain: Not controlled ..... [complaining of abdominal] pain due to history of bowel problems."

I think this lady had had abdominal pain for a significant period.
A I mean, reviewing the notes, this had been very extensively investigated by at least, I think, two consultant teams, and it was thought to be either due to irritable bowel syndrome, or a functional abdominal pain problem, or to adhesions from previous surgery.

Q I think very early on she had had abdominal surgery, had she not?
A Yes, but it was not quite clear what the final diagnosis was, but this abdominal pain, certainly in the past there had been no suggestion that it should be treated with opiates, and you would not treat chronic abdominal pain with opiates?

Q Why not?
A Because with chronic pain, opiates you try to avoid because they are not particularly effective, and you do get problems of dependency and difficulty getting people off opiates for non-malignant chronic pain, and certainly for irritable bowel syndrome you would not give opiates. I mean, that is not an appropriate indication.

Q Being realistic with this lady, the question of getting her off opiates probably is not going to be a significant issue, is it?
A No, but it is a lady you are intending to rehabilitate, you want to avoid the adverse effects of opiates as well. Just because she has a severe level of disability from her stroke is not an indication, or lessens the issue of giving her opiates. We would not in any circumstances start approaching this sort of problem in a patient with a severe stroke who is complaining of abdominal pain by prescribing opiates.

Q Well, let us look at what Dr Barton did prescribe. If you go to page 20, which deals with the prescription written out on the day of admission, I am not going to deal with all of

A the drugs, but we can see that Oramorph was prescribed, 5-10 mg as required, and that was actually administered at a rate of 5 mg three times on the day of admission.
A One of the things I was not able to determine from reviewing the notes was what Dr Barton prescribed the morphine for, because this patient had been transferred on PRN subcutaneous diamorphine for chest pain and cardiac problems, and it was not clear to me if the Oramorph was being prescribed potentially as a replacement for the diamorphine or for the abdominal pain, or for some more general palliative pain relief reasons.

B

Q Well, diamorphine was also prescribed in a rather different way. We can see that she prescribed 20-200 mg, midazolam 20-80 mg by syringe driver. Again, I am not going to take up time, you have commented extensively on these sorts of prescriptions, in your view appropriate or inappropriate?
A Inappropriate, because this lady has been transferred because it was thought she was medically stable, she has got a stroke, she is coming for rehabilitation, her outlook, as
C I describe in my report, is poor. I mean, this is a lady who is going to require care either in a nursing home or with considerable care package from her family and other carers if she were to be able to return home after what would likely be a very prolonged period of rehabilitation, but she is not in any way expected to be dying within the near future, from the information presented in the notes.

Q Let us look at what happened to her the day after her admission.

D

MR LANGDALE: Can we just note the prescription on page 20, at the top, the other drugs.

MR KARK: Yes, certainly: digoxin; enalapril; aspirin; isosorbide. Isosorbide is?
A Is a nitrate for angina.

Q Is it "Suby C"?
E A I am afraid I do not know what Suby C is. I have not looked this up. I believe it is a wash-out solution for a nasogastric tube.

Q We will have a look. Can we go then to see what happened the next day. Can we go to page 21, please. At 11.30, this is the bottom entry on page 21:

> "To have GTN spray PRN. Now on regular ..... oramorph 10mg" four hourly.

F

Then Philip Been made a note at 18.00 hours:

> "Uncomfortable throughout afternoon despite 4hrly oramorph. Husband seen & care discussed, very upset. Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life."

G

Bearing those words in mind, "Agreed to commence syringe driver for pain relief", can we just look at the drugs that she had been on and to see whether she was given an equivalent dose and whether it was necessary in your view at all. She was on Oramorph and it was actually administered to her, 7.35 in the morning she gets 5 mg, and then at 10 o'clock and 2 o'clock in the afternoon she gets 10 mg each time. Yes?
A Yes.

H

Q So she gets 25 mg on that day. The day before she had had just, I think, 5 mg, and then at 7.20 in the evening, 19.20, she was put on diamorphine of 20 mg via a syringe driver and midazolam of 20 mg.

MR LANGDALE: I am sorry to interrupt again. Maybe I have got it wrong, but you said the previous day, looking at page 20, the Oramorph, I may be getting it wrong, but it looks like three administrations of ---

MR LANGDALE: Mr Langdale is absolutely right. I missed that.
A I think I had estimated in my corrected report that she had received a total dose of 35 mg of oral morphine, three doses of 5 mg and two doses of 10 mg.

MR KARK: Thank you very much. Then she started on 20 mg of diamorphine coupled with 20 mg of midazolam. In terms of sedative effect on this particular patient, what effect is this going to have?
A Well, I have already commented that I, from reviewing the notes, was not of the opinion that the opiates were indicated, but if we accept we are at this point and she has had 35 mg of oral morphine, the diamorphine equivalent would be around a third, 12 mg, over 24 hours, and if one wanted to, say, increase that, if one thought she was in increased pain – an equivalent is 12 mg, to answer your initial question.

Q Yes.
A A 50 per cent increase would be 18 mg. So it is a bigger increase than what she was on. She is receiving more than the equivalent. We are starting at 20 mg over 24 hours.

Q Coupled with midazolam.
A Then the midazolam. My comments are the same, that this is a high starting dose and there was no clear indication that this lady had terminal restlessness, which would be the indication.

Q The patient is described, top of page 22, as:

"Remaining poorly but comfortable."

She remains on the same rate of diamorphine and the same rate of midazolam until she dies that night at 10.30 in the evening. Again, with this patient, she has died effectively, I think, within two days of transfer.
A Yes.

Q In your view, is the diamorphine and the midazolam likely to have had any significant effect upon her?
A Again, this was a lady with a severe stroke. She could have died suddenly from a pulmonary embolus or other problems, but the timing is very suggestive that the drugs contributed to her death.

MR KARK: Professor Ford, that is all I ask you. Thank you very much.

THE CHAIRMAN: Thank you, Mr Kark. Mr Langdale, I was going to announce a break at this point anyway. It is a matter for you. We can either take that break and then come back

for half an hour before lunch, or you might prefer to merge the two so that we take an early lunch and return for you to start in an hour. It is entirely a matter for you.

MR LANGDALE: Sir, thank you for the discretion, as it were, for me. I think, bearing in mind our time constraints, whatever arrangement means that we get on with Professor Ford's evidence as soon as possible, that would suit me, so it sounds as if one break now would ---

THE CHAIRMAN: Would merge the two.

MR LANGDALE: --- assist in terms of everybody needing some time.

THE CHAIRMAN: Yes, indeed. It would make a net saving of about 15 minutes.

MR LANGDALE: Right. So let us go for it.

THE CHAIRMAN: Very well. We will break now, Professor, and we will take an early lunch, so we will return, please, at 1.15, when Mr Langdale will start his cross-examination. Thank you very much indeed, ladies and gentlemen.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Mr Langdale?

Cross-examined by MR LANGDALE

Q Professor Ford, obviously I have a number of questions to ask you. I am going to try not to repeat points where repetition can be avoided, but may I make two things perfectly clear at the outset: although I may be challenging some of your assertions, I am not seeking to cast any doubt upon or aspersions upon your expertise. Secondly, I am not seeking to cast any doubt at all upon your integrity as a witness.
A I fully understand that and I equally understand your role.

Q There are two major disadvantages in terms of the situation in which you find yourself, neither of them of your making: firstly, because the note-keeping in this case in relation to these patients was inadequate, which of itself presents you with a number of difficulties in trying to assess what the appropriate course of action might have been.
A I recognise that and I agree with that.

Q Secondly, again it could hardly be your fault, you yourself never had any opportunity to observe the patients in question.
A That is the nature of being an independent expert, of course.

Q Of course. That is a very important consideration to take into account when trying to see why it was a doctor did or did not do certain things.
A Yes.

Q You are aware that Dr Barton has accepted that her note-taking, I am speaking just generally, her note-taking was inadequate.
A Yes.

Q You are aware too, I think, that she has accepted, not in every case but in most of the cases where it applies, that the range of dose in relation to her prescriptions, the typical one we have seen many times 20-200, was excessive.
A Yes, I am aware of that, yes.

Q You are also aware that there has been no evidence that her lack of adequate notation meant that anybody, either a doctor or a nurse, was unable to follow what it was were the requirements of Dr Barton. Nobody has said, "I could not understand what to do because of inadequate note-taking", or anything like that. You are aware of that?
A From my reading of the transcripts, I have not heard any complaint of that.

Q I appreciate you certainly have not been through every word of it, but that is the general picture. Similarly, there has been no evidence called, and no allegation made, that any nurse within the latitude of the range did something absolutely out with the possibilities in that range. There is one case where a nurse appears to have made a mistake, because it was not prescribed and nobody instructed her to do so, elevating a dose of midazolam; where it should have been 40, she actually administered 60.
A My understanding is all the nursing actions were within the prescribed drug ranges, yes.

Q Also, we have to bear in mind when we are considering the ranges that, in respect of the patients generally, the position is this: that I think only one patient – I am just trying to refer to a note that summarises this – that only one patient received as much, by the time of his death, as 120mg of diamorphine, and that is Patient A.
A That was the maximum dose received over a 24 hour period, yes.

Q We just have to bear in mind that there is one example of a patient receiving 100 – I am not asking you to pluck figures out of thin air, but I am just putting it to you – two patients, a maximum of 80 by the time they died; two patients, a maximum of 60 by the time they died; four patients, a maximum of 40 by the time they died; one patient, a maximum of 30 by the time she died; and one patient, a maximum of 20 by the time she died.
A This is a diamorphine infusion, and I am sure that is correct, yes.

Q Just to give us the general picture.
A Yes.

Q Before I ask you something about your experience in relation to an approximately equivalent situation, may I just ask you one thing about note-keeping, to try and get it out of the way: are you able to give any informed opinion about the standard of note-taking with regard to GPs, or GPs in the same situation as Dr Barton, during the period in question? If you are not, I am not going to ---
A I have answered this. I gave a view of the standard of note-keeping I would expect in that setting where junior doctors were operating, and I have not seen any survey of note-keeping by GPs in that period, so in essence I would say no.

Q I am not going to trouble you with that topic again. May I, however, ask you about the experience, and I may have misheard the name, or what the name was, was it Walkergate?
A Walkergate Hospital. It is still an active hospital taking patients for rehabilitation, but, as I indicated, I no longer practise there, but did do so in the 90s.

Q I appreciate that. That is the hospital we are talking about.
A Yes.

Q I wonder if you would just help, because looking at your CV, I may have missed it, I do not think it is mentioned. Maybe it is covered by another---
A That hospital is not specifically mentioned, no. I talk about my involvement in care of the elderly services. I did not give a full detailed description. I am happy to enlarge on that if you wish.

Q Do not worry. It is not the same as Freeman Hospital, which is the one hospital I had noticed?
A No. It was part of the same hospital, and in fact part of a larger hospital Trust, and it was part of the service that I was head of service for.

Q Again, without going through all the detail, you gave us certain figures about the acute medical unit, and so on, acute geriatric, rehabilitation, continuing care.
A Yes.

Q At one point I think the total involved in that hospital in Newcastle, I think you were saying at one point about 120 patients?
A I said there was a situation where, as a consultant – sorry, are we talking about the beds at Walkergate Hospital?

Q Yes, when you were talking about beds in general, you said at one point 120 patients.
A There were actually more than that, but, as I started, the beds were being slowly reduced as continuing care wards were closed. So we started off with seven wards and we ended up with four, which was about 80-something beds.

Q All right, something like that. Continuing care, I think you gave a figure for about 20 beds.
A By the time we had made the changes, of changing continuing care beds, some continuing care wards into rehabilitation wards, there was one ward left of 20 continuing care beds, and there were three rehabilitation wards of 22, 20 and 17, and the smaller ward became a nurse-led unit in the late 1990s.

Q None were palliative care wards, is that correct?
A No.

Q In terms of your dealing with patients, very, very roughly speaking, that would fall into a similar sort of category to the patients we are dealing with at Gosport War Memorial Hospital, in terms of your time, as I understand it, you as a consultant would be doing a weekly round?
A Yes. As a senior registrar I probably visited the similar ward twice a week for just under three years, and then as a consultant, as I indicated, each consultant did a ward round once a week.

Q So in terms of medical care, the provision of medical care, in relation to patients of the sort of category we are talking about, what was available in terms of doctors being there and doctors being available?

A A Yes, I thought I had briefly explained that, but I will go through that again. I understand why you are asking. Each ward was overseen by one consultant, and that consultant would go down once a week and do a ward round, typically, I think, very similar to what I could see was happening at Gosport War Memorial Hospital, with a multidisciplinary team, meeting with the nurses and any therapists that might be available, and would go round the patients, and then the rest of the week the problems on the ward would be covered by the registrar, which would be a group of three or four doctors who B would go down there usually once a day, so there would be some input of a round, and they would do their ward round and then deal with any issues on the other wards.

Q Again, maybe I got the figure wrong when I made a note, how many sessions of medical cover from the registrars? I think you said five or six.
A From my recollection, there would be at least one registrar going down once a day, sometimes twice, and they would clerk new patients in, for example, who were transferred, so C I estimated it would be about – it was not ten sessions, but it was probably six or seven I suspect were covered.

Q In terms of your activities when you were acting as a senior registrar, what sort of period of time are we covering in that post?
A That was 89 till 1992, in August.

D Q So three years.
A Yes.

Q About how many patients of a similar kind to the kind that we are dealing with in this case, this may be an impossible question to answer, but can you give us any idea as to how many patients of this kind you would have encountered?
A You mean, elderly patients in this environment?

E Q Yes.
A Well, again, as was common in that period, often the supervision of the wards was actually delegated to a senior registrar, you would not see that now, so I would be down there once, twice a week to review patients and undertake ward rounds.

Q Who might be palliative care sometimes, might they?
F A Well, as you rightly point out, it was not a palliative care ward or service. We would care for older people there who were dying, and, similarly, that would also happen, sometimes not infrequently, in the acute geriatric or acute medical setting as well.

Q Then when you were a consultant at the same hospital, about how many patients of a similar kind to the kind we are looking at in this case would have come under your remit, or whatever the appropriate phrase would be?
G A Well, initially when I started I had responsibility, trying to remember, for at least of one continuing care ward. I think it was one continuing care ward, which eventually closed, and the ward I took over, which became a rehabilitation ward, had mixed function, I mean, similar to how the wards have been described, and many units, as I explained, changed their continuing care beds into rehabilitation beds. So I had a 22 bedded ward, which I set up half of the beds to be stroke rehabilitation, and the other were general elderly care rehabilitation.

H Q At that period, acting as consultant in that sort of way, covers from 92 to---

A To about, if I remember correctly, 1998. I think another colleague started then and the stroke rehabilitation beds transferred to a combined stroke unit/rehabilitation unit on another site, and at that point I transferred that ward to the care of a new consultant geriatrician who was appointed.

Q I think that is all I need to ask you about that particular topic. Thank you. I want to ask you about general matters with regard to palliative care, and I appreciate that expression is not absolutely precise, and that there are obviously times when one might well be embracing end of life care, or terminal care at the same time, but just using that as a broad brush expression, I want to ask you some questions about that, which of itself will throw up various topics which you have already given evidence about. Some of them we may have to come back to in relation to individual patients, but in terms of these general matters I wonder if you would be kind enough to look at a particular document that we have heard about in this case, and it is in file number 1, and in file number 1 if you go, please, to tab 6, and in tab 6 page 27.
A Yes.

Q I do not know if you have had an opportunity to see this. I would rather doubt it.
A I do not believe I have read this document.

Q It does not matter. It is pretty basic and it is not throwing up any sort of complicated slant on things, but the Panel have heard evidence about it and I want to use this as a starting point. So that you know what it is, it is a note made by a Dr Logan, who was a consistent geriatrician – it was not Gosport War Memorial; it does not matter – one of the other local hospitals.
A I understand.

Q He is making a note in relation to a meeting which was held in 1991, at which he spoke about various matters to do with the use of syringe drivers and so on, and I just want to draw your attention to it to see whether there is any disagreement that you would express with the views he expressed back in 1991. If you look, please, at the second paragraph, you can see how he recalls that he was invited to talk in general terms about the use of opiates in long-stay wards. He expressed the view that it was often very difficult to know what was best for very frail, elderly patients who could not clearly express their symptoms, and that one could only do one's best in interpreting them. I take it we can be in agreement about that, as between you and Dr Logan?
A Yes, I would agree with that.

Q These are very general. He said:

> "I felt when there was any question that the patients had pain then they should be given the benefit of analgesia."

Well, obviously no dispute about that.

> "Unfortunately there were no really very useful middle range drugs between Codeine and Dihydro-codeine and Diamorphine."

In general would you agree with that?
A Could I just make one comment on the previous statement?

Q Yes.
A I mean, of course, if there is a significant concern about pain, I would word it slightly differently, people should be given the benefit of trying analgesia to see if that relieves their symptoms, and I think there is a question about what we mean by any question; is that responding to any view, is it the doctor's view, so I would be slightly just cautious in the interpretation of that, but the principle I agree with. I do agree we would go, in general, on the analgesic ladder, you have got a choice; if you are giving people adequate doses of codeine, the next step is stronger opiates, unless you try another approach, such as with non-steroidal anti-inflammatory drugs or treating the pain with a different approach, but that statement, yes, I agree with.

Q He goes on:

> "I also explained that, besides their pain relieving properties Diamorphine and Morphine had very useful psychological effects producing some psychological detachment and euphoria which can do much for a patient's tranquillity."

A I would agree with that, but in the context of patients who are in pain. I would not agree with that in broad terms that they are a treatment for producing euphoria in elderly, frail patients who are not in pain.

Q So there has to be, in your view, some element of pain to allow for the fact that besides their pain relieving properties they have those other effects?
A When you read the BNF or most guidelines, that is the context; where they talk about the additional benefits is in the context of producing this detachment and euphoria ---

Q Forgive me, Professor Ford, I do not mean to interrupt you, but I am asking you for your view.
A My view would be they do have that effect in the context of pain, but I do not think it is general accepted practice to, for example, give it to frail older people who are not in pain, who are miserable for other reasons. As a very last resort, if you have tried other approaches and you cannot work out if someone is in pain, you might consider it, but I think that benefit, in my view, is mostly in the context of patients who are in pain.

Q I am going to come on to an issue relating to that later, but that is your view.
A That is my view. I am not saying there are not geriatricians out there, and other people, who might express a view to use it for that purpose, but it is not in the palliative care literature and guidelines promoted or recommended in that context, which may be being implied.

Q He goes on:

> "I said that it was, however, vital for us to make sure that there were not more simple reasons for the patient's pain or distress, such as a full bladder or faecal impaction that could be quite simply dealt with."

No disagreement there.
A I think I made those points myself in earlier evidence.

Q "Having established that and being content that the patient was distressed and probably in pain, then one should not hesitate to use opiate analgesia if necessary."

Would you agree with that?
A I agree with that. The challenge is its interpretation when patients cannot communicate whether their behaviour indicates they may be in pain, and that is, I think, the difficulty in management in general of this patient group.

Q Perhaps I can touch upon that, because it embraces one of the things I was going to come back to. With patients who cannot communicate it presents particular problems, for obvious reasons?
A Yes.

Q And it may very well be extremely difficult, if not impossible, for a doctor to determine precisely what it is that is causing the agitation and distress?
A I agree with that.

Q It may be essentially pain, it may be essentially mental distress, it may be a combination of the two?
A It very much depends on the individual patient and their context.

Q And once again that is an illustration of the importance of actually seeing the patient?
A Yes, and in taking account of their previous behaviour, the way they have expressed themselves, what their usual behaviour is, the nature of their underlying condition.

Q That also embraces something you have already mentioned in your evidence but I would like to deal with it now. It is very important indeed for a doctor in these sort of circumstances, the circumstances we are considering in this case, to have information from the nursing staff?
A I think most geriatricians would consider that nursing perspective is absolutely critical, and also I have to say the perspective of relatives and carers, who would know the patient much better from before their admission to hospital. So those would be two perspectives you would always try to obtain in any case where you have difficult symptom control in patients who cannot communicate.

Q And assuming your nursing staff are experienced and competent and all the rest of it, they, in your experience, become very experienced, indeed, at assessing the sort of stage that a patient is at in terms of a palliative care route and an end-of-life route?
A Experienced nurses are very good at recognising when patients are deteriorating. I think this opens up a broader issue about what the general approach to end-of-life management was in the Gosport War Memorial hospital by the nursing and medical teams as a whole.

Q And it follows, too, that one has to look to, in trying to assess the importance of the doctor's opinion, the doctor's experience, obviously, in that sort of field?
A Yes. I think most people practising in this field would say experience and training and interaction with peers and experts in the same area is important in developing one's expertise in this field.

A Q Yes, and over years you would expect a doctor who had been involved in care for patients of this kind to develop a particular expertise in making a judgment about the state of the patient's medical condition, leaving aside all the tests and all the rest of it?
A I would, but I do think the interaction with other experienced clinicians, particularly if we are talking about Dr Barton with other geriatricians and one's exposure to general thinking about management of the elderly in terms of continuing education, going to meetings, is important in developing one's expertise. One does not necessarily gain expertise
B alone from having exposure to a patient group. It has to be accompanied by specific training or working with peers and developing one's skills interactively in that context.

Q I am not taking issue with you about that, but I was trying to look at a slightly different aspect, and that is the experience of seeing patients, the hands-on experience of seeing patients in this sort of situation. It aids considerably, does it not, to the weight to be attached to a doctor's judgment about the sort of state a patient is in?
C A I think very much so. There is a tendency for many other groups of doctors who are not practising in geriatric medicine to think that because they see old people there are no specific skills about how you manage and treat. It is, as I have indicated in my earlier evidence, a very challenging area and group of patients to look after, and exposure to the area and experience is very important.

Q May I just go on with a little bit more of what Dr Logan was saying after the passage
D I just put to you. He goes on, having said that one should not hesitate to use opiate analgesia if necessary:

> "Obviously the oral route is the best if the patient can manage it, but if not, as is often the case, then injections or subcutaneous infusion were perfectly acceptable ..."

Yes?
E A The oral route is preferred, yes. One thing he does not mention there is the use has to be accompanied by an observation of the response. Since you have a working hypothesis in the diagnosis the patient may be in pain, it is important to review that when you initiate the treatment.

Q I am going to miss out the next passage, as he is talking about how vital it was for a team effort and so on, and in the next paragraph a particular nurse raised a particular point.
F Can I just deal with what he said three lines in because the nurse was saying it appeared to her that it was routine for patients to receive opiates before they died and she questioned whether this was necessary. Dr Logan said:

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

A Unless the indications are the pain is not severe and troubling the patient, I would fully agree with that.

Q That is all I need to ask you about that general statement because the Panel have heard
H some evidence about it already. I want to ask you about a proposition with regard to

Dr Barton in relation to her time and her responsibilities in terms of her working in relation to those two wards, Daedalus and Dryad.

You are aware from evidence that you have either read or been told about, it does not matter, what the general picture was. Dr Barton had, I think, a job involving her devoting five sessions a week to her work in that way, and were you aware that of those five sessions one and a half of those were apportioned to out of hours cover and commitment. In other words, her practice would deal with one and half hours?
A Yes. I was not aware had that been agreed but I was aware that was the split stated.

Q And I am not worried about precisely because that is just to give us the general picture. So therefore, sticking to the terms of the contract, she would be in effect doing three and a half sessions, and we think of a session - forgive me if I get this wrong - as being three and a half hours, is it, in general terms? Or was it then?
A I actually thought it was four hours, but if you state it is three and a half hours, I will accept that, of course.

Q I think it may have changed.
A It is four hours we work with now and I do not know what clinical assistants' jobs were, but if it is three and a half hours, it is three and a half hours.

Q And, as you know, and the number may have varied a bit, 40 plus beds under her care?
A Yes.

Q And that I think - one can say generally - was an unreasonably excessive load, was it not, for a sole clinical assistant?
A In my report I was not persuaded in comparison to my own experience that it was necessarily - I forget the exact phrase used - clearly excessive. I think it was a lot to do. It would depend on the extent to which the consultants when they visited the ward, put in input, and this is the whole problem. It depends on the framework. As I indicated in my report it certainly would not allow documentation of every contact with patients or relatives.

I think also the way Dr Barton had to put that input in which, as I understand, was visiting in the morning and then going back later and then sometimes again, has the advantage of being able to respond at frequent intervals to problems throughout the day but it does have a disadvantage, in my view, that you cannot focus on, for example, going round all the ward in one period and dealing with everything. Now, I am just making an observation about the nature of doing multiple, relatively short, visits within that constraint period of 12-14 hours that we are talking about.

My view was that a proportion of the patients would continue in care, and one would expect them to be reasonably stable; often these patients would not need any input on an individual week so many of the patients depending on the proportion would not need to be seen every week, but clearly there would be the new patients to see, and I am talking in my report about the typical time that would take, say half an hour for each patient, and there would be the problems that arose and then there would be the extent of communicating with patients themselves and families and relatives. So it is potentially quite a lot to do: it has not got a full medical team one might have in an acute unit, so you would have to be prioritising what you were going to do

A Q It is very far from being the sort of medical cover you would get on an acute unit, is it not?
A Yes, but I think this level of cover was very typical for many units like this. I indicated it was analogous for all ours for the number of beds to our own unit.

Q And that workload, that pressure, would be increased if there was not within the terms of what was on offer, full consultant cover?
B A Undoubtedly. I think the extent to which consultants were going round, dealing with the non acute problems, talking to relatives would be critical. If there was not a lot of that input, clearly more of the burden would fall on Dr Barton.

Q Yes, and I don't know whether you are aware of this or not: were you aware of the fact that in terms of 1998, Dr Tandy, who was Dr Reid's predecessor, was away on [redacted] leave and there was a decision not to provide any locum cover for her until she returned
C in February 1999?
A I was not aware of that when I wrote my report; I have become aware of it since listening and reading the transcripts.

Q So, therefore, there was a significant resource problem?
A I would agree that would make a difference and an impact, yes.

D Q Well, you know what the general pattern was in terms of the evidence that was available as to how Dr Barton worked, and the times she would visit the wards and so on. Were you aware of the fact that in 1991 she had raised the increasing workload difficulty with the Trust?
A I was aware in broad terms that the issue was raised. I did not know when it was raised. I did not know, for example, it was 1998: I was just aware at some point between 1998 and 2000 it was raised, and I had no information to refer to that in my report.
E
Q I am not trying to test you: I am trying to set the scene in a general way, and some of this you may not have been specifically aware of.
A I think you are aware of the fact that during the period of time that she was at Gosport War Memorial Hospital, more than ten years, there were no changes suggested to her in terms of her mode of work or her prescription habits or her abbreviated note-keeping. You are aware of that just in general terms?
F A In general terms, yes. If I can make a comment?

Q Please do.
A I do think this issue is quite an important one. I do not really comment on it in my report because I did not feel I had the information and background to be able to comment, but my impression was that Dr Barton was in some ways in quite a vulnerable position if the input from consultants was not strong, if there was not an audit programme or strong
G programme for looking at the quality of care in the service. When things are inadequate in terms of patient care, in my experience it is rarely that it is due to the actions of one individual, there is usually a system problem, and I think there was evidence from what I could see of some, if you like, system problems in Gosport War Memorial hospital. I made some comments about that in my original reports to the Hampshire police but I did not comment on it because I did not feel I had the full information and picture to really make an informed comment on it, but I will say that there seemed to me to be other factors which
H contributed to the pattern of prescribing.

Q It is not your function in general in this case to be brought in to express a view about management and resources but it comes up and I must raise it with you in terms of trying to look at the practicalities in terms of her medical care on these rather important issues that have come up in this case.
A I agree it is very important.

Q In general terms, when one is looking at the general issues, and you have covered in your evidence a number of general issues - we have looked at the BNF, we have looked at what the Palliative Care Handbook has to say, you have given a number of pieces of evidence about what should or should not in general terms apply, and I am not taking issue with those general precepts, but in reality, bearing in mind all the generalities, the only way to judge accurately a particular patient's needs for analgesia is by careful, clinical observation over time in the ward?
A Absolutely.

Q And obviously one cannot judge that by simply using abbreviated medical records?
A Well, I think you are raising a more general issue about can one look as an audit exercise or as an expert at the quality of care from the information recorded in medical notes. It is an accepted principle that we often do this in medicine: we audit the quality of care by looking at the information in medical notes and I think I and others have said before, if something is not recorded, there is an assumption that it was not done, and that is the way one approaches this issue. Now, if you have a culture which accepts that one does not record one's findings, and I am not just talking about the medical notes but the nursing notes, the fraternity of notes in terms of observations, if the contention is that there were a series of observations done, these were carefully considered in the treatment decision, clearly one cannot judge that from looking at a review of the medical records. One can only judge, and this is what I have done, I have not made any inferences about what may or may not have been done, I have tried not do, I have tried to draw my conclusions on what I have seen as being recorded in the medical records.

Q As I said, there is no criticism of you, what else could you do?
A Exactly.

Q But we have heard this expression more than once in this hearing that if there is not a note of it or it is not recorded it did not happen.
A I did not say that.

Q That is my broad brush. You put it in the way that you would think appropriate if I misspoke.
A Well, one makes an assumption that it did not happen which is not the same as saying it did not happen, which is very important, and if my reports at the time did not make that clear then that should be corrected. I have genuinely tried to say in my reports if I did not see something that there was no evidence in the records that a particular assessment happened, if I did not see it.

Q It may be a jolly good thing to hammer home particularly to medical students and others in training, "Make a note", because the assumption may be that if there was not a note it did not happen. But we cannot apply it in this case again, it is not your fault, because the Panel are going to be hearing evidence about when Dr Barton, for example, clerked a patient

in, of course she examined the patient and of course the nurses took blood pressure and so on and so forth, but it is not recorded on occasions.
Another matter one has to consider, and this is again by way of generality in relation to what nowadays is always called a generic report but the general approach, is the wide individual variation between patients to opiate need.
A Yes.

Q That is there as a given, in terms of the issues we are considering in this hearing. Also one has to consider the balance between effective psychological support through good nursing care and drug therapy to relieve anxiety and distress.
A Yes, I fully agree with that.

Q They are two routes, or two methods, two ways and there has to be some sort of balance between them. If there is not the adequate nursing care, that side of it suffers.
A I think most doctors would wish to see these as entirely complementary. You do not use more drugs because you cannot give the psychological and spiritual support. If you look at the end of life care pathways at Liverpool Care Pathway now, they are emphasising points of providing adequate input for both of those.

Q The degree of nursing care available and the degree of time available for medical care might influence the actual drug therapy, the amount of it and the regularity of it to relieve anxiety and distress, might it not?
A It might do, but it should not.

Q I am not suggesting it should, but the situation might force that on somebody.
A If we are saying – and I understand where you are leading with this and this has been a general issue of controversy and concern in the management of, for example, older people with dementia and behavioural disturbance in nursing homes – best practice is to use as little drug therapy as possible and to provide as much support and an appropriate environment and personal input. There is the opportunity, particularly where one has as required doses for nursing staff, if they feel they cannot provide the input that is needed, to give more drugs. So I accept what you are saying, but there can be situations where the lack of skilled nursing time may lead to the prescribing of more drugs than might be desirable.

Q We will come on to this in another aspect in due course. I think again, without asking you to act as someone who has conducted a thorough examination of all the history of this case in terms of what went on, you are aware of the fact that the evidence shows that the clinical workload of the Gosport War Memorial Hospital changed very significantly during the time that Dr Barton was there?
A Yes. I think that mirrors again – I am aware of some of the figures and I think that also mirrors what generally was happening in these sort of hospitals in the 1990s. There was quite a radical change in moving from a culture of continuing care where there was actually very little input, into producing rehabilitation units which required a higher level of both medical and nursing and therapy input.

Q That again having its inevitable knock-on effect on the responsibilities and workload of Dr Barton.
A Yes. One of the issues of good management of services is to argue the case for the additional resources in terms of therapists and medical time that is needed when you change a unit. As I indicated, hospitals do not offer this out easily; you have to repeatedly make a

A strong case to get the necessary resources and it can be quite an arduous time – I will not say battle – to get the necessary resources in this sort of clinical setting.

Q In general terms, is the general picture this so far as you can judge it on the information you have? Dr Barton really had inadequate clinical consultant support, would you say?
A I am hesitant to comment, because all I have seen is the 12 cases which have been B presented before me.

Q May I interrupt you? I am not going to try to ask you to make a comment about something where you may not feel you are fully equipped to do so and you are not here as a kind of committee of inquiry into the running of the hospital. It is a view that ultimately the Panel will have to take.
A I think my review of these 12 notes to me raised concerns that there was inadequate C consultant, or let us say suboptimal consultant input. I am not going to use the word "inadequate".

Q Let us leave it there, unless you want to add anything in particular.
A I think there is a whole issue of oversight of Dr Barton's practice, which is in my view a consultant and hospital responsibility, and I think there was evidence that that was suboptimal. I do not want to go beyond where I should be commenting as an expert witness, D but I am commenting as somebody who ran a similar service, as head of the service, and my impression from the very limited picture of these 12 patients.

Q It is obvious that so far as we can judge and you can judge, the staffing model at the War Memorial Hospital did not really change, despite the changing patient mix and so on.
A There is no question that the workload of Dr Barton must have been greater in 1998 to 2000 than it was in the first seven years she worked there. I think there is no question about E that.

Q We can leave it there. Would you agree with this? Where good nursing care – and I stress this – with adequate staffing ratios and regular patient supervision is lacking, the use of drugs earlier and at a higher dosage to control symptoms can help to ease the distress of patients and indeed their relatives.
A I think I do have trouble agreeing with that. I think I understand the argument you are F putting forward, which is when you do not have enough skilled nursing staff and time, you cannot adequately, for example, titrate the drugs you are using to the best response. So in that context, where you may be concerned that if you start a lower dose with the nurses to adjust it, they will not adjust it. This has been a concern about treating older people, that they were not being given adequate analgesia – there is the opposite aspect as well to consider – and that therefore to give a higher dose is all you need to do to keep the patient comfortable. The problem with that is of course the problem of inducing unnecessary adverse effects. That G is the problem with the approach. Of course, if you have an environment with a low level of nursing time, you will not get equally the monitoring for that and so you are ending up with a situation where you are having to use potent drugs in a very undesirable, one can say more risky way. So it is a difficult situation you have there. If you have people at the end of life, where that is agreed, I think one would definitely want to make sure they were comfortable and you might be willing to accept a higher degree of adverse effects, but if you have patients who are not at the end of life care, you have a very risk strategy, a very risky approach, one H has to put in place as a doctor who has to make prescribing judgments.

Q The other risk being if you do not do that, in other words, aim higher rather than lower – and I do not mean out of reasonable ranges – the patient is going to suffer.
A Yes. What the response to that should be of course is that that environment, even more than a well-staffed environment, needs guidance and protocols to be implemented, because that is the only practical thing you can do in that environment in the short-term, if you have short staffing, to try and make sure people are working to at least some protocol which reduces the risk of either under-dosing or giving excessive drugs.

Q Ideally, a protocol in writing.
A Yes. And I do not think it would have been the responsibility of Dr Barton, for example, to create that protocol. I would say that as a comment.

Q May I just ask you about this as well, which touches upon what you have just been saying? It may well be the case in terms of the administration of opiates to patients of the kind we are talking about that doctors may legitimately disagree, have understandable reasons for disagreeing about the particular starting dose in a particular case.
A They may. Certainly within the starting range that is recommended by the standard guidance in the BNF, I do not think there is any problem. I think where the disagreement goes beyond what is recommended in the BNF or in appropriate guidance, the individual doctors, they may certainly disagree, but they have to justify their variance from the standard guidance.

Q Of course. One is assuming that the approach is rational and there is a reason behind it. I cannot remember whether you were present when Dr Reid was giving evidence about the sort of variation you might encounter, because I was putting it to him that you might get two doctors genuinely disagreeing as to whether an appropriate starting dose was 10 mg of diamorphine or 20 in a particular case and he accepted you might.
A Yes. It is not even a disagreement; it is a difference in judgment as to what the appropriate starting dose is. Clearly whenever you ask a range of doctors what they would do, you get a range of responses. Unless you have a very straightforward problem with very clear trial evidence and very clear guidance, you inevitably get a range of different responses that individual doctors would take.

Q That covers the point I was going to raise. Just dealing with that particular fact, in terms of the figures – and I am hitting on 10 and 20 because 20 is a figure we have come across an awful lot in this case – one appreciates of course there is a difference, but the difference between 10 and 20 in relation to a starting dose, assume the patient has been on some form of opiate already, the difference between starting at 10 or 20 is not really that significant, is it?
A The answer is, it can be or it may not. I am sorry to be not giving simple answers.

Q Fair enough. It might be, it might not be.
A Could I say, I think the issue here is not merely the selection of the initial dose; it is the monitoring and actions that are taken in the light of the patient's response to that dose. That I think is in a sense the more important issue than the choice of initial dose, because even in the recommended doses, one will see patients – and we have seen evidence here today where small doses within the recommended range have resulted in serious adverse events in individual patients. A patient has had 2 mg of morphine and was hallucinating and confused. We talked about that earlier toady. So it is the response one takes when that

A happens which is the key and the mechanisms in place for nurses to report that and for appropriate action to be taken.

Q Of course. Again we come back every time to the particular patient. That is inevitable. Can I put it in this way? It would not be a surprise, would it, if a doctor had formed a view after some years' experience that where a patient had been on some form of opiates already, a starting dose of 20 was one that was rather more effective and sensible than
B a starting dose of 10, which would appear to have little or no effect.
A 10 mg of diamorphine does not sound a large amount, but it is not the number that matters. As we talked about, it is the equivalence in terms of where you are at. So I think, if I understand you, you are saying that through their own experience they may have found that starting people on 10 mg over 24 hours did not produce the desired effect and that they used 20, I can see that might happen. I think, as I have said in some of my earlier evidence, one of the issues is when you use a syringe driver and how you start using it. If a patient is not
C already stable on a previous dose of oral morphine or injected subcutaneous morphine or diamorphine, you will not see the full effect of that infusion until quite some time later, 20 hours or more. It is the case that many doctors do not understand the principles of clinical pharmacology – and I am not talking particularly around what Dr Barton may or may not have known – but actually we know that most doctors do not understand the principles of clinical pharmacology very well and so do not appreciate often the delay in getting to the steady state and the response you are going to see. That is why guidance is there to help
D guide doctors, for example, when they are switching to an infusion pump from using another route of oral medication.

Q May I just ask you something relating to that? The question as to what is actually going on when a patient is receiving subcutaneous analgesia – I will stick with diamorphine for the moment – without getting too involved in half lives and things of that kind, in particular because I confuse myself when I go into that sort of topic, dealing with, let us say,
E subcutaneous diamorphine administered at the rate of 20 mg in 24 hours. You have already indicated that of course you have to allow for the fact that that is going in slowly over that period and therefore it is going to take a bit of time to take effect. If you have an immediate, acute pain problem, very often the best solution is an intravenous injection or I suppose an intramuscular injection.
A Yes.

F Q To get the effect straightaway. We have seen cases in the histories of some of these patients where they have been given intravenously say 2.5 or whatever it might be in a hospital.
A We call that a loading dose as an approach.

Q I would just like you to help us with this process. Taking 20 per 24 hours as an illustration. A syringe driver administers the diamorphine at a steady rate.
G A Yes.

Q Morphine as I understand it will reach its peak in general terms four hours after it is administered. Is that right or wrong?
A Not with that injection route. It will be substantially longer than that, because ---

Q Can you stop there? I do not want to waste time on that.
H A It is longer basically.

Q Four hours for morphine on a single injection, is it?
A Sorry, that was the average half life. A rule of thumb is four or five half lives. So you will reach the maximum effect and then you have, with the metabolite at about 20 to 24 hours, about a day after you start you will be at the maximum effect.

Q On a single injection?
A One single injection?

Q Yes.
A No. You will absorb that within half an hour to an hour. You will have the maximum effect at around half an hour.

Q You were giving these ranges ---
A It is a single injection under the skin. You will absorb it within about half an hour or an hour and you will have a maximum effect at about one hour.

Q Going back to 20mg subcutaneously, the diamorphine is going in at a steady rate, what sort of rate is actually going in per hour? Do we simply divide the 20 by 24?
A Yes. I do not want to make this even more complicated than this. Of course, you are injecting it under the skin, and then it has to be absorbed from under the skin, so there is even a lag there. So there is a lag of it starting to be absorbed of an hour or so, and then it is going in 20 divided by 24, just under a milligram per hour, yes.

Q Right. Is this right in terms of the way to think of it: since it is being administered at a steady rate, there is not, apart from the initial achievement of the level, there is not actually a peak, or is there a peak?
A No, there is a peak, and it is a peak at five half lives, which is around 5 x 4, for example, 20 hours, and then to further complicate it you have got the morphine 6 glucuronide active metabolite, which is also accumulating, and then they have a lower half life, and this is a particular issue in patients with renal impairment, for example, where the metabolite is excreted through the kidneys, so it will be even lower than that, but certainly you would not get the maximum peak of morphine until about beyond sixteen hours.

Q All right, something like that.
A I mean, in textbooks it is shown with diagrams and it is much easier to understand. To describe it all verbally, which I know is what lawyers always do, it makes it more difficult.

Q Lawyers occasionally use diagrams and things as well, but that is enough for our purposes. Can we just in general terms think of this issue in terms of fentanyl.
A Yes

Q Does the same principle apply in terms of it being administered into the body at the same steady rate, or not?
A Through the transdermal patch the administration absorption is, but it has got a much lower half life, so it takes longer to get to the peak effect and it takes longer for the effect to work. So that is the important difference between fentanyl and morphine and diamorphine.

A Q Thank you. That clears that up. The fentanyl patches we are concerned with in this case were three-day patches, I think---
A Yes.

Q ---in terms of the general picture. I suppose it is a complete truism, and I think you have already covered it, that it is impossible to determine in advance the opiate dose required to control pain in an individual.
B A Very difficult.

Q That is a given.
A Particularly difficult in older people, because their range of responsiveness is greater.

Q As you have already made the point, in dying patients there is not a problem; you do not have to worry about drug dependency, and large doses of opiates are often required.
C A You do not worry about the adverse consequences of necessary opiates in people who are dying to control symptoms.

Q Obviously, pain and distress are also enormously variable?
A Of course.

Q Would you agree with this: the severity of pain depends on the clinical situation and
D its perception varies with anxiety, fear, other symptoms and whether the patient himself or herself has come to terms with the fact that they are dying?
A I would fully agree with that.

Q It is impossible to determine clinically the causes of deterioration in elderly patients with multiple co-morbidities. Would you agree with that?
A I think in all the comments I have made about individual patients I have said it is
E impossible, to use a legal phrase, to be sure beyond reasonable doubt about the cause of deterioration in most of the patients we have seen, because these were frail individuals, they were in hospital for the most part because they were unwell, and they are at high risk of developing acute medical problems, and I hope I have acknowledged that in most of the statements I have made.

Q Professor Ford, I am just trying to get down to some basic propositions to see whether
F there is a disagreement. Would this be right: the only certain way to determine the contribution from symptom control medication, in this case opiates, is to stop it completely for at least 24 hours?
A Yes, or give an antidote, which I have not suggested, I do not think, in any of these patients should have necessarily have been done. You know, one can give naloxone, and that is what we do, if we have got somebody and we are not sure if opiates are the cause of their depressed conscious level or reduced respiratory rate, we give them the antidote and we see
G what happens.

Q In patients of this category, patients who are in this situation, it would be unethical, would it not, in this patient group, simply to stop the administration of opiates subcutaneously just to see what the effect was – stopping it for 24 hours?
A I have seen that comment from one of the experts. I do not agree with that. It is over-simplifying the issue. It depends on whether these patients are at the end of their life, and it
H depends whether they were clearly in pain or had another symptom that has responded to the

intervention you have given. If they clearly had severe pain and you started opiates, one knows that if you stop it completely they will get severe pain back. I mean, I do not think it is a matter of ethics, I think it is a matter of good medical practice you would not do that. I mean, ethics is not the approach I would take to it. It might be appropriate, and again I know some experts have criticised my comments on this, to stop until the opiate level has gone down, if you think that is the toxicity, and then start at a lower infusion rate. What would generally happen is one would reduce the rate of the infusion if you think the balance of benefit and adverse effects is not right, if, you know, you have got over-sedation or you have suppressed the respiratory rate more than is necessary. It very much depends on whether they are in this end of life management phase, and I think the issue with some of these patients is there is a question mark over whether they were there or should have been there.

Q All of this, all of those aspects that you have just been telling us about, show the difficulties of making judgements about these matters with regard to particular patients.
A In an individual patient, and of course it has been looked at in another context, to conclude that drugs definitely caused their deterioration or death is very difficult.

Q Yes. It may be that even then it is still impossible to tell one way or the other.
A Yes.

Q Would you agree with this, if I can just put it to you in a bald way: diamorphine and other opiates are extremely useful not only for pain control but for alleviating the secondary anxiety and distress caused by the fear of death?
A Well, I think I have answered this with my earlier response, that opiates are very good in patients who have pain at reducing these other symptoms. In patients without pain - and I think one is in a difficult area here; we do not routinely look to opiates to reduce anxiety and distress in people who are pain free who may be near death.

Q I am not suggesting "routinely" used, but it is something that would be legitimate to do in a particular case, would it not?
A I think there is a reasonable body of medical opinion, despite the indications for opiates in BNF, and despite guidelines not mentioning this, there would be a body of opinion out there – I have to say I do not think it is certainly palliative care guidelines, and palliative care physicians in my experience do not hold this view, that they would use opiates for this purpose – but there are people who would, and might consider using opiates in that context, but I think palliative care specialists would seek to deal with fear and anxiety in people without pain through other approaches rather than using opiates. Now, that may be best practice, it may be very specialist care, and I am trying to answer your question to reflect the range of opinion in this area.

Q If I may say so, quite rightly. (To the chairman) Sir, I have got one more matter on this topic which I was going to ask the witness about, and then it might be convenient to have a break.

THE CHAIRMAN: Yes, I think it would. Excellent.

MR LANGDALE: Just one more matter touching upon that same issue. I am using a passage from your report. For your assistance, and you probably will not need to turn it up, but in relation to Patient C, Eva Page, the lady who was suffering from carcinoma.

A A Yes, I think I recollect what I said in that report.

Q You said, in relation to the prescribing of opiates by Dr Barton, and we will come back to this when we take a look at this particular patient, you were saying there did not appear to be any evidence she was in pain---
A I did.

B Q ---and you indicated that you thought the reason might have been to provide relief for Mrs Page's anxiety and agitation, and just to give you the whole quote, "This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma". So there is an illustration of a set of circumstances which, in your view, would justify the administration of opiates to relieve anxiety and agitation?
A There are two things: I am well aware of that statement, and I am very happy to stand by it. It is not an approach I would take, but I think there are two things: first of all, a patient
C with no malignancy, I think one has to say most doctors have a lower threshold for using opiates if there is any suggestion, and that was where Mrs Page, I think, is different from other patients; and, second, I did believe and do believe certainly at that time there was a reasonable body of doctors, even though it would not have been necessarily my approach, or palliative care specialist approach, who would use opiates in that sort of context.

MR LANGDALE: Then that is as far as I can take that topic. Sir, that covers that aspect.
D Thank you.

THE CHAIRMAN: Thank you very much indeed. We will return at quarter-to three, please, ladies and gentlemen. Thank you.

(The Panel adjourned for a short time)

E THE CHAIRMAN: Welcome back, everyone. Yes, Mr Langdale.

MR LANGDALE: Professor Ford, one individual matter relating to what sort of number of terminally ill patients on a long-stay ward receive opiate analgesia. This is not a test of your amazing powers of recall, but you will be aware that there are studies relating to that in terms of the number of terminally ill patients on a long-stay ward who receive opiate analgesia.
A I have not seen those studies actually. My own experience is we do use opiates in a
F proportion of patients, frail older patients, in a long-stay continuing care ward setting. My estimate from my own personal experience is that probably less than a third, probably around a quarter would be my experience, but I have not looked at the published literature, and I suspect it varies quite widely between units would be my prediction.

Q I am sure, and I do not want to give you homework over the weekend, but may I just mention to you a study, and if we need to pursue it we can: this is Wilson J A et al on
G palliative medicine, and I will make sure you get the reference, 1987, 149-153, a percentage of over half; but if I simply give you the reference at the end of the day, if you would be kind enough, it does not matter if you cannot, but if you just check it, the percentage, I understand, was 56, but as you rightly say it may vary from---
A I do not think it is out of keeping with my own experience of a third from recollection, so I am very ...

H

A Q All right. Now, just some individual topics, if I may. I am sorry if they are a little bit miscellaneous, as it were, but it is the only way of tying these aspects up. It is apparent in this case, I think, even on your own view, that there were cases where patients were sent to Gosport War Memorial Hospital who were not medically stable on admission.
A Oh, yes, I agree with that. There were at least two patients, I think, who clearly in retrospect were not medically stable.

B Q One has to be aware in real life of the possibility of doctors on acute wards either overstating a patient's clinical abilities and potential for rehabilitation, or maybe perhaps understating the patient's post-operative pain.
A Whether overstating or understating is the issue, I mean, certainly I would agree with statements made that non-geriatricians, non-rehabilitationists, may over-estimate, because it is not their area of expertise, the likelihood of recovery, and they may do it both ways actually: they may underestimate likely recovery, and they often may give an overly
C optimistic picture, and that is part of geriatric practice of adjusting patients and their families to the likely outcome, and families often may have a belief about what they have been told which is not necessarily what the doctor on the referring unit has told them, so it is a very complex issue, the one of expectation of recovery.

Q I just want to put this: would you agree in your experience that pain is often under-recognised and under-treated on acute hospital wards?
D A I think there is no doubt about that. I think a number of studies, and I cannot quote them to you, but have undoubtedly shown that under-treatment is well recognised.

Q Thank you. May I just ask you about deterioration generally, and we appreciate that we have seen "deteriorated overnight", whatever it might be, in a large number of cases, and sometimes there may be no detail as to quite what that means, but it would be right, when looking at the patients in question, I suppose, in any case when one is considering what
E happened at the end of a patient's life, one must not close one's mind to reasonable possibilities that significant and progressive co-morbidities contributed to worsening clinical states?
A In the patients, I absolutely acknowledge that, and I hope that was reflected in my report.

Q It is. You certainly refer to it in certain cases, but I am flagging it up as a very
F important matter. It may be very difficult if not impossible to tell in cases where the balance lay between those and the effect of opiates.
A I would agree with that. In some cases, my view, and it is an opinion, is that drugs may have placed a bigger part, and in other cases patients were clearly going to die in the near future, and whether the drugs played any part, it may have played no part, I would fully acknowledge that.

G Q In some cases, in terms of treating patients in these sort of situations, it is just not possible to control pain without the patient becoming drowsy, or even sustaining a depressed conscious level.
A No, and again I hope in some of my previous evidence, statements, I have acknowledged that point, and sometimes one has to accept to achieve pain control you do get some adverse effects. The point is one tries to minimise the adverse effects, but in some cases you may have to accept sedation and drowsiness as the price for controlling pain.
H

A Q That very often is the price in general terms, is it not?
A Yes. I think it is further complicated by the fact that end of life patients become drowsy even without drug treatment, so it is not even clear always that it is the drug treatment.

Q You are dealing with something I was going to proceed to clarify with you and I think you now already have, that that may be part of the end of life process?
B A Yes.

Q May I just come to double effect. I know you have touched upon it and I am not disagreeing with what you have said, but is another way of expressing the proposition with regard to double effect in this way: if measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable, provided the doctor's intention is to relieve the distress and not to kill the patient, putting it in very blunt terms?
C A I agree with that statement. My only qualification is it applies to people who it has been agreed are at the end of life. I mean, clearly, if we have people who have got a reversible, treatable condition, and their pain is difficult to control, we would not in that circumstance give them treatment which might lead to their death. So, yes, I agree with it. I am just putting it in the context that the principle of double effect is usually discussed.

Q I am putting it in the same context myself in the way you have already indicated. You
D in your evidence put it in this way, I think: when giving opiates it is important to be aware of the adverse effect of respiratory depression; if the patient is at the end of life it is not the same issue. It may be a necessary consequence of end of life---
A Yes, absolutely.

Q It follows, I think, in terms of post mortems, or anything of that kind, in relation to patients, it may well be that toxic doses of drugs and their metabolites could well be present
E at the time of death in patients who have been appropriately treated.
A Yes. I do not think drug levels would have been particularly useful, and I do not believe I comment on them in any of my reports. Drug levels are more of help where one is uncertain about what has happened or the cause of death in unusual circumstances. So I do not think they would have provided any particular insight into these cases.

Q No, I am not suggesting they would, but that is a fact, is it not, that that is what you
F may well find as a result of---
A You may well find high levels of opiates in patients at the end of life. Indeed, you would expect to in certain cases.

Q Yes, as you have already indicated. Although in fact the administration of opiates, subcutaneous analgesia obviously in this case, may have played a part in a sense in the patient's death, it is not something that people normally put on death certificates.
G A I think I acknowledge that in the discussion of one particular patient, yes.

Q I think you are aware of the fact that the view was, in terms of increasing doses of opiates, that doubling the dose, in general terms doubling the dose, where an increment was needed, appears to have been a generally accepted rough guide?
A Generally accepted incorrect view compared to the guidance that was apparently referred to, but, yes, I have heard statements to that effect, so, yes, I would accept that those
H

A statements were made, and I also believe again people did hold that view, although it was not what was recommended best practice, but I agree with that, yes.

Q I am mentioning it specifically because it is one of the things Dr Reid talks about when he gives his evidence.
A I understand, yes.

B Q In terms of the conversion I appreciate you have been saying one has to try and keep track of which one is the right one to use. You either use a third or a half, and I think you would probably be aware of the fact that in the Wessex Protocol or in the Palliative Care Hand book it says the conversion rate is a third to a half depending, in effect.
A I thought it actually said it was a quarter to a third ---

Q Shall we just check?
C A I did check on this point specifically. I think the half I did put in my reports, but I could not find a guideline which specifically recommended a half, unless I have misread the Wessex protocol.

Q I may have got it wrong, so shall we just check, while we are at it?
A I think it is page 9. Opioid equivalents was where I took it in the Wessex - yes, sorry, page 9 of the labelling of the guideline itself, where it says: "Broadly equivalent to
D Oramorphine 30 mgs diamorphine subcutaneous 10 mgs".

Q Would you look at page 8 of the guidelines on that same page, on the left hand side, where the column is headed "Use of morphine". If you look at item 7 that is where I have got that figure from.
A Sorry, yes, you are indeed right, it was there. So there is a conflict between what it states there and what it states on the page, but in my reports I did include the half. I have
E corrected my reports to allow for that reference.

Q You do and you have done in your evidence, and when we get to cases where one has to go into the conversion figure, you will forgive me if I use a half.
A It is perfectly reasonable to, yes.

Q Anticipatory prescribing, just as a general topic; we will be looking at it with regard to
F individual patients. The fact of anticipatory prescribing is not something you would criticise?
A It depends what drugs we are talking about and in what context, but I discussed how anticipatory prescribing is done for some drugs all of the time.

Q Yes, I am concerned obviously in this case with the opiates that we are considering. In general terms there are perfectly sensible reasons for doing it.
G A There are circumstances in which to make a prescription for an opioid on a p~~u~~rn basis would be reasonable. I think when we get to discussing subcutaneous infusions, I may have a particular view about that.

Q Well, I am going to confine it to that, if there is no further qualification in relation to analgesia other than subcutaneous. I am asking about subcutaneous analgesia. I think you may have been present when Dr Reid gave his evidence where he said he had come across it elsewhere and he said we do so, or they do so, on the palliative care ward at Queen Alexandra
H today. Do you remember that evidence being given? It does not matter if you do not.

A A I do not particularly recollect that statement from him, but, of course, I accept it.

Q And he indicated that, of course, his view was that that was good practice, if there was somebody who was very frail or had been seriously ill, and the doctor did not know what direction their course was going to take. Would you agree with that view or disagree?
A My experience from talking to palliative care physicians is certainly most palliative care settings where a patient is on oral opiates might well put in the provision to move to
B subcutaneous infusion at the equivalent rate if the patient becomes unable to swallow. That is an appropriate prescription and strategy. I think the issue is around opioid naive patients who are put on PRN subcutaneous infusion prescriptions of diamorphine and midazolam. Where I indicated this was not a practice I was familiar with or had seen or heard of in elderly care ward settings, I did certainly think there might well be a case for one-off PRN doses of subcutaneous drug, I indicated in an opioid naive patient indeed why starting an infusion would not really be the best strategy because you would take some time before you had
C a response, so I think one has to differentiate between patients who are taking opioids orally already and those who are opioid naive.

Q There is no difficulty if, in fact, the intention is that the prescription written for subcutaneous analgesia is only going to actually be administered when the appropriate stage has been reached.
A And if there is discussion with a doctor - yes.
D

Q And obviously - and I do not see any dispute about this, whether it is best practice or not the objective is to prevent the patient suffering unnecessary delay in the administration of subcutaneous analgesia?
A Yes, and the whole issue then becomes it is not just a prescription it is the environment and the framework in which that prescription is going to be used and how it is going to be used which is the issue as to whether it is a safe prescription or not.
E

Q But if that is the understanding, that it is only going to be administered if the doctor is able to authorise it, for example, if the doctor is not available but can say "Use the anticipatory prescription I have written up, no problem"?
A No, absolutely. But I emphasise this was not a practice I had seen in the sort of elderly care rehabilitation ward ---

F Q You have said that. In connection with the same topic, if you like, of anticipatory prescribing or proactive prescribing or whatever phrase one uses, is this something which does occur in relation to cases of patients who are terminally ill either at home or in a nursing home? That an experienced practitioner, a doctor, would have to make an assessment of the appropriate starting dose of opiate to control the symptoms until their next visit?
A Now you are asking me to comment on an area I do not practise in in nursing homes or the community so all I would say is that again that seems to me a sensible strategy, to have
G anticipatory prescribing which can start with some check with the doctor. That would be safe, sensible prescribing.

Q It may be perhaps common sense; I appreciate your expertise. And of course in such cases the actual appropriate starting dose, because of delays and the problems that go with those sort of situations, it might by necessity be a larger dose than would actually be used in a hospice or a palliative care unit?
H

A I have some trouble with this in applying it to this setting because there was one and a half sessions of out-of-hour support where the staff could, at the very least, get what should be fairly quick phone contact to discuss an issue, and I would have thought, even for a general practitioner on call with their other duties, one would expect them to be able to attend within a period of, say, four hours, maybe slightly longer, depending how busy they were with other patients, if that were needed

B Q There may be a lot of practical problems associated with it and one cannot, without running a film, as it were, of everyday life at Gosport War Memorial Hospital, be precise about that, but there is a perfectly reasonable issue to take into account in terms of trying to ensure that patients do not suffer unnecessary pain and that their pain relief is not unnecessarily delayed?
A Yes, but if one has set up this system of anticipatory prescribing to relieve pain quickly, you should not need larger doses than one would be starting if one had immediate medical
C attention. That surely is the point of it.

Q No, not in anticipatory prescribing in that sense. You are using an anticipated starting dose, alright?
A OK.

Q It is important to bear in mind, and this is another general issue with regard to patients
D in the sort of conditions or situations we are dealing with in this case, that pain and restlessness, once controlled, do not remain at a static controlled level, do they?
A No, they vary, and that is the whole point of why one needs to monitor symptoms and adjust treatment upwards or downwards.

Q And in general terms the patient's condition continues to change as death approaches?
A Yes. You would expect it to, in fact.
E

Q Part of the process of dying?
A Yes.

Q And the few days before death are anything but a stable situation, for the reasons we have just discussed?
A Things can be stable with a steady slow deterioration or they may not be, and I would
F fully acknowledge that point.

Q We are all operating on the basis that things can be very different with different patients, and the deterioration might be very sudden; it might be unexpectedly prolonged?
A But you need a system to be able to monitor and adjust treatment to relieve symptoms.

Q Of course. That is the importance of nurses, keeping observation on the patients when
G they are the only treatment staff in a general sense available, because as the body symptoms shut down changes occur which require constant monitoring?
A Yes.

Q Another generality I think, that has probably already been covered by you in your evidence, is that poorly controlled pain is more difficult to overcome and control than inadequately controlled pain.
H A Yes ---

Q May I just add one thing for you to deal with? I think you were indicating yourself in your own evidence, unless I have got my recollection wrong, that analgesics are more effective in preventing the development of pain than they are in the relief of established pain, is that fair?
A I am not sure I put that forward in my own evidence but there is work that certainly supports that concept in terms of the basic theory of pain and in practice of anticipated pain, if you are going to do a painful procedure on someone you give analgesia beforehand, so it is a well-established principle and there is evidence to support that. I am not a pain specialist. In this area of practice in the elderly again there is no specific data about it but the general principles we would apply to a frail elderly group as well.

Q And then this: in terms of transfer it is another general topic I want to address in this way before we move on to individual patients. You have already indicated how the event of the transfer itself may cause a deterioration in a patient, and you also indicated that, generally speaking, patients would recover to their former state having got used to their new surroundings after two, maybe three days. It depends. It is not every patient who, as it were, continues to go downhill as a result of the transfer. But there are patients on whom the transfer can have that effect, are there not?
A It can do, but I think it is important to emphasise you are certainly trying to minimise this and this is one reason for not transferring medically unstable patients or patients who are at high risk of deterioration on transfer, and this is an important part of the selection. You do find patients who have deteriorated on transfer and I could talk through whether that was the transfer itself or something that happened during the transfer, or just that they would have deteriorated, and I think we saw that in some of these patients, if they had not been transferred because of their underlying medical problem, so it is again a complex range of causes for deterioration.

Q And we have obviously got one case in this case where a patient was transferred in such a hamfisted way, or whatever the right expression be, that that itself caused a problem?
A Yes. Absolutely.

Q But it is something that doctors receiving patients would obviously be aware of as a possible problem as regards a deterioration?
A I think everybody working in this setting would be aware of this issue, yes.

Q Whether with a sigh of relief or a sigh of despondency I am now going to turn to the individual patients.

Patient~A, please. Sir, what I am going to do is stick to the same order. It may be that issues will be thrown up in the course of this but I am going to try and go through it in the same way as we have already. There seems to be no other sensible way of doing it. I am going to try to use the summaries wherever possible. I think there may be a couple of occasions where I need to refer to an individual note within the file itself but I am hoping we can use the chronologies.

Patient~A, Leslie Pittock. We have been through the history more than once, depression and the other problems that there were in this case, and I am going to move, if I may, to page 9 of the chronology, please, which takes us to 4 January, the review by Dr Lord setting out the

A situation there, chronic resistant depression, et cetera, and we can see towards the bottom of that same page the last box on the left in correspondence Dr Lord saying:

> "Has recovered from recent chest infection, but is completely dependent with Barthel of 0. Eating very little, but will drink moderate amounts with encouragement. Overall, prognosis poor. Happy to arrange transfer ...",

B et cetera. Well, "overall prognosis poor" - one never knows, of course, but is an indication that in the view of Dr Lord this patient was unlikely to get better and unlikely to live for any significant period of time.
A And I think any geriatrician looking at this from the information would fully agree with that.

Q Then on the admission on the 5th on page 10 of the same document, one can see what
C the situation was in relation to that general position, "Poor physical condition", say the transfer details and so on, Dr Barton's description of the situation when she clerked that patient in, as it were.

Over the page, page 11, I would like to ask you about the drugs the patient was receiving prior to transfer.

D I think, sir, what happened in one of these cases, and it may be this one, is that we had a replacement page but to avoid my having to write out a whole series of notes I kept the same document, but I think at the top of page 11 in red it says "Drugs patient was receiving..."?
A Yes.

Q "Sertraline, lithium, diazepam, and thyroxine". Sertraline --- ?
E A --- is an antidepressant. It is a mood stabiliser usually used in depression with mood swings.

Q Diazepam we have covered already; thyroxine we have covered already.
A Yes.

Q What would be the effect in general terms, if you can give an opinion about it, if those
F drugs were withdrawn from a patient like this, because there was an antipsychotic element?
A There are two issues. If we start with sertraline. If you withdraw most of the antidepressants, there is a risk of a withdrawal syndrome. So general recommendations now, which I think were not so much in place at this time, are to withdraw gradually and to halve the dose for a period and then stop. So you can get agitation and you can also get obviously a recurrence of depressive symptoms, but we know this man is already depressed on an antidepressant.

G

Q I am envisaging an immediate stop. The result would be a risk of increased agitation.
A There is a potential risk of that and also with lithium, if it stabilised his mood and one stops it, there clearly is a risk, if that was having a useful effect, that mood swings could be worse as well.

Q Then the next drug down on that same page on 8 January is where Dr Barton
H prescribed Arthrotec, a painkiller which you said was perfectly appropriate to prescribe.

A Again, the withdrawal of that, just treating it in the abstract for the moment, means a likely increase in pain, does it not?
A If it improved his symptoms to begin with, and I am not sure we are clear whether it did or not. I comment that the issue of stopping drugs in people who are frail and deteriorating is actually quite good practice to see if they are having a useful effect, because you may only be getting adverse effects from these drugs as well. Lithium in itself can produce problems if it is at toxic levels and antidepressants can certainly suppress appetite
B and produce other problems, including agitation. So the decision to stop these I think was entirely reasonable and appropriate.

Q We have the note which was added to the original version, on 9 January, when he was reviewed by Dr Barton, the painful right hand and so on:

"Try arthrotec. Also increasing anxiety and agitation ? sufficient diazepam ? needs
C opiates."

So the doctor is considering whether his condition may require the administration of opiates, a perfectly sensible consideration to have in mind. Do you agree?
A Yes. I think I commented that one would first perhaps want to try codeine if he has not had that, or an opioid at the middle of the analgesic ladder.

D Q Then 9 January, "Generalised pain". Do you see that?
A Yes.

Q Would you go to the entry with regard to 10 January, "Reviewed by Dr Tandy", where she says, "For TLC".
A Yes.

E Q As you described it yourself, having considered this situation in your evidence, you said anyone who saw him – we are talking about 10 January – would realise this man was near the ending of his life.
A Yes.

Q Would you just help us with that? Dr Tandy is saying what she found:

F "Will eat and drink. For TLC
Telephone call with wife – agrees in view of very poor quality for TLC."

Why would the realisation be that this man was nearing the ending of his life? Could you just explain that?
A Because he has had a significant deterioration in the previous weeks and it is in the context of a long history of difficult, disabling depression. Now he is losing weight, he is
G becoming increasingly frail, he has less function. Functional decline is one of the biggest factors predicting death in an older population. And he has pressure sores. So the picture is very clearly pointing to a continuing path of deterioration.

Q As you have indicated, it was reasonable for him to be prescribed Oramorph and commenced.
A Yes.
H

A Q So you have no difficulty there with the administration of that opiate.
A No.

Q If we go on in relation to the drug charts, still relating to 10 January, the Arthrotec is discontinued on that day. Yes?
A Yes.

B Q We have dealt with the question of the effect of that. Then comes the point where Dr Barton prescribes anticipatorily diamorphine, hyoscine and midazolam. You indicated with the dose range of diamorphine here, if the starting dose was appropriate – if the starting dose was appropriate – then that range is not something one would take exception to, 40 to 80. Assuming 40 was the right starting dose, you indicated it would not be a problem in terms of the range of the dose.
A I did. I think the concern I had was with the starting dose in the context of the
C morphine dose prescribed.

Q I appreciate that, but I just wanted to make sure that was right.
A There is a range; a two-fold range gives an appropriate leeway for the nursing staff to adjust.

Q In terms of issues between us, no problem. Just that limited issue.
D A Yes.

Q You have dealt in your evidence with the normal subcutaneous conversion and you indicated you were criticising that. I think you indicated it should have been, say, 15 if he could not swallow and then a two or three-fold increase to give leeway, getting to, say, 20 to 30 at the top level. If the prescription had been 30 mg, you would not quibble with that.
A Well, 30 mg would be 90 mg of oral morphine equivalent. Let us take the half
E conversion as referred to in the Wessex protocol. 30 mg over a 24 hour infusion is 60 mg. So if he had been receiving prior to starting the infusion half of that, say 30 mg of oral morphine, that would be an appropriate range, but I think it was a large increase compared to the morphine he was receiving.

Q I am just trying to see what the difference is. If you are allowing for the fact that because his symptoms are not being controlled by the Oramorph, therefore when you start off
F the subcutaneous analgesia, you are aiming to take care of that by an increase.
A Yes.

Q You are also allowing for the fact that the sertraline and the lithium and the Arthrotec have stopped. What figure are you saying ----
A He was on 30 mg a day. I think I have covered this in my report. 30 mg of oral morphine. If we take the half conversion, 15 mg of subcutaneous morphine, and if one
G allows for some increase in that – and here, is it 50 per cent we are taking, is it – I indicated that the appropriate lower end if one were converting would be 10 or 15 over 24 hours.

Q But supposing Dr Barton had prescribed, say, 30 mg, you would not quibble with that?
A If he was not having adverse effects at the time, no. But I think this prescription was instituted of course before – we do not have the date – but my understanding is that that was
H instituted before he had received the doses of morphine.

Q This is an anticipatory prescription. The first time it is administered is on the 15th. This is on the 10th. The first time the diamorphine is administered, and it is administered at a higher level still, is on the 15th. So five days later. To anticipatorily prescribed diamorphine like that, had it been 30, say 30 to 60, you would not be saying that was unreasonable?
A Well, it is too high. It does not allow an appropriate starting dose.

Q Too high by only a very small margin.
A An anticipatory prescription is being made. At the time, one is yet to see his response to oral morphine. So you need to have a lower band of that which would reflect the fact he might receive the lower dose that he has been written up for, which was, looking back to those prescriptions, 5 mg and 10 mg doses. So you would want to have the lower dose of that prescription for anticipatory prescribing to cover the situation to give the appropriate lower dose.

Q The logic is this, is it not? Here is a patient on such and such a dosage of Oramorph. I am concerned that the situation may be reached where his pain and distress may be such that he will need a subcutaneous analgesia administration at some time in the future.
A Yes. He may have problems swallowing , so one needs to move from the oral route to the subcutaneous route.

Q Assuming there is a reason of course for the switch, the odds are, it is very likely that if the switch takes place or when it takes place, the Oramorph will no longer be working at that same level, that he will have reached a higher pain level. Does that make sense?
A Possibly, but not necessarily. The main indication to switch is the inability to swallow, not lack of pain control, because one can deal with that through increasing the oral dose, as we have discussed earlier.

Q Let us go to 11 January. Would you look at that as a starting point? I think it may be page 14. Do you see there where Dr Barton has prescribed 80 for the diamorphine?
A Yes.

Q So it has gone up. Dr Tandy was indicating that the fact of the anticipatory prescribing, although she said she would not have started that high, was a reasonable thing to do in a functioning unit where you trust the nursing staff.
A My concern is not the anticipatory prescribing. In this instance, it is the dose, the starting dose. I do not criticise. It is reasonable, if you are establishing a patient on regular morphine, to have a strategy to be able to convert them to subcutaneous infusion should they need it.

Q You indicated in your evidence by way of general proposition that this man is dying, but your concern was that the levels were too high.
A Yes.

Q You said there is a note that he has anxiety and agitation, so a good indication for those drugs, but difficult to separate out the cause of his anxiety and agitation. Yes?
A Yes. So my conclusion was an appropriate starting dose would have been at 15 to 20 mg or 30 mg if he was showing signs of still being in pain.

A Q If we can move on, please, to the 15th, when 80 mg of diamorphine was administered and midazolam 60 mg. You indicated that you could not find any clear indication in the notes for going on to the syringe driver. I think that is right in this case. Yes?
A Yes. There is no information that said why there was a need to change from oral morphine to subcutaneous infusion. That could have been recorded in either the medical or, more likely, the nursing notes, since the nurses were initiating the prescription.

B Q You can see the note underneath that in relation to 15 January:

"Now unresponsive. Unable to take fluids and diet."

A Yes. My comment was more, we were not clear about what his status was before he started. He may well have not been able to swallow, but the notes do not give a description of that.

C Q I accept that. You can only go on what is in the notes. "Pulse strong and regular". That is an indication that he is not suffering from over-sedation or respiratory depression.
A No, I would not accept that. You can have respiratory depression without impairment of circulation and you can have sedation without impairment of the circulation.

Q Of course, just trying to analyse the situation, if he had started on 20 to 30 mg
D diamorphine and, say, 10 midazolam, just to give a basis, and he had ended up two days later on 80 mg of diamorphine and 60 mg of midazolam, there would not be any complaint about the course, would there?
A If he had restlessness, we know he is in pain and he starts at those lower doses and that was described and there are continuing observations which indicated he had continuing symptoms and there were appropriate increases that were reasonably consistent with the guidelines or showed that they were still needed, of course one would have no questions
E whatsoever.

Q So it is not the level that eventually he reached, it is the progression which is your concern?
A It is the starting point and the problem of the lack of documentation which justifies the dosage used at any time in general. I am making a generalisation here. The problem is the lack of documentation, which leads one to be secure that there was an appropriate
F response in terms of the way drugs were initiated and then increased.

Q Professor Ford, I accept that entirely. It is a similar comment that can be made in later cases. That is the problem that is there. It is the product of a failure to keep adequate records of the reasons and so on. We can just note, however, that on 16 January at 2000 hours, eight o'clock in the evening:

G "Condition remains very poor. Some agitation was noticed when being attended to. [Seen by] Dr Barton."

That is when the haloperidol is added.
A Yes.

H

A Q I just want to make sure I understood your evidence. You are not objecting to the addition of the haloperidol. I think you were indicating that you thought it was high in the circumstances. Is that correct by way of summary or not?
A My concern was the use in the context that he is already on a high dose of midazolam. It is unclear whether there has been any response to that. The haloperidol is certainly an appropriate response if he has agitation. That is not recorded in the medical notes. We have this one entry which I am not sure is before or after, but presumably relates – one can
B interpret that the nursing staff had reported agitation and then Dr Barton had prescribed the haloperidol as a response to the reports of agitation. So I do not think I was overly critical of the dose – I do not think I was critical of the dose of haloperidol that was given; it was in the context of the other drugs.

Q If we go on to the 17th, we can see the increase to 120 for the diamorphine.
A Yes.
C

Q Then on that same day, the note underneath the section setting out the drugs, against the name "Douglas", one of the nurses:

> "09.00. [Seen by] Dr Barton medication increased 08.25 as patient remains tense and agitated, chest very bubbly."

D The significance of that? Is that something indicating ---
A At this point, he is clearly having problems with secretions and it would be appropriate to give hyoscine. We again have some evidence that he is agitated and so it was reasonable to treat that symptom.

Q He is remaining tense and agitated having been on 80mg of diamorphine for two days; something for a doctor to consider in terms of increasing the analgesia, to do something about
E that?
A Well, the difficulty is that the opiates could be indeed contributing to the agitation, or it could be he has got uncontrolled pain. It is very difficult to be certain what is the cause of the agitation, but obviously one of the issues is the opiates could be in part contributing, or it could be his underlying problems of depression and the agitation from that, and you have alluded to the problem that the withdrawal at this point of his antidepressant drug could be a factor, and I would acknowledge that, so there is a number of different causes, and the
F response to treat that with antipsychotic drugs I am not critical of.

Q No. Can we move on, please, because what the picture was, this man, whatever he was suffering from, if he was, from any kind of respiratory depression, or any kind of over-sedation, remained in the situation that he was for a number of days. Indeed, it was not until 24 January that he died. We have to bear in mind, of course, that Dr Briggs saw him at a certain stage. If we move on to 20 January---
G A I am not sure he saw him. I think he was contacted about him.

Q Well, I think a verbal order on that evening and then he saw him the next day, I think.
A Oh, okay, my apologies.

Q I think that is right. I may have misremembered it.
A No, there is an entry, he did see him, you are quite right.
H

Q What happens is the nurses are concerned about his state, his agitation; they contact Dr Briggs, who is on call, and he does, which I think is something which everybody accepts is totally sensible, he says, "Well, take away the haloperidol and increase the Nozinan".
A Yes, and I thought that was appropriate because of the undesirability of prescribing two antipsychotics at the same time.

Q He gave his reasons for doing just that. So he says that over the telephone, and there is a note, which does not appear on the chronology, immediately above 21 January, if we move to 21 January, and it says there, in a note, which is one of the notes in terms of the collection shown by nursing care plan:

"Now unable to cope with dietary or fluid intake".

That is what is set out in the nursing care plan:

"Please give regular mouth care."

A Sorry, I---

Q It is not on the chronology. I am just pointing it out to you as a little bit of history. Then we move to 21 January. Dr Briggs, who does make a visit:

"Much more settled. Quiet breathing. Rate 6/min. Not distressed. Continue."

He told the Panel that although that is obviously a slow breathing rate, he did not form the view that he was respiratorily depressed, as he said he would have made a note of it if it was, and he was content that the treatment that was being given was appropriate.
A I find it difficult to accept with a respiratory rate of 6 per minute that any doctor would claim he has not got respiratory depression. I am not saying he did not need at this point necessarily the drugs to achieve symptom control, but he has respiratory depression.

Q What he said was, "I checked his respiratory state. I did not conclude he has respiratory" – I cannot quote his exact words – "or that he was over-sedated", and in his view, obviously by his note, the treatment should continue.
A The treatment may well need to continue, but he has got respiratory depression if his respiratory rate is 6 a minute. It is not normal.

Q Well, all we can do is go on the evidence of Dr Briggs as to what he did or did not do and why. May I just pause, Professor Ford, because I think that may be all I need to ask you about this patient, and I want to just check. (After a pause) That is all on Patient A. I move on, if I may, to Patient B.

THE CHAIRMAN: I am getting non-verbal signals, Mr Langdale, from the Panel. I think we will take a break at this point and then come back to the next patient, if we may. So fifteen minutes, please, ladies and gentlemen. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Langdale.

A MR LANGDALE: Professor Ford, Patient B, Elsie Lavender. Again, I will try to use the chronology at the front of the file if possible. This is the lady who fell down the stairs at her home address. On the very first page of the chronology there is an indication of X-rays being conducted initially on arrival at Haslar. I am simply going to mention this to you, I think probably if only to discard it, but there is a note, and I will give the page reference, I am not asking people to turn it up, but in A&E there is a note, the reference is actually page 130, where whoever examined her in A&E has put "Cx spine" and ticked it, which indicates on
B the face of it no problem with the cervical cord, or spine, on the face of it.

A Sorry, X-ray cervical spine or cervical spine?

Q You had better look at it because you will know what it is.
A I think I did look at it. 130?

Q I am not suggesting it is necessarily of any significance at all. 130.
C A I now have it. I agree, what that refers to, I think they have clinically checked the cervical spine, I think that refers to, not that they have ordered a cervical spine X-ray.

Q No.
A I mean, I still think this lady most likely had, and I know other experts think, a neck injury – if not fracture, contusion to the cord.

D Q I appreciate that. I just wanted to establish with you your view. That is of no particular significance because it is somebody in A&E carrying out a pretty basic check.
A Yes.

Q Right.
A I mean, I think, just to expand on that point, that was good practice by the A&E doctor. At that point it was not clear she had any problems with her hands and arms, so they
E would have checked her cervical spine in somebody who had had a significant fall, so a very good assessment.

Q Then moving on to page 3 of the chronology, just to take notice of the fact that really throughout her stay at Haslar she has got problems with pain.
A Yes.

F Q Halfway down that page, in the box last but one, last two lines:

"Regular analgesia given with poor effect."

Over the page, page 4, it is a continuing picture with regard to the pain, just in general terms?
A I do not think it was really sorted out at this part of her stay the cause of the pain, and it might have been neuralgic pain rather than musculo-skeletal. We just do not know.
G

Q Then on page 5, looking at the date of 16 February when Dr Tandy saw her, she concluded:

"Most likely" – that is the way she put it – "problem is brain stem stroke leading to fall."

H

We know from the documentation that she apparently was told by the patient she had had her neck X-rayed, so she, Dr Tandy, assumed it was normal, just to cover the picture.
A I did not know that.

Q That is on one of the letters we looked at, it is page 935, and saying in that letter "not sure we will get her home but will try" is a comment she made.
A Yes.

Q The Panel have already heard about that. You have indicated in your view you thought a stroke unlikely, symptoms were not typical, more likely a fracture of the spinal cord, a cord injury of some sort. Then we can go on to page 6, where she is seen by the physiotherapist and so on, and the other problems are set out. We can go on to page 7 of the chronology, and may we just look at the admission to Daedalus under Dr Lord, "Reviewed by Dr Barton". You have indicated already, and I do not need to take it up with you any further, that that was a reasonable assessment and you would not expect Dr Barton in the circumstances to challenge the brain stem finding.
A No.

Q For obvious reasons. Now, in relation to that, just in general, looking at not only the previous descriptions of the condition of this patient, but also the summary by Dr Barton, she has obviously got co-morbidities, correct?
A Yes. She has got diabetes, and she is---

Q AF, atrial fibrillation, which appears earlier on, I think.
A Yes.

Q The blindness, and so on.
A Due to cataracts, yes.

Q It is clear, when she is Barthel 2, she is obviously pretty dependent. In general terms, chances of recovery small?
A Well, I am not sure I would agree with that. The reason is she was managing independently at home, limited mobility around, she has had an acute event. This is where the whole issue of what the diagnosis is becomes important, but let us accept that the working diagnosis, probably wrong, is that this lady had a brain stem stroke, it is really too early; she has not got a major deficit at this point, but you would say this patient has rehabilitation potential. I mean reasonable: she was obviously precarious at home beforehand.

Q Yes. All right.
A Sorry, I am trying to paint my view of it. It is certainly a completely different picture from the last patient. I mean, this is somebody who has potential.

Q I am not suggesting it is the same.
A Yes.

Q We can see that Dr Barton is obviously allowing for the possibility of her improving:

"Assess general mobility ? suitable for rest home if home found for cat."

So it is there as a consideration.

A A Yes.

Q Then we move on, and there is no problem with what was prescribed by Dr Barton. She does not go, as it were, straight to Oramorph.
A Yes, very reasonable.

Q Dihydrocodeine. There is no issue between us. 24 February, page 8, the pain is not
B controlled properly, and then there is the progression to MST, all right?
A Yes.

Q You said you do not usually convert to MST from DF118, but I do not think that is going to be an issue which is going to---
A No, it is not optimal, but I am not going to ...

C Q I think in the Wessex guidelines it looks as if you can, but you are not saying it is not usually---
A I would not be particularly critical of it. It is just you do not know what pain control this lady needs at this point.

Q You are making the point that the MST is slowly absorbed---
A It will take a while, yes.
D

Q ---and so on and so forth, but once she is on the MST, as it were, no problem about that. We can see that it still does not achieve the effect of controlling pain, correct?
A I think at this point, this is where I think there should have been an evaluation when you are failing to get pain control in somebody who has had a fall, it is attributed to musculo-skeletal injury, and that was one of the aspects I was critical of.

E Q Yes. In a lady born in 1912, so she is 83, who has had a pretty massive crashing fall, you might well still expect pain from that, might you not?
A You should not be expecting it to be worsening at this point. You should be expecting some recovery if it is general musculo skeletal injury, you know, bruising and the like.

Q I see. Anyway, the pain is not controlled. She is seen by Dr Barton. I am not going
F over every entry, but on page 10, 26 February:

> "Not so well over [weekend]. Family seen and well aware of prognosis and treatment plan. Bottom very sore ..... Institute [subcutaneous] analgesia if necessary."

The nursing notes record that she was seen by Dr Barton, the same way.

G

> "Son and wife seen by Dr Barton - prognosis discussed. Son is happy for us to just make Mrs Lavender comfortable and pain-free. Syringe driver explained".

Then the prescription is written up for the diamorphine, over the page on page 11, anticipatory, right, and you say starting dose there too high?
A I do.

H

Q I am not going to go over the calculations, but you are saying if you calculate in the way you would have thought appropriate it is too high. Can I just check in relation to that whether there is a particular point I need to put to you. Would it be sensible to bear in mind that this is a case where transfer of somebody who had a pre-existing illness, with a significant event in terms of the major fall, followed by transfer, might well have a very serious deleterious effect on her condition, that series of events, in any event?
A My reading of the information we have got in the notes was that this lady had not deteriorated. She was very dependent prior to transfer and she was at a similar level of dependence at transfer, unless I have misinterpreted the information. So the process of transfer did not appear to have resulted in a deterioration in this lady. At the point when Dr Barton and the nurses assessed her on arrival at the ward, she seemed, as far as one can tell, very much like she was the day before she left the ward.

Q Going on the notes that we have got.
A Yes.

Q All right.
A If she had a cervical cord injury, and was, you know, taken on a long ambulance journey – I do not know how long this journey was – that might well have worsened the pain she was getting.

Q Then on page 12, 1 March 1996, we have to remember, and I do not think there has been any alteration to the document, but the Panel have been reminded that on 29 February, so the day before that, Dr Barton was contacted because the nursing staff had raised an issue about her blood sugar level. Does that---
A I am not sure I covered that in my report, but---

Q I do not think you did, and this is not a criticism. Can we just look, please, to register the fact, at page 1022 in the file itself. We can see that on that page 1022, about two-thirds of the way down, can you pick up the date 29 February?
A Yes.

Q "Blood sugar at midday 20mmls. Dr Barton contacted. Ordered 10 units", is that?
A "actrapid stat", and that was an appropriate response.

Q So there the nursing staff still keeping a check on things.
A Yes.

Q Dr Barton is contacted, sensible response in relation to that particular condition.
A Yes.

Q Then the pain goes on, as we know, and you have already said. Then on page 13, if you would, of the chronology, the date 5 March, the note by Dr Barton "has deteriorated over the last few days", the note did contain and should reflect in this chronology but it is not there, "not eating or drinking".
A That is in my report. I did notice that, yes.

Q I am sure it is. It is just a reminder that the entry was:

"Has deteriorated over the last few days. Not eating or drinking. In some pain. Therefore start subcutaneous analgesia. Let family know".

Bearing in mind you say, well, I think there should have been an examination, further consideration as to what was causing the pain, that response in terms of subcutaneous analgesia, bearing in mind your reservation, of itself is not something you would criticise?
A If the indication for opiate was appropriate, and that would depend on the nature of what was being treated.

Q Yes.
A But if the opiate was helping control her symptoms - I mean my criticism of the case is the lack of evaluation of either the pain or the cause of the pain, and she is not eating and drinking, and I comment that may have been an adverse effect in part from the opiates; to convert to an equivalent subcutaneous dose to achieve pain releases an appropriate action.

Q It may be that the deterioration was because of her general slow process ---
A It may be.

Q --- towards terminal decline.
A Well, it may be, but this is a lady who has not got a progressive illness. The natural history from stroke is to recover unless you get a complication, which was what the working diagnosis was here. I fully accept she is elderly and frail and it may have been a general deterioration, but there should have been some thinking about that.

Q By this stage with a lady in this state what, then, were the options? For her to do what?
A Well, re-examine, re-think why is she having the pain, has a fracture been missed in her shoulder? Is it actually, as I was indicating, neuralgic pain? At this point there should have been a re-think about the working diagnosis because stroke does not, certainly not at this stage in general, present with pain, so it cannot be that. She has had a fall, yes she has injured herself, but, again, we are some weeks on from that so you should not be getting pain from that unless there are complications, so that would be what I would expect in somebody who has not got a progressive malignant disease or other life-threatening problem at this point ---

Q I do not want to cut you short but what actually would you do?
A Oh, sorry. You would examine the patient, you would look for focal tenderness, you would look at their movement, you would examine power to see if there was any neurological deficit, you would consider whether to re-X-ray. I think at some point having gone through that process there would have been a thought, actually, this maybe does not look like a stroke, particularly because of the nature of the symptoms, and then discussion with a consultant or specialist ---

Q Can I move on? Supposing the decision was that she needs an X-ray, and the X-ray revealed some kind of cervical problem.
A Well, I think she would have needed an MRI scan, as I indicated, because an X-ray in itself of the cervical spine would not necessarily tell you what was going on with the cord. Now that would have needed her to be transferred back. I think at this point there was a question what was going on, and you have a choice. You either try to determine the underlying diagnosis because she is not recovering or improving as one would have started to expect, or you could look at the patient and say: There is no prospect of recovery here. I do

not see that that was the case in this lady but I did not see her, I was not there, but I think there should have been a discussion about what was happening in this lady at this point.

Q Yes, and it may be that the product of that discussion would have been: "There really is not any intervention that is sensible --- ".
A It may have been. For example, if it was a neck problem she might have had a collar applied, that might have relieved her symptoms. If it was a nerve entrapment you might have tried carbamazepine or other, a drug approach to controlling symptoms. There were a number of things that might have been done. I mean, she clearly did not seem to be responding very well to opioids.

Q And your point is that the admission of subcutaneous analgesia was at too high levels, assuming it was the right thing to do?
A Yes.

Q We can notice that in that situation the subcutaneous analgesia was commenced on the 5th at about 9.30 in the morning, and there was further deterioration which you say may be the effect of the opiates; on the other hand, it may not, correct?
A Yes.

Q And we can see that the time of death is recorded at 9.28 that following day.

I am going to pause for a moment because I think that may be all I need to question you about in relation to that patient. It is.

Sir, I do not know what time the Panel was thinking of adjourning but I was going to try to deal with Patient C, and it may take up the rest of the time that is available. I am in the hands of the Panel.

THE CHAIRMAN: I think the Panel can still absorb another patient today.

MR LANGDALE: Good. Professor Ford, one more patient for today, Patient C.

Again, trying to use the chronology, we have touched upon this lady already in relation to an earlier issue about something in your report. She is the lady who had a diagnosis on 6 February 1998, "probable carcinoma of the bronchus and depression", and then we need to look, please, because I do not think this has made its way on to any version of the chronology, in the main file, if you would, for Patient C, page 299. It is not a very good photocopy, Professor Ford, but looking at 12 February, do we see in that top section in what is the third paragraph down:

> "In view of advanced age: Aim [something] management should be palliative care. Charles Ward is suitable",

I think it says.
A Yes.

Q "Not for CPR", and then the following day, still at the hospital, there is a reference to a discussion with the son, and the last section of that I think is probably all we need to look at:

A

"Discussion with son, explained probable ca bronchus. Agrees not suitable for invasive --

A -- treatment."

Q This is something you touched upon in your evidence when we looked at this?
B A Yes.

Q And then the remainder of it I will not trouble you with. But we need to bear that in mind on 12 and 13 February in relation to this history, and we can move on with regard to general deterioration and so on, please, to page 4 of the chronology which at the top, before she gets into Dryad Ward, has a review by Dr Lord:

C "Confused and some agitation. Says she is frightened. Not sure why. Tends to scream at night. Not in pain. Try thioridazine."

Transferred to GWMH on 27 February and the diagnosis is given there on the transfer form from the hospital requiring total assistance and so on.

Would it appear that she is on the palliative care route?
D A I think very much so and everybody agreed. Nobody would disagree this was not appropriate.

Q And then "Reviewed by Dr Barton". I do not think we need to go through it all but at the end of it she is saying:

E "Get to know. Family seen and well aware of prognosis. Opiates commenced. Happy for nursing staff to confirm death",

and you have described that as entirely reasonable. The rationale was not described but you made no complaint. Use of opiates if she is not showing pain we have covered already because you made the comment in your report that in cases of this kind it might be appropriate. Then on page 5, the drug chart showing the prescription of Oramorph, you are not making a criticism of that, right?
F A Correct.

Q Over the page, page 6, we have the duty doctor calling on 28 February; Oramorph was being given with no relief, and a doctor - I think Dr Laing - sees her. She was asked whether she had pain: "Yes, on movement", the next box down. The Oramorph continues. On to page 7, please, and we can see on page 7 on the night, it appears, of 1 March she had problems:

G "Slept well but calling+ [out]. Shouting from approximately 5.30. Spat out all medication."

Then Dr Barton sees her on what, in fact, is a Monday, Monday 2 March:

H "No improvement on major tranquiliser. I suggest adequate opiates to control fear and pain. Son ... seen",

so there is nothing you criticise about the proposal with regard to opiates?
A No.

Q And obviously over the page, in fact, Dr Lord, as it were, confirms that same view.
A Yes.

Q She approves opiates and it is clear that one is talking about terminal care now?
A Yes.

Q Which, again, you have made clear. The fentanyl is commenced that morning.

"Very distressed this morning. Seen by Dr Barton",

She has an intramuscular diamorphine injection, appropriate.
A Yes.

Q "Seen by Dr Lord" - you have already indicated that is alright.
A Yes.

Q You indicated that the fentanyl was appropriate, you could understand the rationale, it was not unreasonable, it was quite a high dose.
A It was a big increase, as best as I could work out. I think I was not entirely sure when certain doses of opiates had been received, although I think that has been clarified now, but it was a big increase so there was a risk it might be more than was required to control her symptoms.

Q But obviously something that had been sanctioned by Dr Lord in terms of that fentanyl patch?
A I cannot remember if the use of the fentanyl patch had been discussed with Dr Lord.

Q "Reviewed by Dr Lord. Spitting out thioridazine. Quieter on PRN SC diamorphine. Fentanyl patch started today."
A So Dr Lord had seen that and was aware of it.

Q And Mr Jenkins helpfully reminds me that at page 272, we do not need to turn it up, on the drug chart she signed the fentanyl prescription.
A OK.

Q So, if anybody is making a note of this, page 272 shows that the prescription is written by Dr Barton and signed, but also Dr Lord's signature appears there as well, or her initials do. Then Dr Barton writes up a prescription - it is not administered on that day, it is undated I think - for diamorphine, midazolam and so on, and you indicate that the notes do not indicate specifically that she was in pain and the notes do not actually record any terminal restlessness.
A Yes.

Q And you gave us some calculations. You indicated that the fentanyl patch would reach its peak 24 hours after administration?
A Probably at least that but it would certainly take longer than would morphine.

Q You say there is no indication if the patch was removed. If it was removed there would still be some effect, am I understanding that correctly?
A There would be a sustained effect which would be longer than ---

Q You take it ---
A Yes. The BNF which we looked at at the beginning of my evidence said "can take up to 17 hours for it to fall by 50 per cent".

Q And then the administration of the diamorphine at 20, midazolam at 20 on the following day, 3 March. "A rapid deterioration of condition" says Sister Hamblin. "Neck and left side of body rigid - right side flaccid".
A Yes. Meaning weak and low tone.

Q I know what it means; I was not sure of the pronunciation. What is the indication?
A Well, that may indicate she has had a stroke or, as I said when we discussed this patient she may have had a cerebral metastasis and there had been swelling around that in the brain which produced weakness. Those are the two most likely causes.

Q So if the patient was demonstrating terminal agitation and restlessness, then it would be reasonable to prescribe midazolam?
A It would be reasonable to start prescribing midazolam. Again, we have commented before that guidelines would suggest preferably starting at a lower dose of 10.

Q And here what happened on 3 March might well have happened in any event without the administration of the subcutaneous analgesia?
A Yes.

Q It might have happened in any event without the ---
A This lady was clearly deteriorating, so the deterioration I think I acknowledge might have happened. I say again drugs may contribute and the indication was not well-explained or recorded, but the deterioration - she had a lot of opiates at this point with both the fentanyl and the infusion.

Q Maybe it played a part: maybe it did not.
A Yes. You could not conclude in this lady that her death was clearly ---

MR LANGDALE: I think we have covered those general issues already and I am not going to repeat them.

Thank you. That is the end for that particular patient. Sir, that is the last patient we deal with today. I am confident that I will be able, without unduly rushing, taking care I hope of the proper issues, to complete my cross-examination about the remaining nine patients before the end of tomorrow.

THE CHAIRMAN: You will be on your own then, Mr Langdale!

MR LANGDALE: I am sorry. On Monday.

THE CHAIRMAN: I think you have made excellent progress today. Everybody has. Thank you very much. We will break now and we are returning, Professor, for 9.30 on Monday. Thank you very much indeed, everybody.

(The Panel adjourned until 9.30 a.m. on Monday 13 July 2009)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 13 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWENTY-THREE)

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.
Tel No: 01992 465900)

INDEX

THE CHAIRMAN: Good morning, everybody. I trust you all had a good week-end. I understand, Mr Kark, that the railways have presented us with a problem.

MR KARK: Yes. Unfortunately I have had a message from Professor Ford. His six o'clock train from Newcastle broke down. It had to be towed back to Newcastle. He is now on another train, but his estimated time of arrival at Euston is 11.15 and then he hopes to be here at 11.30. He is going to update me if he has any more delays or better information. Obviously many apologies for that.

He also wanted to apologise for not having come down last night but he had to cover for a colleague who is ill and so he could not do anything other than get the six o'clock train this morning. One has to say, up till now, that has not proved a problem but today, typically....

THE CHAIRMAN: It is always a risk, but we understand the circumstances. It is particularly unfortunate since it is he who has the timing problem in terms of his own evidence. I hope that that is not going to present too much of a problem but, as I indicated before, if the thumbscrews need to be applied, then they will be.

MR LANGDALE: Part of my very good week-end was spent reviewing really quite how much more I had for Professor Ford on the remaining witnesses. As I have indicated to my learned friend already in conversation this morning, I think I shall be able to move through them in terms of the issues I have to raise with Professor Ford fairly rapidly. Certainly had we started at 9.30, there would have been no questions but that I would have finished well within today. I am hoping that despite the late arrival – and I know it is not his fault – it will not throw the timetable out too much, and I would have thought there is still a reasonable prospect of completing his evidence by the end of tomorrow, which I seem to remember was the critical point.

THE CHAIRMAN: That is good news. I must say, it did appear to the Panel that a lot of the issues appear now to have crystallised and speed is picking up, which is useful. The time will not be wasted from the Panel's point of view. We are going to remain now and we will be reviewing the evidence which has already been given by Professor Ford, and doing any other reading that might assist us. It is not entirely wasted.

MR KARK: Looking forward just for a moment, hopefully we will finish Professor Ford by tomorrow evening. There is one further statement to read to you. I do not want to take up time doing that now because we are still waiting for information in relation to that, as to how much of that we have to read. The reading of the statement will take some three or four minutes. Then that will be the close of the GMC's case.

Can I just mention that there was an issue that you will recall about identifying a particular nurse. I think it is Nurse Collins whom we were looking at. We believe that that is being dealt with by the defence. The GMC are not proposing to call further evidence about it.

Once the GMC case has closed, there may have to be a period, as it were, of reflection as to whether there need to be any submissions made in relation to any of the heads of charge. Then, of course, we have to remember we have Dr Lord set up for a video link. My recollection is Thursday and Friday morning. Mr Jenkins tells me it is nine till one – thank you. It is really a matter for my learned friends and the Panel whether they wish to start

Dr Barton and interpose Dr Lord, or pause and wait for Dr Lord's evidence. Perhaps we'll see where we are on Wednesday but we will be very much in the hands of Mr Langdale.

MR LANGDALE: What Mr Kark has just said gives you the general possibilities, as it were, that we have been considering between ourselves. I think it is probably preferable if Dr Barton begins her evidence even if we have had a morning of Dr Lord or maybe Dr Barton starts her evidence on Wednesday, depending on what the issue is in regard to submissions. In any event, I would suggest that is preferable. It may be that if Dr Lord is dealing with matters on Friday morning through till one o'clock, it may be that if her evidence has not quite completed by then, we might be able to use the telephone because the Panel will have seen her and there is no problem about communication in that way – we have already done it once in the hearing. It may be we would run into Friday afternoon. I do not know – one has to bear in mind the time difference and the situation that Dr Lord would be in giving evidence, her time some time after midnight, I think. I cannot quite figure it out. May we leave that open? There is a possibility therefore that Dr Barton might not start her evidence until next Monday. There is, however, another defence witness whom we will need to try to interpose, who will not be available from Tuesday of next week onwards. It may be we will be seeking to interpose her evidence in the course of this week.

Neither Mr Kark nor I are concerned about the interposition of evidence from further defence witnesses while Dr Barton is either waiting to give evidence or is giving evidence in chief. The problem that might arise would be if it were in the middle of cross-examination, when we would be in a different situation, but I do not think that is going to arise.

THE CHAIRMAN: I agree. I think we keep it fluid and we cross bridges as and when we come to them, but it is always helpful to have a view over the top, as it were, as to what may be ahead of us, and we are grateful for that.

MR LANGDALE: May I also just add in terms of the long term view, defence evidence, whatever happens at the end of this week, it will certainly take up all of next week and we imagine the week after, very roughly speaking. I think that is what the Panel ought to have in mind.

THE CHAIRMAN: You are aware that the 23rd is a non-sitting day.

MR LANGDALE: Thank you. You have reminded me. We have been told.

THE CHAIRMAN: That is very helpful. Thank you very much indeed. As I say, the Panel will now read independently and we will resume as and when the Professor arrives.

MR JENKINS: May I just add something?

THE CHAIRMAN: Yes, Mr Jenkins.

MR JENKINS: I have made up a number of indexes. I have an index of the evidence that the Panel has heard already. It is just a chronology. It is done in three different ways. I have not shown it to Mr Kark. I will do that, and if he is content I will make sure you have that this morning. Also, the statements from Dr Barton that you have received, you have not had them for patients C, D or L – Page, Wilkie or Stevens – but for the others, there are a number of references to entries in the medical records and nursing records. I have not, I am afraid,

completed it but for those where I have been able to give you page references to cross-refer to paragraphs, I will make sure that you have those – again, once Mr Kark has seen it and if he is happy with those. It seems to me the Panel will be going through those statements, will see things that they have not seen before and will want to cross-refer to the medical records in each case. Again, if Mr Kark is content, I will hand in those that I have done, hopefully in the next ten minutes.

MR KARK: So far as the latter document is concerned, we are very happy for the Panel to have that. If corrections need to be made, we can make them. It is not going to be a contentious document. It simply correlates what Dr Barton is saying with patient notes, so we could not object to that.

THE CHAIRMAN: We are very grateful then. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everybody. Professor, welcome. We understand the problems that you have had. There is no need to go into them. We will go straight now to Mr Langdale.

GARY ASHLEY FORD
Cross-examined by MR LANGDALE, Continued

Q Straight off the train and into questions about patients again, I am afraid.
A That is fine.

Q I am turning to Patient D, please, Alice Wilkie. Again, unless I say to the contrary I will be using the chronology sheets every time, and I will refer you to things if I need to. This lady has advanced dementia and UTI problems, just by way of very broad summary. We can pick that up on page 2, for example, of the chronology on the 1 August 1998:

"81 yr old lady with advanced dementia."

There is a mention of UTI. Then perhaps we can move on to page 3 of the chronology. There is a section in the middle of that page dealing with the drugs and QAH on 1 August. I just want to make sure I have understood you correctly; that there is haloperidol being prescribed there and indeed administered. Did you indicate that in your view that was on the high side?
A I indicated the maximum dose would be a very high dose to give a frail, older person but the initial starting dose of 2.5 mg is reasonable. The maximum dose comes from the British National Formulary. That is where the prescriber has taken them from.

Q Yes, thank you. Page 4, then, please. On 4 August, still at QAH, reviewed by Dr Lord. Just to clear up one little point, one can see that she has said the overall prognosis is poor. That "+" sign, which we looked at when you gave your evidence in chief, looking at the note, it is clear it is an "and"?
A Yes.

Q It is not suggesting "Prognosis poor ++", so it is clearly an "and".

"... too dependent to return to Addenbrooke's..."

and so on. Then over the page, on page 5, the transfer to Daedalus. Dr Peters is the doctor who clerks her in, and the remarks – the referral letter – half way down that page ends with pointing out:

"Mentally she is dependent and needs feeding."

Then, over the page we carry on with some of the notes made at Gosport War Memorial Hospital. On page 6 we can see that the medical history is summarised as:

"... advanced dementia, urinary tract infection and dehydration."

It goes on to say:

"Patient has dementia – withdrawn + does not communicate."

I am missing out the next few words. Then:

"Appetite: Poor. Does have pain at times, unable to ascertain where."

A similar note just below that:

"Does have pain occasionally but cannot advise us where."

And you have already given your evidence about the difficulty with patients with dementia. It may well be they are in pain, but unable to communicate precisely where and so on. We can then see on page 7, on 10 August the review by Dr Lord when she is in Daedalus.

"... if no specialist medical or nursing problems D to a N/Home."

In fact, obviously that did not turn out to be the case.

"Very need, not expected to return to Addenbrooke"

is the CPN note on the same day. Then, over the page to page 8, 17 August:

"Deterioration recorded"

it says in the contact record.

"Condition generally deteriorated over the weekend. Beed"

that is the nurse, Philip Beed, from whom the Panel heard evidence:

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

It is clear then, would you agree, that the deterioration was taking place without any administration of opiates at that stage?

A A Yes, at that point she was not on opiates.

Q It is an example of precisely what can happen. That leads to a difficulty, does it not, in relation to opiates once they are administered in the patient who has been deteriorating, deciding quite what degree of deterioration is due to the opiates or not?
A Yes. I think particularly there is no additional description of what the deterioration constituted, so I agree with you.

B

Q Thank you. You yourself made the comment: "This is not a lady where an aggressive intervention was going to occur," and we then come on to question of the prescription which Dr Barton wrote out in case this lady was going to need the administration of subcutaneous analgesia - right?
A Yes.

C Q Because we note that the first administration is in fact on the 20th, so I think it is three days later. Nothing wrong with the doctor writing that up by way of a safeguard for a situation which might arise?
A There is nothing wrong with writing up analgesia if it is required, but the prescription of a continuous infusion I am critical of, because it would be usual to prescribe as required single PRN doses of diamorphine, subcutaneously, if the patient was not swallowing or Oramorph if they are able to swallow, depending on what their status was. The problem, as
D I have discussed before, is that one cannot determine what this lady's opiate needs are. The majority of frail, older patients dying in continuing care need low doses of PRN analgesia. I looked at the paper you referred me to last week and indeed that point is made in that paper. It is not the prescription of analgesia which is being criticised here; it is the very high starting dose and wide range, as of before, for both diamorphine and midazolam.

Q Your same point as it were in terms, if you like, of the character of the prescription.
E A Yes.

Q You indicated in relation to the situation on the 20 August, you said in your evidence that there was not any indication of pain in relation to the administration of the diamorphine and the midazolam. All right?
A It was not recorded in the days preceding the commencement of that. Obviously I note that there was a description she was in pain some days before.

F

Q Yes. The thing that I do not think has been drawn to your attention is that on the date in question when the diamorphine was administered, on that day, and before it was administered, the daughter of this particular patient – that is Marilyn Jackson – was in the hospital and her mother had indicated to her she was in pain. As a result of that she was so concerned about it that she summoned a nurse, who said, "We'll give her something," and it appears that after that, that is when the subcutaneous analgesia was administered, so there is
G an indication of pain and that was the response by the nursing staff.
A Yes. I may not have picked that up if it was recorded in the nursing notes, but clearly if the relative had expressed that, I would considerable appropriate give analgesia.

Q It is not your fault.
A No.

H

Q Because it was not in there. That was the evidence the Panel have heard and you just do not have the information about it. I am not complaining.

Q And I think the use of diamorphine again I would not criticise if the patient was not able to swallow. It is a matter that the dose and starting point I would be critical of.

Q Because you said yourself, one would want to see a record of the rationale.
A Yes. I accept that.

Q I am not going to go through that. We can see on the 21st on page 9 the entry by Dr Barton:

> *"Marked deterioration over last few days. SC analgesia commenced yesterday. Family aware and happy."*

The nursing note following that:

> "Patient comfortable and pain free."

Then the administration is recorded in relation to the 21st of diamorphine and midazolam and she died that evening. You expressed the view that the drugs may have contributed to the deterioration but you cannot conclude that the effect of the drugs was, as it were, to play a part in death in the other sense?
A Yes.

Q She was going to die in the near future, I think were you words?
A Yes.

Q May I also just indicate to you the evidence that the Panel heard from that same witness, the daughter, Marilyn Jackson. She had indicated that she was in pain on the day when the subcutaneous analgesia was first administered and she was very sleepy. It appears she was very sleepy before the subcutaneous analgesia was administered. Again, that is consistent with the general deterioration, presumably. "In pain", I have already put to you, and she also said, "If I had known my mum was in a lot of pain" – and she probably was in her last few hours – "and someone had sat and explained the benefit of the syringe driver, maybe things would have been different." So it appears there is another indication from somebody that this lady was in significant pain towards the end of her life?
A Yes. I think the clear justification has not been recorded for the use of the sedative midazolam, and my criticism is not of the prescription of diamorphine if there was indication of pain, which there clearly was from the evidence presented to the Panel, it is the high starting dose, which was beyond what she required in terms of not seeing a response to more usual doses one would use in this age group.

Q Well, again we face the same difficulty, if a smaller dose had been applied and sometime later the pain was still there one could easily reach the level which was eventually administered.
A Yes, but I think the problem I have with that is clinical practice, you have very few patients who go to this level. I mean, after you had asked me the question last week, at the weekend I went and looked at all the diamorphine prescribing on three wards – continuing care ward, Walkergate Hospital rehabilitation ward and the stroke unit – and I looked at the

59 patients who had died in the previous eight months, and 19 had received opiates, which was about a third, which accorded with what my anecdotal impression was, and of those 19 only 4 had received doses more than 5 mg over a 24 hour period, and the highest dose was 20 mg over 24 hours, so this is a very high dose that you would not normally require to achieve pain control in terms of usual clinical practice.

Q So none of the patients you looked at in that sense, and I appreciate this is just looking at it from a particular point of view, and I am not going to attempt to go into any kind of detail for obvious reasons, so none of them were in the stage of Mr Pittock, who for several days required rather higher doses than any of those?
A Some of them were. Some of them had been on fentanyl patches for a long time, but most had required opiates just in the last day or two of life. I cannot conclude that this lady definitely would not have required 30 mg every 24 hours of diamorphine if it had been titrated up to that, but my view would be it would be very unusual for a patient like this to require that amount to achieve symptom control, and I think there still remains the issue of the midazolam and the lack of clear indication for that if she did not have terminal restlessness.

Q Very well. May I move on, please, to Patient E, Gladys Richards. This patient, we can see at the beginning of the chronology, was assessed on 4 February 1998, bearing in mind she was transferred to Daedalus Ward some months later, some six months later, and I am not going to go through all of the history, but I do want to pick up the first entry here, if I may:

"Assessed by Dr Banks."

The Panel heard evidence from Dr Banks.

"Severe dementia. Deteriorated since Christmas."

I am not going to read out all the rest of it, but he mentions at times being quite agitated and distressed during the day. This is the note where one has to add – and, sir, I think we gave the reference of page 110 in the nursing notes – Professor Ford, end stage illness, you may remember that expression we looked at; not surprising, there are considerable periods when she is asleep; obviously needs some help to relieve the distress she experiences when awake. Just this, please: end stage illness, when that is noted with regard to a patient suffering from severe dementia who is deteriorating, what does that encapsulate?
A I think to most geriatricians that would be describing someone who has severe dementia, and in the latter stages one sees increasing frailty, less activity, less food intake, often the patient develops further wasting and becomes more withdrawn, and one is anticipating they will die within a relatively short period of, say, weeks from usually bronchopneumonia or other complications.

Q Well, that gives us the general picture. I appreciate there may be variations patient to patient.
A Yes.

Q Then this lady unfortunately, as we can see on page 2, had a fall, but no apparent injuries, and then a rather more serious incident on top of the history we have just looked at; she is taken into the Royal Hospital Haslar after a fall where she fractured the right neck of her femur, and we can see the history that goes on for some period of time. Perhaps we can

move on, please, to page 4, because we now move into August of 1998, when she was reviewed by Dr Reid:

> "Confused, but pleasant and cooperative. Able to move left leg freely. A little discomfort on passive movement of right hip. Sitting out in chair. Should be given opportunity to try to re-mobilise. Will ..... transfer to GWMH."

Dr Reid's evidence was that he felt her prospects for remobilising were not good; perhaps understandable in the circumstances.

A I think anybody would agree with that.

Q Then over the page, please, page 5, the transfer to Daedalus, and this is the case where, on the referral, the top of the page, "Now fully weight bearing, walking with the aid of two nurses and a zimmer frame", appears to be rather over-optimistic, perhaps, in the circumstances, and we can see on the 11th, when she is admitted:

> "Not obviously in pain. Transfers with hoist."

We can move on, please, to the next page, still on Tuesday, 11 August, the assessment notes at the top:

> "No apparent understanding of her circumstances due to impaired mental condition".

Then there is the administration of Oramorph on that day. You say you could find no rationale in the notes for morphine at that point, co-codamol would have been appropriate, but you can understand, can you not, a doctor considering in these circumstances that Oramorph might be appropriate in relation to somebody who had had an operation of this kind and in that situation?

A Well, I think my view I expressed was only if one could not obtain adequate pain control with paracetamol and codeine, or other similar milder opiates, mainly because of the problems of confusion and drowsiness that the morphine might result in.

Q Because it would appear, because the Oramorph is not continued, the next administration is the following morning, before there is any further problem the Oramorph stops, and you can understand a doctor feeling that a lady in this state, having just been transferred after an operation of this kind, thinking that Oramorph might be appropriate to give her the best possible pain relief and a happier state of mind?

A Well, I still think it would be unusual if the patient was not on morphine when they were transferred from the unit to escalate the level of analgesia unless there had been a clear change in the patient. I do not think that would be usual practice in an elderly care rehabilitation ward setting. What one nearly always does on transfer is continue the medication that the patient is on at transfer and then review after a day or two how they are managing on that, and at that point, if she was not controlled with the analgesia she was receiving, you would escalate it there, but I do not think it would be practice – I know what you are saying, that here was a lady with severe dementia, towards the end of her life, are opiates reasonable? It still is not usual practice. One would look to give PRN analgesia, paracetamol and codeine, and only go to morphine if that was not working.

Q All right. Well, one can only say---

A A That is why I can only express what is my experience of how we would work in most elderly care settings.

Q All right. Then moving on to the next day, we can see that Oramorph was administered the following morning at 6.15, and then, although Dr Barton prescribed further administrations, they are not administered, so the Oramorph is stopped, which obviously you would say was sensible if it did not appear to be being needed?

B A Yes.

Q Then, as we have heard in other evidence, the following day this unfortunate lady has a fall of some sort in Gosport, and Dr Briggs is contacted. He advised an X-ray and analgesia, and there is no criticism of that obviously.

A No.

C Q Over the page, as a result of that Oramorph is administered, and you are not critical of that, as I understand, in the circumstances?

A No.

Q We can see Dr Barton prescribes PRN in relation to that, that is in relation to haloperidol, perfectly sensible if that was needed?

A Yes, very much.

D Q So there is no issue there.

A No.

Q Then the 14th, the next day, which is a Friday:

"Reviewed by Dr Barton.

E Sedation/pain relief a problem. Screaming not controlled by haloperidol but very sensitive to oramorph ..... Is this lady well enough for another surgical procedure? ..... Appears to have dislocated right hip. Referred for relocation."

Dr Barton, again not surprisingly, would you agree, considering asking herself the question, "Is this lady actually up to a further surgical intervention?" In fact, she did go back, but a

F perfectly legitimate consideration for a doctor to have?

A Yes, and absolutely the right action was taken in discussing that with the orthopaedic team.

Q Then carrying on with that, because she goes back to the Haslar in the circumstances, some Oramorph was administered, again there is no criticism about that, before she goes back, and then readmitted, as we can see on page 9. I am going to move on, if I may, please,

G to page 10, where we see the notes which refer to what drugs were administered at Haslar. You can note at the tope of page 10 in red "Drug charts (Haslar)". That shows that she was given 2 mg of midazolam, and that is intravenous.

A Yes.

Q So the effect of 2 mg of midazolam intravenously is what, if you can put it in a sentence or two?

H

A A Well, when midazolam is usually used, it is used intravenously, and it has a different effect from giving it orally or by slow infusion, and it is used as a pre-medication or a sedative to assist in procedures, because the high concentration you get through administering intravenously means you get high uptake into the brain for a short period, and then that what we call redistributes out of the brain back into the blood, so it is very good at giving a short period of sedation and amnesia, and that is why it is used for inducing anaesthesia and for gastroscopy.

B

Q Yes.
A So what was unusual with this lady, what we are commenting on, is normally after giving 2 mg you would expect, with the redistribution, for her to wake up an hour or two later, and what they are describing is that she remained unresponsive, sedated, for a long time after this 2 mg dose.

C Q That administration was obviously in connection with the surgical intervention that was taking place.
A Yes.

Q There is obviously no question of it being appropriate, and so on, but can you just by way of comparison assist us; that is the effect of 2 mg of midazolam injected, a bolus. 20 mg of midazolam over 24 hours; now, is it sensible to try and think of any comparison as to the
D actual effect on the patient, without making an over-precise calculation?
A Yes. I think the point is that after an hour or so the 2 mg midazolam would be distributed in a similar way in the body as if you gave 2 mg very gradually, so what it is saying is, the clue is that she is very sensitive, this lady, to midazolam.

Q Yes.
A Now, a lot of older, frail people are very sensitive, and it is why the starting dose used
E now is recommended to be 2.5 mg, and even back in the 90s the starting dose, as we have seen in the guidelines, was 10 mg, and that is because some older people are very sensitive. So 20 mg over 24 hours given by subcutaneous infusion, you cannot really compare the two, but the clue was there from the 2 mg that she would likely be very responsive to any infused midazolam.

Q If it is not a sensible comparison I will not pursue it with you, because the situations
F may be in effect rather different.
A It is very different. If the midazolam was indicated for having restlessness, you know, when she had adequate analgesia, the problem in my view is the high starting dose at 20mg and the failure to then adjust the dose if she did become very sedated. You could say that taking account of the response to the 2 mg, best practice would have been to reduce it even further, but I think actually they are two very different circumstances and I would not be
G overly critical in not necessarily incorporating that response when then prescribing midazolam. My criticism is of the very high starting dose.

Q Well, that is the point you make throughout really: this is too high for a start---
A Yes, but I would not criticise Dr Barton for not necessarily taking account on board that – I mean, I think one would have to be very au fait with everything that had happened, pick this up, and I think that would be quite difficult, and I do not think I do criticise.

H

A Q I do not think you have sought to do so in your evidence so far. Then can we move on, please, to the 17th on page 10, still on the same page, "Transferred back to Daedalus", reviewed by Dr Barton, who says, last couple of lines:

"Only give oramorph if in severe pain."

Obviously no criticisms about that?
B A No.

Q The doctor obviously being well aware of the situation there. Over the page to page 11, there is an administration of Oramorph when a nurse receives information that she is in pain. Again, no criticism there?
A No.

C Q So that was Nurse Couchman, from whom the Panel heard evidence, and the Panel heard evidence about the circumstances of the administration of that Oramorph. As you yourself have said, it is very clear this patient was in pain. Then can we move on, please, to page 12, 18 August, Dr Barton:

"Still in great pain ..... I suggest [subcutaneous] diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable."

D

Then the nurse Philip Beed has a record of what had happened in relation to the discussion with the daughters, their agreement to the use of the syringe driver to control pain and to allow nursing care to be given. She was peaceful and sleeping.

"Reacted to pain when being moved – this was pain in both legs."

E That is at 7 o'clock in the morning. We can see over the page the prescription that Dr Barton had written with regard to the diamorphine, midazolam and haloperidol. The following day, the 19th, we can look at the administration of the drugs on that day as well. So if one tries to look at the calculations on 18 and 19 August, particularly the starting point, it looks as though she had had in the previous 24 hours, including the dose of 10 mg administered twice in the early hours of the 18th, by the end of those administrations she had had a total of 45 mg Oramorph in that 24 hour period.
F A Yes, that was my judgement.

Q That is exactly the figure you came to.
A Yes. You said you could not find a reason for going subcutaneously, but if there was a difficulty swallowing that might be a reason to switch to subcutaneous.
A Yes. It is just that that was not recorded in the notes that I could see.

G Q No, of course. It is clear, is it not, that the Oramorph really was not enough?
A Yes.

Q Therefore, if you were following the calculation which appears to be the accepted calculation, then, in those days, at that time, halving the Oramorph takes it down to 22.5 mg, and then you allow for some uplift because of increased pain, 40 mg would not be an excessive figure in the circumstances, would it?
H

A A No. In my report, as you know, I referred to a 50 per cent increase in dose as reasonable, which would equate to about 35 mg and my comment was that I would consider the dose infused was high but not unreasonably so and careful monitoring was required.

Q I do not think there is essentially any core issue between us. At that point in your evidence you deal with the 2 mg of midazolam intravenously at the hospital, Haslar, which I am not going to go over with you again. You have indicated at this point that the clinical
B situation has changed: a very gloomy picture unlikely to improve. Correct?
A Yes. There was no apparent new problem. It was in place. It was, in my view, unlikely – I am not an orthopaedic surgeon – that intervention would have been thought about in a patient like this.

Q Then I do not think there is anything else I need to ask you about your evidence in relation to that. You have indicated in terms of her death that the predominant cause of death
C in this case was dementia with the hip fracture. Again it is difficult to say what part the administration of opiates and the midazolam did or did not play – no doubt playing some part, inevitably, because of the state of the lady.
A Yes. She clearly required end of life palliative care, in my view, at this point. I am mainly, as you know, critical of the midazolam that was prescribed and administered.

Q I think I have covered with you those points with regard to that patient, so I am not
D going to ask you anything further on Patient E.

Move on, please, to Patient F, Ruby Lake. The chronology in the case of this patient starts in January 1998 and she is somebody who does not get to the Gosport Ward Memorial Hospital until August, so we can look at the history fairly rapidly, I think. Again this is somebody who had "background problems," as the way I am going to put it. On 24 February 1998 osteoarthritis, rheumatoid arthritis and gout, impaired renal function, and she seems to get a
E lot of joint pain. Just a very general picture on that first page. Over the page, we can see how this unfortunate lady had a fall. On 5 August, on page 2 she goes into the Royal Hospital Haslar with a fractured left neck of femur. She is 84. She had MI three years ago, no residual angina, and various other matters are set out there. On page 3, still in August, she was reviewed by the physiotherapist on 6 August. It says "Currently unwell" and there are various problems with regard to chest observations, and then we see "LVF" – left ventricular failure – on the bottom of page 3.
F A Yes.

Q Over the page, she was commenced on analgesia to wean her off the patient controlled anaesthesia.
A Analgesia, I think that is.

Q Analgesia – I beg your pardon. Again, you have explained that, and I do not think
G I need to go into that any further. We can see the history going on. At the top of page 5, in relation to the heart history,

"Became breathless on movement from commode to bed. Given some oxygen."

This appears to be associated with the heart problem.

H

A A Yes, it seems most likely. There is a question whether she had heart failure or infection, but it seemed there was an overall impression at the end that there was significant heart failure.

Q Thank you. Then there are the problems that she also had recorded on 8 August. Towards the bottom of the page:

B "Unable to tolerate nursing on side ... Paracetamol given for pyrexia. Agitated at times ..."

Over the page again, to page 6, 9 and 10 August are dealt with there. On 10 August there was a review. Blood tests were conducted.

C *"Physio: Appears unwell today. ?MI ?chest infection."*

At the bottom of the page, again she is unwell: she is drowsy but denies pain. Chest infection is referred to and so on. "Much improved" in the afternoon. Again I think this is a case where you can see the ups and downs that happen -----

A Very much so.

D Q -- quite commonly in this sort of history. This lady is an example of it. Over the page there are various problems. I am not going to read through those, but we can take note of them. I am going to move on, please, to page 8. On 12 August, at the bottom of the page, she has improved:

"Has sat out today. Developing sacral bed sore. U+Es improving. Plan: Mobilise with physio to encourage oral fluids, stop augmentin, no IV fluids."

E Then can we move on to Dr Lord on page 9, 13 August.

"Assess this lady re future management. Post-op recovery was slow with period of confusion and pulmonary oedema. Over last two days she has been alert and well, now our intention to work on her mobilisation. Previously lived in ground floor house. Physio has visited for past 6 weeks."

F Then Dr Lord's review itself at the top of page 10. I am not going to go through that because she covers the background position.

"Ischaemic heart disease and LVF have been problems recently."

In the last few lines:

G "Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMGH. Uncertain as to whether there will be a significant improvement."

One can see the doubts that no doubt were in Dr Lord's mind at the time. The physio records in relation to the same day,

H "Unable to mobilise at present due to chest pain."

There does not seem to have been any medical assessment about that. Is that something you would query?
A I am looking back at whether there was chest pain recorded earlier. There certainly was shortly afterwards.

Q We bear in mind, of course, that it does not tell us when the physio notes were made but they appear on the same day. Dr Lord is obviously reviewing her and saying ECGs show atrial fibrillation.

"Ischaemic heart disease and LVF have been problems recently."

She does not suggest any further medical assessment, does she?
A No. That is her medical assessment. Physiotherapists often will not appropriately mobilise patients if they complain of chest pain or significant breathlessness which is atypical. What is not clear is whether the physiotherapy was documenting that chest pain which then leads to the subsequent nursing note talking about central chest pain. What may have occurred here is that the physiotherapist went to mobilise the patient and noticed they were complaining of chest pain, so he or she did not mobilise the patient and then referred that to the nurses. That is what I would read is happening here, but, yes, to answer your question, the chest pain needs an evaluation of course.

Q Dr Lord you would say has carried out a medical assessment.
A Yes, and does not mention chest pain at that time, so one would assume, although she documents ischaemic heart disease, that this lady was not complaining of chest pain at the time Dr Lord saw her and it may be that she developed chest pain when the physiotherapist was attempting to mobilise her.

Q What I am getting at is there is the medical assessment. I appreciate it is difficult to know quite when it occurred, but Dr Lord is just assessing the position and not suggesting that anything further needs to be done medically.
A In terms of further investigation at that point, no.

Q Thank you.
A I agree.

Q As you say, over the page, on page 11, "Unsettled night overnight. Continues to be very restless" and so on. The spray was given. You said that was to relieve angina, if I remember.
A Yes.

Q When reviewed by the physio the next day she is brighter and managing to walk a little but more. Again, part of the general up and down picture we have been talking about. Over the page, please, to page 12, on 15 August, the Saturday:

"Left sided chest pain in the ribs ... since being manhandled. ECG – nil change, no effect with GTN."

A Then:

"Muscular-skeletal pain, consider PE or angina ... Analgesia codeine phosphate ... Consider spinal CT or VQ or pulmonary angiography."

A I think that should be "spiral" CT.

B Q Again, that is a review. Nobody is suggesting any intervention, or at least no intervention was carried out in relation to anybody doing anything. Is that fair?
A No, that is not quite the interpretation I would make.

Q Could you please make it clear. It is my mistake.
A I was not quite clear, in reading the notes, what the "mandhandled" referred to, whether it was the physiotherapist mobilising her or some other event which is not described.
C Obviously because there was no acute change on her electrocardiogram and the nature of the pain, the working diagnosis was of musculo-skeletal pain, and the appropriate treatment is giving analgesia. What the assessing SHO, junior doctor, is obviously considering is that there is a possibility that this was another episode of angina or, more worryingly, a pulmonary embolus – which is an important, not uncommon complication of major surgery. The implication there is that if the situation changed and they became more likely, investigations should be undertaken with a view to treating those. I would not interpret that
D to say that the medical view is for no intervention.

Q That is precisely what I was asking you to explain because I can very easily be misreading this in terms of the medical side. Going on to the following Monday, at page 13, 15 August was a Saturday, 17 August was a Monday. She is still in Haslar. Over the page to 18 August, the Tuesday, that is the day that she is transferred. Looking at that period of time between what the SHO had said on Saturday 15 August and another review on Monday 17
E August, nothing appears to have been done – and I am not suggesting anything should have been, but I am trying to get at the picture. There she is in hospital, somebody is raising these queries, what is done?
A I think at that point the plan was to observe her. Two things which happened prior to her transfer is that there was a spike of temperature at some point – which might suggest infection or indeed a pulmonary embolus – and she is more short of breath. But no interventions were taken or further assessments were taken in response to that, although she
F is reviewed. She is seen on the ward, and clinically she looks well. Obviously with the benefit of hindsight, one can say this lady actually was quite unstable – and we will come on to that, no doubt.

Q I was going to ask you. The same difficulty, that this is a long time ago and looking at other people's notes, but it may be in fact that it would have been wiser to keep her in hospital.
G A I think there is no question about that, in retrospect – and it is easy to say with retrospect – that this lady was not stable and it would have been preferable not to have transferred her to Dryad Ward when she was transferred.

Q This is the case where you had had something of – and this is not a criticism – a change of view. Reviewing the matter, you said you had come to the conclusion that she was not really fit for transfer on reflection.
H

A A Yes. I am not sure I had commented on whether she was fit for transfer prior to that, but my view if I was asked – and I do not think my view has changed – and as I think most people would say with retrospect is that there were clues there that she was not very stable: the spike of temperature – we would normally keep people in 24/48 hours before transfer to a rehabilitation unit on a spike of temperature – and the breathlessness. Difficult judgments as to when to transfer people, in a context where there is often a lot of pressure on beds.

B Q Yes.
A One has to make fine judgments, but ideally one would have liked the medical team who were responsible for her at that point to have contacted Dr Lord or one of the other consultant geriatricians and say, "This has happened, are we still okay to transfer?"

Q All right. We can only deal with what actually happened.
A Of course.

C Q Having expressed that view, inevitably. Transferred to Dryad Ward: there is the transfer letter talking about the slow recovery exacerbated by bouts of angina and breathlessness and so on. On to page 15 of the chronology, still on Tuesday 18 August, the review by Dr Barton when the patient was admitted:

"continuing care. HPC: Fracture"

D and so on.

"PMH: Angina. CCF" – congestive cardiac failure. "Catheterised."

Then the plan is:

E "Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death."

You indicated she had had, in your view, "a very variable medical course" up to this point. I think that was the expression you used.
A I cannot remember. I would have to look at what I said in my report. Clearly she had a very fluctuating course prior to transfer.

F Q It is just the note I made of the phrase you used, but I think it comes to the same thing.
A Sorry. The same thing, yes.

Q On admission she may well have been suffering from recurrent chest pain, which may have been musculo-skeletal in nature.
A Or angina, or another problem, yes.

G Q It may have been musculo-skeletal.
A Yes.

Q Maybe angina. And a justification, in those circumstances, would you not agree, for prescribing Oramorph?
A No, I would not. I mean, if it is angina, the treatment is nitrates and then other approaches. You would use a beta-blocker very cautiously in this patient but there are other H approaches where opiates are used for the treatment of pain due to acute myocardial

A infarction. They are not used to treat pain from recurrent angina. For musculo-skeletal pain you would use moderate analgesics, possibly non-steroidal anti-inflammatory drugs, but it would be unusual to go to opiates for musculo-skeletal pain in the absence of a major fracture.

Q On the issue as to whether there is an element of relief of anxiety and distress we have already covered the views with regard to that. We can see on page 16 that Dr Barton writes B up the anticipatory prescription for diamorphine, hyoscine and midazolam – just to take that on board as we move on. That is the end of 18 August. Over the page, on page 17, 19 August there is a record by a nurse with regard to the complaint of:

"chest pain, not radiating down arm."

That indicating that it was not a case of heart failure, is that right?
C A Not so much heart failure. Heart failure itself does not give chest pain but angina can be associated with heart failure. But what is being written there is that the pain does not have some of the features which would suggest it was angina, and radiation down the arm is one of the features. It is not invariably present. It is also "not worse on exertion," so Nurse Hallman is expressing a reasonable description of the pain and suggesting it is not likely to be angina, although I do not think he or she is trying to be a diagnostician at that point.

D Q No. But the clue there is, is it musculo-skeletal rather than angina? Would you agree? It may be impossible to say.
A I think it is very difficult to tell with this lady at this point the cause of a pain. It still could be cardiac in nature. She is not looking very well with this pain, but it equally could be musculo-skeletal, yes.

Q Therefore the situation might indeed justify the administration of the subcutaneous E analgesia?
A At this point, one of the problems was that the morphine prescription did not clearly describe what it was for. We do give opiates with acute left ventricular failure, for example, but again one would normally give it intravenously or intramuscularly so there was not a clear description in the prescription of what the indication for opiates was. But I would not be critical at this point of giving an opiate. I do not think I am critical of giving an opiate for that particular pain in that circumstance but, again, we do not know if that is controlling her F symptoms, what dose of opiate she is going to need if one chooses to switch, with good reason, to using a syringe driver.

Q We can see, just in relation to the conversion that by that time, I think she received 40 mg of Oramorph in the 24 hour period. That is the Oramorph 10 mg being given that morning, and taken the previous 24 hours – unless I have calculated it wrong, I think it is 40 which she received by way of total in that 24 hour period.
G A That may mean I have not seen all the prescription charts extracted or the information.

Q That is what it may very well mean – I have been wrong.
A The doses I have were that this lady had received a 5 mg dose at 14.15 hours on the 18th, a 10 mg dose at 15.00 on the 19th, a 10 mg dose at 11.50 hours on the 19th. So I had her as receiving 25 mg in the preceding period.

H

Q Very well. Do not worry about it. It may well be I have that figure wrong. We can check on it. It does not mean that I have to pursue any particular point with you because it is simply a question of using the mathematics to see what the conversion would be to 20 diamorphine. We can move on in relation to 20 August, the Thursday. The deterioration overnight, general condition continues to deteriorate. "Very bubbly". What is that indicating?
A Usually secretions on the chest and in the mouth.

Q So again, associated in any way with her chest problems?
A Could be or, again, could be a problem of sedation of her respiratory function and swallowing from the sedatives and opiate she is receiving at this point.

Q All right. Again, it is one of those cases where the fact that she was rousable and distressed when moved, as is recorded in that same section, appears to indicate not over-sedated, would you agree? "Rousable and distressed when moved"?
A Yes. Of course, as we commented before, there is not a good assessment of conscious level, but if she was rousable and able to communicate when moved, I would agree that would imply she was not overly sedated but the notes, again, are very poor in this respect.

Q I appreciate that at numerous points, as with other case ---
A Yes.

Q --- it is difficult to say because there is not a detailed note. You have already indicated your criticism of the increase of the dosage that took place, looking at Friday the 21st. All right?
A Yes.

Q And you have indicated that in terms of the cause of her death, you cannot conclude that the doses were the cause of her death because of her other conditions?
A I think in my view they contributed to her decline, but she had had a very unstable course beforehand and was developing new problems and could well have deteriorated.

Q And if this is part of palliative care, in other words, that the subcutaneous analgesia is justified, inevitably there may well be a part played by the subcutaneous analgesia?
A Yes.

Q As part of her treatment?
A I think the problem is, I am critical that there was not a fuller assessment of her pain, with obtaining a cardiogram at that point and more details about her blood pressure and the rate of escalation of the doses was rapid and would be judged to be excessive in terms of guidelines and not clearly justified by the nursing records.

Q That is all I need to ask you about that patient, thank you – Patient F. Can we move on to Patient G, please. This is the case of Mr Cunningham. Admitted to Dryad Ward on 21 September. We can look very briefly at the history, I think, which starts in terms of the chronology in March 1998:

"Reviewed by Dr Lord...".

A Towards the bottom of the entry there, five or six lines up from the bottom of it:

> *"Wonder if he could have had problems with intermittent left ventricular failure, but overall symptoms not too bad at present. Taking Leva-dopa for Parkinsons."*

Then various items of medication are set out. Reviewed by Dr Lord on the 19th. Over the page on 19 June, Dolphin Day Hospital:

B

> *"Low in spirits .... Breathless occasionally. Oedema not a problem. Has had two falls since moving to Rest Home."*

Various problems which we need not go through in detail.

> *"Transfers extremely hazardous..."*

C and other matters mentioned. Towards the bottom of the page:

> *"Loss of independence and mobility. Possible visual hallucinations due to medication."*

Over the page he is reviewed by a psychiatrist, Dr Scott-Brown at the Gosport War Memorial Hospital.

D

> *"Reviewed on behalf of Dr Banks...".*

Then again, another reference by Dr Lord. He is reviewed again at Gosport in July, on page 4 of the chronology. Various matters are set out. Reviewed by Dr Lord again, later on in July – page 5. 20 July at Dolphin Day Hospital, carrying on with a similar sort of picture. Then, on the sixth page of the chronology, 21 July, an informal admission to Mulberry.

E

> "Discharged to Thalassa Nursing Home..."

Various issues and problems referred to there and then we can move on, I think, probably to 21 September on page 8 of the chronology. That is a Monday, in case the days of the week matter, and they sometimes do here.

F

> "Reviewed by Dr Lord .... Admitted to Dryad.
> *"Reviewed in DDH today. Has large necrotic sacral ulcer, extremely offensive."*

As you have already indicated, the central problem at this stage essentially is, "What are we going to do about this sacral ulcer"?
A Yes.

G Q By way of nursing care and so on. Then over the page at page 9, still on this same day, Dr Lord is recording:

> *".... Very frail. Tablets found in mouth – some hrs after they're given."*

May I just ask you this: in terms of a problem for nursing care, is this something which happens from time to time with patients in this sort of condition, by way of a refusal of taking

H medication?

A A Yes.

Q Or for what?
A For old patients and also patients with Parkinson's disease, they can have problems swallowing. So you do find nursing staff reporting patients having trouble swallowing tablets, or that they have not swallowed them. They are unaware of them and been unable to initiate, in effective, effective swallowing.

B

Q And on some occasions spitting tablets out?
A Yes.

Q Which may be part of a refusal to take medication or ---
A It may be, or that they are unable to.

C Q Yes, all right. She refers in terms of the diagnosis to the sacral sore, the old back injury, depression, an element of dementia, diabetes mellitus – diet; catheter for retention. "*Plan*:" She sets out the stopping of various drugs. Dryad today and she says – we can perhaps take note in this first section on the top of page 9:

"... high protein diet, Oramorph PRN if pain."

D There is Dr Lord suggesting if in pain, go straight in – my words – to Oramorph. Would you criticise that?
A She had underlined the PRN. If you have a very large ulcer, most people would say best practice is to go through the analgesic ladder and start with that.

Q That is what I was going to say to you. If we apply the principles you referred to earlier on, you would say, "I would have thought, go up the ladder" but in your evidence you
E said that you thought it was reasonable here to go to Oramorph. I am suggesting that when one looks at these things, it may well be reasonable to go to Oramorph in a number of situations which do not necessarily follow or recorded the analgesic ladder.
A If he was in very severe pain, I think Dr Lord must have been struck by the severity of this pressure sore, but the recommendations would be to use the middle grade of the ladder first before going to opiates. She did emphasise the "PRN". She was being cautious is how I would interpret that PRN, is how I would interpret that PRN.

F

Q Absolutely, but I am just making that point.
A No, it is a fair point to make.

Q For obvious reasons.
A Yes.

G Q Perhaps it highlights the fact, and we have seen it in other patients as well, that these sacral sores, bed sores and ulceration, can of themselves and often do produce a lot of problems with pain?
A Yes, there is no question about that. They can be very painful.

Q We can see at the end of her comment, she puts "Prognosis poor," which we have already covered?
H A And we have agreed.

A

Q And I do not need to go over that any more with you. Then over the page, page 10, reviewed by Dr Barton. The Panel will be hearing in due course that I think Dr Barton, Dr Lord having reviewed in the Dolphin Day Hospital, same building, actually came down with the patient, as it were, from Mulberry Ward to transfer to Dryad Ward.

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

And you have indicated obviously that this was a sick, frail man with many problems who could – could – die suddenly?
A Oh yes.

C Q And, as you say, you would need to look at that particular note – I appreciate you were not there to see what Dr Barton did or did not do, but looking at the note, you said one obviously need to look at that in the context of him having already had a detailed assessment?
A Yes.

Q So no complaint.
A Yes.

D Q I am sorry. I think there is a mistake on the chronology there, where it says "Mulberry Ward", it should, I think, be DDH but it does not matter. I do not think it is being suggested that the patient moved from Dolphin Day Hospital to Mulberry Ward then to Dryad?
A No.

E Q And admitted from DDH. Perhaps we can just amend that: "Mulberry Ward" should be "DDH". Thank you. Would it be right to say – and I appreciate the precise point of time may be difficult to establish – but at this stage he was probably on balance entering a terminal stage? If it impossible to say, I will not press you on it.
A No. I think, going by Dr Lord's assessment, there is a common situation. You have somebody who is very frail. One can see they are highly likely to develop complications which may be fatal, but your approach is, even if there is only, you say, a ten or twenty per cent chance that you have this frail older patient, that they are going to leave hospital and get F back to their nursing home, your approach is to bring him for rehabilitation. We are down to how we use words. I do not think at this point Dr Lord – we will have to ask her – was viewing him as being on a formal end of life care pathway, but there was clearly a view, which I think any geriatrician would recognise, that that might happen.

Q Yes.
A Within a short period, but the approach being taken was an active approach to try and G heal his sacral ulcer.

Q Then we can see Oramorph was administered prior to the wound dressing. There is no criticism of that.
A No.

H Q This is on page 10 still. Then we come on to the period of time in the evening where the syringe driver was commenced. We will just need to follow through the history in

relation to this. Over the page on page 11 there is a further nursing care plan about what the situation was. It is a little confusing. I appreciate we are trying to piece together things which happened some time ago and using these sometimes brief notes but it appears, looking on the record on page 11, that he is very agitated at 17.30, if we can pick up that time.
A Yes.

Q So 5.30 in the afternoon. Oramorph 10 mg is administered – assuming this is accurate – at 20.20 – twenty minutes past eight, and he is described as pulling off the dressing to the sacrum?
A Yes.

Q We will be hearing some evidence from a nurse about this occasion, but could we move on to page 13 for the moment just to follow the history through. On page 13 there is a record made on 22 September, so the day after, and this is a record made by a nurse who had been on duty the previous night, Hallman – do you see that name at the top of the entry?
A Yes, sorry. Yes, I do.

Q Just so you know what the picture is, that nurse has given evidence that that night she was on duty and this note which is made the following morning, when she is going off duty.
A Yes.

Q And she records a conversation with Mr Farthing, the relative, and she sets out an incident which she herself had not witnessed, but what she understood had happened with regard to him wiping sputum on a nurse, saying he had HIV and was going to give it to her, try to remove the catheter and so on and later syringe driver charged at 20.20. That is what she has recorded.

> "*Contains diamorphine 20 mg and midazolam 20 mg. Appears less agitated this evening.*"

This is in fact, I think, a later note, if I remember it correctly. That appears to be the history in relation to this. You indicated in relation to the prescriptions shown on page 12, which are dated the 21st --- All right?
A Yes.

Q You could not see a clear indication of why he needed to be written up for subcutaneous infusions?
A I could not see a clear indication for why it was started. He was on opiates.

Q Yes.
A He was swallowing the Oramorph at 20.20, as you described and so there was no evidence presented that he was not able to swallow and he had only had two doses of the oral morphine so, again, difficult to know what his opiate requirement would be.

Q All right.
A So if one is saying here is a man who is being given PRN oral morphine, is it reasonable, because, as we know, he had had some evidence that he might have difficulty swallowing, albeit with tablets rather than a solution, that he might need to move to a subcutaneous route, and again my response is it would be appropriate to give PRN doses

A rather than a continuous infusion. That is my view of it. It is not inappropriate that there was some provision to be able to give a subcutaneous dose of diamorphine.

Q I follow. I think in relation to this patient he had been taken off antipsychotics. Would that influence what would be sensible to give by way of analgesia?
A Well, I think I comment in my report that it was appropriate the pain he was having with PRN opioids, if they had helped, but his agitation should have been treated with
B antipsychotic drugs, and I cannot recall what he had been taking in terms of antipsychotic drugs prior to admission---

Q To avoid delay, over the adjournment we will check and see if we can direct you to anything about antipsychotics. Just to follow through the history to get the picture as fully as we can---
A Sorry, just to answer that; certainly, if he is agitated and he has had antipsychotic
C drugs in the past and he is not on them now, your first approach would be to give antipsychotic drugs.

Q Yes, but the fact that he has come off the antipsychotics for some good reason, might that influence the dosage of diamorphine and midazolam you would think it sensible to apply?
A Well, this is a man who had agitation and behavioural problems before he had – a
D significant pressure sore is what the history is telling us, so I do not think diamorphine would be the appropriate agent to use. There is a difficulty that most of the antipsychotic drugs do worsen symptoms of Parkinson's, which is why one tries to cut back on antipsychotic drugs, and there is a fine balance to be struck there, which is difficult, so you would certainly want to control pain. You might consider using a sedative rather than an antipsychotic drug, but---

Q I was going to ask you, does midazolam then come into the picture?
E A I do not think it is unreasonable if he is very agitated. Again, my criticism is the dose used and the failure to then review the response to it. Most people would introduce a small dose of an antipsychotic if somebody was acutely disturbed like this.

Q Just to follow through the history as we try and piece it together, back to page 10 of the chronology, there is a reference again at the bottom left hand section, and this is still Monday 21st:
F

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

A I am trying to recall what "BS" stands for.

Q I was hoping you were going to be able to say because I have forgotten. Blood sugar?
G A I think it was blood sugar, and if he has diabetes that would make sense as to why they would refer to it.

Q Perhaps we can just notice the next thing:

"2 glasses of milk taken when awake."

H

A So it does not appear he was over-sedated and it appears that he could drink milk at that stage.
A At this point the driver has only just commenced. As we have talked about before, we have not got any of the accumulation and the final response one is going to see to the doses that are being administered.

Q Yes, we do not know what time he was awake, of course, it may be difficult to say,
B but some time during the night it would appear in any event.
A Yes.

Q That is as far as we can take it on that score. If we can just follow through the history, bearing in mind that he is on diamorphine of 20, midazolam of 20, as from that night---
A Yes.

C Q ---if we can move on to page 14 of the chronology to 23 September, that is a Wednesday:

"Reviewed by Dr Barton."

The nurse's note says:

D "[Seen by] Dr Barton. Has become chesty overnight. To have hyoscine added to driver. Stepson contacted and informed of deterioration. Mr Farthing asked if this was due to commencement of syringe driver. Informed that Cunningham on small dosage which he needed."

That is what the nurse has recorded. Then we look on, that same day, the evening:

E "23.00, syringe driver boosted with effect",

indicating that something had been allayed, or alleviated, yes, "with effect"?

"Seems in some discomfort when moved. Driver boosted prior to position change. Sounds chesty this morning. Catheter draining" et cetera.

F So, again indication, not, as it were – I appreciate the expression "unconscious" may mean more than one thing – but not so over-sedated that---
A Well, I think that is difficult to interpret. I mean, obviously I would not agree that he is on a small dose – the comment made by the nurse. These are quite large doses, particularly midazolam. I mean, one can be both sedated and intermittently agitated. Certainly, he is not being presented as a man who is communicating or awake, but there is a record that he was agitated and that led to certainly the midazolam being increased very substantially, I have
G from 20 mg to 60 mg, and then the following day the diamorphine was increased.

Q Yes. It would appear terminally ill at that stage on the 23rd? If it is not possible to say, I will not---
A Well, again, we have got a problem here. He has deteriorated. He has had a period of behavioural disturbance where he is awake, he is tearing off his dressing, he is throwing things around, he is being aggressive to nurses. We now have a man without much
H

A description, all we have got is he is agitated, but he is lying in bed and we do not know how alert he is, but it does not sound like he is very alert.

Q If we can move on to the 24th, over the page to page 15, the Thursday:

"Reviewed by Dr Barton.
Remains unwell. Son has visited again today and is aware of how unwell he is.
B [subcutaneous] analgesia is controlling pain just."

Well, perfectly legitimate concern of the doctor to make sure that the pain was controlled properly, correct?
A Absolutely.

Q The CPN note:

C

"Physical decline, pressure sore's developed, admitted to Dryad Ward. He is terminally ill & not expected to live past w/e [weekend] according to sister on ward."

So really the picture here is that both the day and the night staff report pain on 24 and 25 September.
A It is unclear what they are observing in their response to pain. I mean, this is a man
D who was, as far as we can see, not complaining of major pain, he was obviously thought to have some discomfort when he was seen at the Dolphin Day Hospital, and then he has escalated within a very short period, 21 September, to a very high dose of diamorphine. So it is a very dramatic change, and at the same time he has also been escalated to a very high dose of midazolam, and I find it very difficult to know what signs the nurses were interpreting as to whether this man was in pain or not.

E Q All right, but if he was in pain, let us say they are not completely wrong, this man is deteriorating, for whatever reason, background circumstances, he is clearly indicating he is in pain, and it does make sense, does it not, to increase the painkiller?
A If he is clearly indicating he is in pain, and we do not have a good record that I can confidently look at that and say this man clearly was in pain; all I am saying is it is a very high dose of diamorphine to have increased to within a short period for a man like this. I mean, one cannot say he was not; I was not there, and we do not know the exact details.
F All one can say is the notes do not provide a very clear justification and adjustment in the context that this is a very high dose for a patient like this. I mean, I think we have a general issue here that almost the commencement of the infusions marked the start of the end of life care pathway, and yet it is never very clearly described in the notes. One is trying to surmise what the thinking was of doctors and nursing staff around the use of it.

Q Can we just follow through the rest of it.
G A Sorry.

Q No, no, absolutely, what you said saves me having to ask you another question. Page 16, just to follow through the picture. This is still on 24 September:

"Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees."

H

A Now, I appreciate it does not give you any detail, but there is an indication that there is a specific site apparently for pain, at least at some point.

> "Syringe driver renewed ..... with diamorphine 40mg, midazolam 80mg ..... Dressing renewed this afternoon. Mr Farthing seen by Dr Barton this afternoon and is fully aware" and so on.

B Then:

> "21.00: Nursed on alternate sides during night, is aware of being moved. Sounds 'chesty' this morning", and so on.

Then "Peaceful night's sleep" is recorded. We can see what happens over the page on Friday the 25th, when a doctor, Dr Brook, saw him. The note:

C

> "Remains very poorly. On syringe driver. For TLC",

is Dr Brook. It does not matter, but that is another medical person seeing him. That is Friday, the 25th. Over the page to Saturday, 26 September:

> "Condition appears to be deteriorating slowly" and so on.

D

The diamorphine then at 80, midazolam at 100, hyoscine 120 micrograms in 24 hours. By way of conclusion, you indicated he was at a high risk of getting bronchopneumonia anyway.
A Yes.

Q You thought it was difficult to conclude that the drugs did not play a part in his demise.
E A Mainly because of the very high dose of midazolam he was being infused in the context of his diamorphine, but I am very critical of the midazolam, that that was progressively increased without documentation that he had terminal restlessness or marked agitation. This is a very high dose of midazolam that is being infused.

Q Had there been such a report that he remained agitated in any way, or restless in the sense that you are talking about, then the midazolam dosage might have been justified on the
F record?
A Well, I think it has gone beyond certainly the recommendations in the Wessex protocol, which would tend to 60 mg or 80 mg for 24 hours, but, yes, I think adjustment of the dose in response to symptoms is appropriate. I mean, what we have failed to see in any of these twelve cases is an adjustment downwards. It was only one way adjustment upwards, apart from the one occasion when Dr Reid reduced the dose in one patient.

G Q So in those circumstances it would not necessarily be the adjustment as the amount of the adjustment that one would be looking at?
A Yes, and the failure to have recorded a clear justification. So, for example, the Liverpool care pathway did not exist then, but now if you run a protocol you have a four-hourly assessment of pain, agitation and other observations of the patient, and your treatment interventions are based on those four-hourly observations of nursing staff in patients at the end of life. Now, that is best practice, you would not expect to see that in all cases, but in
H many of these we just have a complete paucity of any description of the symptoms.

Q Yes, that is the problem one is faced with, you are faced with it, everybody is faced with it, and I am not criticising you as a result obviously. Just out of interest – last question before lunch – when did the Liverpool care pathway come in?
A Now, you have asked me a question I do not know, but it certainly was not being used in---

Q No, no, I know it was not, I was just curious as to when.
A I think we started using it three or four years ago. I think it was being developed in the early 2000s, but I do not absolutely know.

MR LANGDALE: No-one is going to hold you to that. Sir, would that be a convenient moment? We are making fairly good progress, I think, on the patients.

THE CHAIRMAN: Yes. Thank you very much, Mr Langdale. We will rise now and return at five past two, ladies and gentlemen. Thank you.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Langdale.

MR LANGDALE: Professor Ford, if we could move on to Patient H, please, the patient with cirrhosis and so on, the liver problems that we have looked at more than once, and if we look at page 2 of the chronology, the fall fracturing the left humerus, and it is described on page 3, at the top, as a left greater tuberosity fracture. I think you have already indicated this in your evidence, it is a very painful fracture, that fracture, is it not?
A My understanding is it can be. Again, I am not an orthopaedic specialist.

Q No surgical repair carried out, and, as we know, if we look at page 3, at the bottom, he received a single intravenous injection of morphine for analgesia and then paracetamol.
A Yes.

Q Over the page, on 23 September, page 4, in terms of the analgesia:

"Morphine is now [subcutaneous] injection and codeine phosphate has been added. Was administered this morning for pain."

He is complaining of pain and severe discomfort and given codeine. The bottom of the page, still the same date:

"Not helped by present pain relief so try morphine 2-5mg".

We note intravenous.
A Yes.

Q Not subcutaneous in terms of that. Then page 5, he is still experiencing pain:

"Experiencing severe pain ..... Addressed with diamorphine."

A One can see the history there with diamorphine being given with little effect, and then some more being given, and at the bottom of the page a further reference to diamorphine. Top of the page, page 6:

"Pain +++ from" the obvious cause.

We have got a situation where this pain goes on really, does it not, throughout the history of B his time in that hospital? He is described as drowsy on page 6 on 25 September. He gets codeine phosphate and co-dydramol. That carries on. Can you just help us with one matter in relation to co-dydramol? If you look at page 7, this is not the only administration but it is administered as it is described on 26 September, just to take one date by way of an example, it is administered four times. Can you make any equation of that to something in Oramorph terms, or it is a meaningless---

A Well, I would not because we tend not to, as I think I said before, alter the starting C dose of morphine in patients who have been on milder opiates. It does not affect the initial starting dose.

Q Right, but I am just trying to get a feel of what are we talking about; is it---

A Well, they are just much milder. I mean, I am not aware that people have generally tried to equate the moderate opioid to a dose of morphine, but probably ten-fold, I would have to look it up, but ten-fold less potent. There are much less strong drugs that---

D

Q Somebody has handed me note suggesting it is equivalent to 30 mg of Oramorph. Does that sound barking mad or possibly more or less right?

A That surprises me. I would have to look at that reference. I have not seen it in the *British National Formulary* or other---

Q It sounds as if I have been given a barking made note.

E A I cannot see it is equivalent to 30 mg. I would be very surprised at the source of that.

Q Maybe I have been misinformed. Can we look back very quickly at file number 1, tab 4, just to see if this helps. If we go to the numbering inside the tab, to page 6, on the right-hand side of the two columns, what is in fact page 9 of the *Palliative Care Handbook.*

A Yes, I have it.

F Q The opioid equivalent. That is the thing that is in my mind, where equivalents do seem to be at least worked out. To give us an idea, for example, eight coproxamol tablets would equate to 30 mg of morphine. Does that make sense?

A I am surprised at that. I would be interested to know on what basis that has been derived.

Q Would you just take a moment to look at the other codeine, dihydrocodeine. I will G stick with those three.

A Yes, I said a potency of ten to one just now. I said approximately and that would fit with those figures there of 30 mg of morphine to 360 mg of codeine or 300 mg of dihydrocodeine.

Q And co-dydramol, if I am getting it right, is dihydrocodeine plus paracetamol.

A Yes, with paracetamol. It is a combination. I cannot exactly remember the amount of H dihydrocodeine in co-dydramol.

Q Would you agree that a doctor considering whether to administer Oramorph would be entitled to consider the patients immediate previous history with regard to the administration of more moderate opiate type drugs, opioids?
A As it is indicating there, you certainly can do on the basis of this information, yes. I think most doctors do not, though, in terms of the starting does of opiates.

Q In any event, if one had a mind to, if one had a mind to the *Palliative Care Handbook*, you might think it sensible.
A You could, but you would have to look at the exact amount being taken because these are larger doses of dihydrocodeine or codeine than you would typically take with the combination tablets which have quite low does of codeine or dihydrocodeine in.

Q That is why I was asking about the co-dydramol, because it just says "administered four times".
A Yes, and that is quite a low dose. I would have to look it up, but I think it is about 8 mg or 10 mg each tablet.

Q We can check it in the drug chart if necessary. To carry on with this same patient, we can see the problems on page 8 that carry on with regard to his arm and other matters, sleepy and drowsy and so on. At page 9, 29 September, seen by Dr Birla:

> "Will be reviewing resuscitation status. Says medically there is little more to be done. May need nursing home placement."

Toward the bottom of that same entry:

> "Not eating and drinking this pm."

Then, at night:

> "Settled well with analgesia."

Poor quality of life and poor prognosis is set out halfway down the page in terms of his history.
A Yes.

Q Over the page, he remains when he is seen by Dr Ravindrane on 30 September. The state of the arm we can see, and appetite very poor.

> "Complaining of pain in left arm, says the tablets are inadequate."

Despite that, the medication does not seem to have been changed to increase the analgesia and at the same time it is noted towards the bottom of the page that he frequently refused that kind of analgesia. The pain carries on, on page 11, 1 October. The analgesia is spat out. Discomfort continues. Indeed, on 2 October we can see him refusing analgesia despite the pain. On page 12, 3 October 1998, discomfort continues on movement. I suppose one would say hardly surprising, if he is on just one paracetamol, one gram of paracetamol. We appreciate, of course, that the nursing staff are having the problem that he is certainly at times refusing medication.

A A Yes.

Q Then the time comes when he is given some morphine: 2.5 administered. That is intramuscular. No problems there.
A No.

B Q Then over the page, page 13, he is given some more morphine on 4 October, one presumes intramuscularly, and also paracetamol. He knocked his arm. That of course created further pain and morphine is administered the following day, 2.5 mg. Then 6 October, page 14 of the chronology, he is still in pain. Halfway down that entry:

"Taking prescribed analgesia for pain in arm with only small effect."

C It carries on; the picture remains pretty much the same. He improves a bit on one day or so. Over the page to page 16, on 8 October we heard from Dr Lusznat. One can see what the problems are that she has set out. Towards the bottom of that entry, we see "physically obese". This man had put on a great deal of weight, as I recall, when he was in hospital. This is fluid building up in the body. We will come to the figure later on, but I think it was something over 10 kilos of extra weight.
A Yes.

D Q Obviously there is additional deterioration, if we look at the bottom of Dr Lusznat's note:

"May have developed early dementia. Might be early Alzheimer's disease of vascular type dementia. Also depression."

E And so on. Over the page, pain still not controlled. We can see towards the bottom of that entry on page 17:

"Asked doctor to consider stronger analgesia, not prescribed codeine phosphate."

F That does not seem to have been done to any significant degree. If we look at page 18, there is codeine phosphate 30 mg administered, if we just take that on board. Pain continues, discharge home, on 9 October on page 19, totally unrealistic. Codeine phosphate. Then paracetamol. PRN: co-dydramol. It goes on with him still staying in pain with the analgesia not apparently coping with it. If you look, please, at page 22 on 13 October, towards the bottom of the page, if we could just take that on board, 13 October,

"Still in a lot of pain ... Legs very oedematous, at high risk of breakdown secondary to cardiac failure and low protein. Needs 24hr nursing care. Medication: Paracetamol 1g" –

G plainly not enough to control the pain. Yes?
A Yes, he is clearly not being controlled on paracetamol and the occasional tablet of codeine that is being given.

Q Cardiac failure is obviously now an issue.
A Yes, or fluid retention to his alcohol-related liver disease. I think that could well be a
H factor.

Q I will come back to that in a moment. Would you look at page 23 for the transfer to Dryad, please. On 14 October, which was a Wednesday, he is transferred. Dr Barton reviews him.

"HPC: Fractured humerus left ...PMH: Alcohol problems, recurrent oedema, CCF" –

she has noted –

"Needs help with ADL. Hoisting"

and so on.

"Plan: gentle mobilisation."

This is a man, obviously, who has been in pain for the last three weeks really.
A Yes.

Q Since his fall. Over the page on page 24, Oramorph was administered, it having been prescribed. We can see the prescription is recorded on page 25, where Dr Barton on that Wednesday, 14 October, had prescribed Oramorph PRN. In fact, 10 mg administered first of all, in the afternoon, and then 10 mg at night. You said it would be preferable to establish him on a regular moderate opioid analgesia but is it right that you would not really take much exception to the fact of that prescription of Oramorph at that stage?
A Yes. He had not had a proper trial of a good dose of regular moderate opioid with codeine or dihydracodeine, so given his liver disease and age one might have wanted to see if one could achieve control with that. You make obviously the point that he had had odd doses and had remained in pain, so one might well anticipate a need to move to morphine, but you could have tried that. I do not think I am overly critical. I was saying one has to be cautious in a man like this about the dose one uses because of his liver disease and so it is important to start with a low dose and monitor response in someone who is going to be more vulnerable to the adverse effects of morphine.

Q But we have seen the picture that paracetamol ----
A Yes. He needs better analgesia, it is quite clear from the notes.

Q All right. I will leave it at that. Just in relation to this particular painful fracture, pain can persist for a long time whatever you do, because nothing has been done to the fracture.
A Yes.

Q Is there also a problem with pain with regard to bleeding tracking down the arm?
A It is slightly out of my remit, but I would not have thought so at this stage. One of the problems was obviously that he had refused any fixation. One might have gone back and re-explored that with the orthopaedic surgeons, although he had indicated he was not willing to have intervention.

Q He was not having any of it, yes.
A But this would have been a difficult discussion to have had with a man who had cognitive impairment. But clearly there were problems getting ----

A Q Yes.
A The hope was that this would heal and what normally happens is the pain reduces over time and then the analgesia required is reduced over time, but in some patients, if one does not get effective healing you get a continuing problem of chronic pain due to lack of the fracture healing and clearly you are in a difficult position then, when the preferred approach, which he had declined, was to fixate the fracture.

B Q Looking on page 24 at the other drugs prescribed by Dr Barton, towards the bottom of the left-hand section: frusemide and the others, in general all of those makes sense.
A Yes. I think the trazodone he had been on long-term as a sedative, and if he was stable on that that would be reasonable to continue, yes.

Q Over the page on page 25, at the top of the page, where it says:

C "Unclear. Drug charges indicate:

Hyocine: A doctor other than Dr Barton" –

that is in fact Dr Knapman, we know, and it was not administered. Then if we look at the general picture with regard to Dr Barton's prescription on Wednesday 14 – this is her anticipatory prescription – that would be reasonable, would it not, for a doctor who is
D concerned to ensure a regime of pain relief and medication, and it was still available with a patient like this whose condition could seriously deteriorate at any time?
A Again, my comment is as before, that it would be better to prescribe single PRN doses of diamorphine to allow the patient to receive analgesia but not the continuous infusion over 24 hours of diamorphine and midazolam when one has not stabilised this man and known what his requirements are. I was critical that if you are going to start, as was started this man, on a high dose of regular morphine, one has to recognise he was at potential risk of
E development encephalopathy or drowsiness and he needs close monitoring and dose adjustment if necessary.

Q If you are following the single dose route, which you are saying in your view would have been preferable ----
A Yes.

F Q A single dose of diamorphine.
A Yes.

Q Does not control the pain. Another dose at a higher level.
A Yes.

Q Then another dose at a higher level. The consequences to the patient are that he is
G getting – what? – two, three, four injections, if the pain is still not being controlled?
A One does not know. That was not done. But in most patients one would achieve control of the pain. In somebody who is already on opiates, let us be clear, the injection in his thigh or arm, his good arm, is going to be trivial in pain compared to the pain he is getting in his facture.

H

Q Yes.
A So I think this is not a strong argument in this sort of patient. The ability to observe response and adjust the dose of drug of morphine appropriately is much more important in terms of managing the patient.

Q If you are doing that and if it turns out that it does not control it, he is getting breakthrough pain every time, is he not?
A Yes, but you see we get back to the assumption that the syringe driver is a good way to initiate opiate infusion or maintain it in somebody who cannot swallow. The advantage of giving a single injection is you get an initial loading, high concentration, absorbed quite quickly. With a syringe driver you have to wait hours before you are getting much of it absorbed, so the idea that the syringe driver is a better way of providing analgesia out of hours when a doctor is not available is, in my view, flawed logic.

Q If you are administering the analgesia by subcutaneous infusion, you are aiming to achieve an avoidance of any kind of breakthrough pain, so that the dose can be adjusted if there is any problem. It is building up to take care of the situation. How does that create more of a problem for the patient?
A If you give a single subcutaneous injection, it is very similar to giving a single oral dose of morphine: you absorb it slightly more quickly in giving it subcutaneously intramuscularly. If you give an infusion, you are going to take longer to get to the same place. Also, there is the issue that is even more difficult to adjust the response to the infusion, because after you have given a single injection, a single oral dose, you know in an hour or two whether the patient has got adequate analgesia for that. With a syringe driver, you are not going to know that for much longer. Syringe drivers are good when you know the dose of opiate you need to establish and you are giving it over that 24-hour period. They are not good in the situation where you have somebody you are trying to get their pain control to begin with.

Q But at the same time you are criticising these doses as being too high. Is it not sensible to allow for the very problem you have just mentioned?
A Yes, I am sorry, I am not explaining myself very clearly, I do not think. We are agreed this man needs pain control, and he needs the opiate adjusting to give him enough to get his pain control. There was a high dose given initially – which one was not going to know if it was the right dose. You need to have a system to adjust that. The usual way to adjust that is to have a range of doses that nurses give – orally if the patient can swallow or subcutaneously – that you give up to four-hourly, and the nurses adjust the doses within that, and then you give the same dose every four to six hours to achieve stable pain control. I am saying it is more difficult once you start to switch to a continuous infusion when you have not established a stable opiate dose, and the dose that was prescribed by the opiate infusion was a very high dose, so you do not have any manoeuvrability in terms of the prescription to reduce it down to what might be a lower dose that the patient requires to achieve pain control without excessive adverse effects.

Q Very well. It would be important, would it not, in terms of considering what it was right to prescribe, to bear in mind the congestive cardiac failure?
A I think the major issue in this patient was the liver disease, in terms of bearing things in mind. If he was breathless from left ventricular failure, which was intractable and not controllable, that would be an indication for opiates, but we do not usually use that to control symptoms of left ventricular failure in patients with chronic fluid retention.

Q He had put on something like ten and a half kilos in weight during his time in QAH.
A Yes.

Q Cardiac failure, therefore, was a risk, was it not, of occurring any time?
A Yes. I think the main reason he was putting on fluid was his low albumen, related to his liver disease and poor nutrition. There may have been an element of cardiac failure there as well.

Q Might I just look with you, please, at page 26. We can see that in terms of the drug charts on Thursday 15 October, the total in terms of the Oramorph had ended up as 50 mg in total for the 24-hour period, three lots of 10 mg and 20 mg at night.
A Yes, that was what I observed.

Q We can take that as 50 mg in that 24 hour period. We can see also that his condition had deteriorated overnight and he was very chesty with difficulty swallowing medication. Yes?
A Yes.

Q Again, would that be consistent with regard to congestive cardiac failure, particularly with regard to his being very chesty? We can see it over the page so we can follow it through. Dr Knapman says:

"O/E [on examination] bubbling."

I think it is part of the same picture, and it is recorded as being "Very bubbly chest this p.m." on the following day. Were these symptoms ---
A They could be but I do not think we had very clear evidence that it was definitely left ventricular failure. It could be. Ideally one would want to see a chest X-ray – more difficult to get in this setting – to show he had pulmonary oedema, but equally, given the time of it, one's main concern would be, in somebody who was vulnerable to the effects of opiates, he has had a dose of morphine that potentially you would not be surprised if it led to him becoming drowsy and then causes a respiratory depressant effect, so that could potentially also count for his deterioration. I am not saying he did not have cardiac failure. I am saying we do not have definitive evidence from a chest X-ray to be confident about the relative contributions of these various factors in this man.

Q One can see a doctor perfectly sensibly taking that into account and deciding what was the appropriate treatment?
A Yes. I was critical of Dr Knapman not considering that the opiates might be a factor here, and then just considering whether to adjust those downwards.

Q You have covered the next point I was coming onto.
A Sorry.

Q No, no. It is not your fault. It is all part of the same history. Dr Knapman you are critical of, but we can see there he is examining the situation and not indicating that in his view there was anything wrong or incorrect about the medication he was on at the time?
A Yes.

Q You say, "I criticise him for that"?
A I think it would have been best practice to consider that, the contribution of morphine given he had just started on that in someone who is vulnerable to the effects.

Q The diamorphine that is administered, if you look on page 28 on Friday 16th in the afternoon, that 20 of the diamorphine is broadly commensurate with the 50 mg of Oramorph he had in the previous 24 hours?
A It is.

Q And no midazolam at that stage, so any criticism there of that administration of diamorphine?
A If one is of the view at this stage that his deterioration is unrelated to the opiates and you are converting the opiates he was on to an equivalent subcutaneous diamorphine dose, that is the correct dose. But again there was an opportunity to consider whether the opiates he was receiving were the contributory factor to his decline and to cut back the dose.

Q Then we have another doctor, still on page 28, on the 17 October, Dr X, showing him as –

"Comfortable but rapid deterioration."

And that doctor's evidence was that it seemed he was very severely ill or close to death. "I have seen enough patients who have been dying to recognise that." So there is another doctor. Are you criticising that doctor's view as to the fact that ---
A By this time he has been deteriorating for some time and, of course, he is clearly ill at this point. There is no dispute about that. He has deteriorated. The notes document that. I am not criticising that assessment that he is very ill.

Q And if you look on page 29, midazolam on 17 October at 15.50 – any difficulty with that?
A No one appeared to have considered that this man's deterioration might have been due to opiate-induced encephalopathy or hepatic encephalopathy, or the effects of the opiates themselves, so the response to his deterioration has been to add another sedative in. Again, when I reviewed the notes, I could not find any clear rationale, if I remember correctly, for the prescription of midazolam in terms of symptoms of restlessness or agitation.

Q Had there been any such record, you would understand it?
A I would, although, there again, there was a failure to monitor carefully the effects of both the opiates that were infused and the midazolam, and to consider that they might have contributed to his initial and subsequent deterioration.

Q Then, on the 18th – the Sunday – the midazolam increased and also the hyoscine. I think you are critical of the hyoscine being increased which in fact, I think, was Dr X who decided to increase that?
A Not in my report that I provided. I do not think ---

Q Fine. If you are not critical then I need not trouble you.
A Hyoscine is really being used as a symptomatic response in most of these patients at the very end when they have problems with secretions, so I have not criticised that. I am critical of the midazolam increase again. These are large doses, it is important to emphasise,

A in frail, older patients, the lack of documentation justifying the increase. One looks at this and it seems one cannot get a clear picture of the basis on which doses of diamorphine but particularly midazolam were increased when there was no recording of the patient's level of agitation or restlessness.

Q In terms of this patient's death, it may be that the opiates played a part. It may be they did not?

B A Because of the time and of his deterioration shortly after starting what is a high dose of morphine in somebody with liver disease, my view as they likely played a part in his deterioration and death. But, again, this – like all these patients, the majority of these patients – was of very frail, vulnerable man who could have developed heart failure or bronchopneumonia.

Q I think that is as far as I can take that issue with you in relation to Patient H. Can we

C just go back for one moment to Patient G. Do you remember, I was asking you about the antipsychotics being withdrawn. If we go back to Patient G's file, I just need to draw your attention because we checked on it over the adjournment. This is in the body of the file itself, if you would. Would you look, please, at page 324. It shows an entry – this is on 14 September.

A Yes, I have it.

D Q "Back to DDH after admission to Mulberry." That is at the top, just so you can pick up the drugs.

A Yes.

Q Mirtazapine ---

A Mirtazapine is ---

E Q Mirtazapine 30 mg; senna; triclofos? Is that right?

A Yes.

Q And risperidone?

A Which is an antipsychotic.

Q That is an antipsychotic. The mirtazapine is an anti-depressant?

F A An anti-depressant, yes.

Q Triclofos is a sedative, is it?

A That is a sedative, yes.

Q And you may remember I was asking about the effect of stopping those, and whether that might affect what was appropriate in terms of any opiate dose; as to whether those ---

G A You did, yes.

Q And those are the ones that apparently apply to that patient.

A My view would be they should not directly affect the need for opiate dose, but they do indicate the need to consider giving an antipsychotic drug and/or sedative if those symptoms re-emerge – agitation or restlessness whilst those drugs are being withdrawn.

H Q Can we also just take note in relation to that same page, coproxamol?

A A Yes.

Q What is that dose – two ---?
A That is two tablets qds – four times a day is how I read that.

Q That is a maximum dose for coproxamol?
A It would be, yes. It is a combination of paracetamol and a mild opioid dose of
B dextroproproxyphene. Again, it is not used so much now.

Q But again, something a doctor considering what to prescribe in terms of any opiates could bear in mind, in terms of the previous prescribing history?
A They could do but, as I say, that is not how the majority of doctors approach when they initiate opiates.

C Q We are back to the palliative care handbook point again.
A Right.

Q May I move on to Patient I, please, Enid Spurgin. This lady was admitted to Haslar following a fall on 19 March 1999, and the chronology shows the history thereafter. Page 2 shows that she received at one point some morphine and then suffered from hallucination, or hallucinations, and therefore "no further opiates" is the note made in the hospital.
D A Just a comment. I think that note obviously does not mean "no further opiates" for life; it maybe means "no further opiates" in the immediate management.

Q Yes. I would have assumed that was the case. In fact we have the picture carrying on – I am moving on to page 4 – on 21 March that despite that note made about "nil further opiates" she did receive 5 mg morphine. All right?
A Yes.
E

Q So that does not seem to have caused any problem in fact?
A Yes, because the problem with her hallucinations may not have been just to the morphine at that point. She was immediately post-operative so there would have been a number of other factors which may have led to the hallucinations as well as the opiates.

Q Thank you. You have dealt with the next point I was coming to, thank you. You
F dealt with the position with regard to the possible bleed into the thigh, noted by Dr Woods. Then paracetamol really carries on thereafter. We have the history which I am not going to go into in any detail until we come to page 7. On page 7 one has the referral to Dr Lord and a review by Dr Reid: "92 year old lady...." in relation to the fracture.

> *"Has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult. ... consideration of a place at GWMH."*

G

Then Dr Reid:

> *"Fully orientated and able to give good account of herself. Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful. Would like to be reassured that all well from orthopaedic viewpoint. If all is well, happy for transfer to GWMH for further assessment....".*

H

Dr Reid gave evidence he had considerable doubts she would get back on her feet.
A Yes.

Q And we know this is the case where, in fact, I think there is no dispute about it and, indeed, the GMC side have called some evidence to make it clear that she was transferred before she was ready for it?
A Yes.

Q So we do not need to go over that issue. One can see the history of it at page 8 at the top. We can see Dr Reid recording the fact she is still in a lot of pain, and he agreed that this case was an example of the hospital tolerating a greater level of pain than on a continuing care ward. He himself had asked, could her analgesia be reviewed. The short answer is, if it was, it did not change. She stayed on paracetamol with the consequences we have seen.
A Yes.

Q Then on page 9 the admission to Dryad Ward. On 26 March the transfer letter, saying what the position was and Dr Reid's evidence – I think you may have been present for it – saying that that letter, the transfer letter, was quite at variance with what he had found two days before?
A Yes.

Q And he would be very surprised indeed if she was able to be weight bearing without a very significant support. On the top of page 20 we have the review by Dr Barton. We can see at the time of transfer what is noted in terms of pain relief in the note towards the bottom half of page 10. A little way through that note:

> *"However, transfer has been difficult here since admission. Complained of a lot of pain for which she is receiving Oramorph regularly now...".*

There is on problem – or is there a problem – about the prescription for Oramorph with this lady, with her history and the pain she was in?
A Again, in my report, I said she would not expect such severe pain this long after the surgery. Indeed, that of course was the issue that Dr Reid was really commenting on: "Is all well? Please check it." I think he was of the same view in the way he was requesting the orthopaedic team to review that. Again, I say it would have been preferable to go through giving a mild opioid because there is less risk of serious adverse effects with the paracetamol and only moving up to oral morphine if that did not achieve effective analgesia. I think the question then to ask was if this patient was requiring opioids two weeks after the surgery was why. What is the problem in this hip that it is so painful this long after surgery, when the patient should not be requiring opiates.

Q That does not appear to have been a question that occurred to the hospital which transferred her?
A Well, they did not have her on opiates then, of course, and they were saying she was mobilising.

Q But the pain. "Still in a lot of pain."
A Yes.

A Q It does not seem to have occurred to them, if your thinking is right, and it may well be, to think, what is it that is causing this pain?
A I agree they should have done. I am not an orthopaedic specialist so I am reluctant to comment on the care on the orthopaedic ward. What I am commenting on is as a geriatrician who sees a patient coming for rehab after a fractured neck of femur. You would not expect a patient to be requiring opiates at that time point.

B Q The first issue is, what is causing the pain.
A Yes.

Q The opiates may be absolutely right for dealing with the pain?
A Oh, absolutely, yes, except that is exactly the point I am making; that it would prompt an examination of the hip and re-X-ray.

C Q As you know, when Dr Reid saw this patient at a later date – we will come onto it in a moment – in April he asked for an X-ray to be taken but appears not to have thought that an X-ray should have been taken before by anybody or that she should have been referred back. Would it be more sensible if we come onto it as we go through the history?
A No. I hear what you are saying. I think it depends what one believes of the previous account. If one believes the transfer letter, because she was transferred, that this lady was mobilising and was on paracetamol and therefore that was the true state of affairs, or the state
D of affairs that the doctors looking after her at that point were led to believe, one can see why an X-ray would not have been requested then. After transfer, there was obviously a change in function as suggested by the function on arrival at the ward at Gosport War Memorial Hospital compared to the reported. I am not accepting there is now some question being asked about how she was at the orthopaedic ward prior to transfer but, either way, when there was a deterioration that should have prompted a review.

E Q There is a 92 year old lady, having had a major operation which carries with it a number of risks in any event, in pain, in real pain; what is a doctor in Dr Barton's position supposed to do? She has got to treat the pain.
A Treat the pain and examine and determine the underlying cause of the pain, and it is two approaches.

Q Oramorph to treat the pain, I am suggesting to you, is a perfectly sensible course to
F take.
A I am suggesting that it would have been preferable to go through a moderate opioid first. That is all I am suggesting. I am not suggesting it was wrong to try and relieve the pain. If one chooses to go to a strong opioid and not through the middle rung, it is incumbent, of course, to ensure you monitor the patient for any adverse effects and adjust accordingly.

G Q I am putting that to you as Dr Reid said in his view it was perfectly sensible to prescribe the Oramorph and administer it.
A I am surprised he did not think the necessity for opioid analgesia at this stage did not require a review of the underlying cause, because, as I said, my experience and understanding is that you would not expect many patients, if any, typical patients, to be requiring opioid analgesia this long after surgery.

H

A Q Then if we can move on, looking at page 13, which at the top of the page is dealing with 28 March, it was noted that she had been vomiting with the Oramorph.
A Yes.

Q Dr Barton advised to stop the Oramorph, and you say that is entirely appropriate.
A Entirely appropriate.

B Q She is on then co-dydramol. At the bottom of page 13:

"Please review pain relief this morning".

Co-dydramol on the 30th.
A Yes.

C Q Then on the 31st, administration of Oramorph, one administration, at 13.20, co-dydramol continues and then MST. Now, Dr Reid said there was nothing there that he would criticise. Do you agree?
A I do not think I was critical of this at this point in my report. I believe I said that co-dydramol had been tried and it obviously was not working, and MST was a reasonable approach.

D Q You do say if in acute pain, you said you would not use MST because it is slow release, but here it is appropriate since she had been on opiates is my shorthand note of what you said.
A Yes, I am not critical of that.

Q So MST runs through for a period of time, as we can see, moving on, and I am moving on pretty rapidly to get to 6 April on page 17.
E A Yes.

Q In relation to that review by Dr Barton, and her note of what had happened, you indicated that the treatment of the pain is appropriate, but the question was what was causing the pain.
A Yes.

F Q That is the same point. Then we can move on to where the consultant comes into the picture on---
A Can I just comment on that? I mean, you do expect, if a patient comes from an orthopaedic ward, that the hip will have been reviewed and the orthopaedic team was happy about it prior to transfer. So the issue is at what point should one begin to have concerns that things are not perhaps as they should be? I am not saying that it was necessarily the minute the patient arrived on the ward and was first seen by Dr Barton, but at some point somebody G had to start thinking, "Why is this hip still so painful?"

Q Then if we can move on to when Dr Reid did see her, on page 18, 7 April, he reviews the situation and we note that Dr Reid did not suggestion consultant with the orthopaedic team. We just register that fact.
A Yes, but when I heard his evidence I think he said it was not appropriate to contact the orthopaedic team until they had the result of the X-ray, was I think what he said, if I recollect H his testimony correctly.

Q I will remind you of it in summary.
A Yes.

Q A number of possibilities in terms of what the problem was: it might be dislocated; it might be deep-seated wound infection, or a superficial wound infection; and might be that the head of the femur had collapsed.
A Yes.

Q Of course, he does ask for an X-ray to be taken.
A He does, yes.

Q He did indeed say that he had to consider was she well enough to refer back to the orthopaedic team if the X-ray did show something. A perfectly proper consideration, is she going to be able to sustain this, survive this. He pointed out the risks even with anaesthetic, and so on, with regard to this lady, I do not think there is any dispute about that, and if it was a deep-seated wound infection a very poor outlook.
A Yes, and I think given this now becomes a complex area of orthopaedic management, you would expect that to be not necessarily an immediate transfer back, but a conversation between a member of the geriatrics team with a senior member of the orthopaedic team, and they would review the X-ray and there would generally be a discussion before any decision was made about the patient being potentially transferred back for any intervention.

Q Following through my own note, he indicated that there would not be much point in contacting the orthopaedic team immediately, because---
A No.

Q ---they would say "Take an X-ray".
A Exactly.

Q One can see that in fact, and I am not going to go into asking you about the reasons, but it appears that an X-ray may have been taken, an X-ray may not have been taken, so far as one can judge it, but in any event none was available, immediately available, and none was presented to Dr Reid when he next saw the patient a week later, which we will come on to.
A Yes. I think that X-ray should have been obtained within a reasonably short period, preferably the same day acknowledging the situation at Gosport War Memorial Hospital, maybe the next day, and that should have been reviewed by a member of Dr Reid's team.

Q Or Dr Reid?
A Well, it depends. One would expect usually the person responsible for the day to day care to review that, not necessarily the consultant who is requesting it, but there is a responsibility of *the* medical team as a whole to review that X-ray. I mean, that is the comment I would make.

Q Exactly. We have seen that in fact Dr Reid did not indicate that he wanted an X-ray taken immediately, and the normal procedure would have been for him to see the X-ray when he returned the following week.
A Okay, but I think the problem with that is if it was dislocated it would not be good practice to leave the patient waiting there another week. I accept he thought, from his testimony, that the likelihood of that was low---

Q Yes, he did.
A ---but that is why one would want, particularly a dislocation, because whereas the other causes, such as deep infection, necrosis of the head, you could argue could wait, and even that you can have a discussion about whether it would be reasonable to wait a week to institute, for example, antibiotic therapy, certainly if there was a dislocation you would not wish to wait that long.

Q Then if we can move on, please, to page 21, 11 April, she is in pain, Oramorph is given. This is all before any subcutaneous analgesia.
A Yes.

Q We note that she was very drowsy and irritable.
A Yes.

Q On the review by Dr Barton the same thing is recorded:

"unrousable at times ..... denies pain when left alone, but complaining when moved at all. Syringe driver possibly discussed with nephew" and so on.

The Oramorph continues, a single dose of Oramorph, and then the MST continues. Then over the page, Dr Reid on 12 April reviews the position:

"Now [very] drowsy".

Diamorphine had been established that morning, just to remind ourselves.
A Yes.

Q You can pick that up from the next page where the prescription is set out, 80 mg at 8 o'clock in the morning. Then Dr Reid concludes that the diamorphine should be reduced, and he thought 40 was appropriate. Do you remember that evidence?
A I do.

Q You are saying that that is a perfectly proper approach, or do you criticise that approach of Dr Reid?
A Well, I say first of all in my report that the initial dose of diamorphine that was commenced at 80 mg every 24 hours was definitely excessive with respect to the comparison to the oral morphine equivalent she had been receiving with the MST. So that is the first thing I say. She is then, after having this infusion for – he sees her in the afternoon, so she has been on this infusion for six hours, I think it would have been preferable to stop it and then re-start at an equivalent dose that she had been on, or only slightly higher, of the MST, and I lay out in my report that equivalent dose would have been between 20 and perhaps up to 35 mg of diamorphine. So I think she clearly needed some opiate analgesia, but the dose she had been given was excessive. So the right strategy was taken; I do not think it was reduced as much as it needed to be and should have been by Dr Reid.

Q Any criticism of him continuing with midazolam, because he does not ask for any alteration in the dose of midazolam?

A A Well, I was critical of it being started, and in the context of somebody who is over-sedated and very drowsy it should have been stopped, unless there was a clear indication for it to begin with.

Q He indicated that she was terminally ill at that stage and he would not consider referral back to Queen Alexandra Hospital. Her prognosis was "awful" is the word he used.
A The difficulty we have got here is I think it is very difficult to assess this patient
B because their situation has been changed quite markedly by the drugs that have just been commenced that morning, and so we are back to what I have said before, that it is very difficult to assess how the patient is because it is in a sense masked or contributed to by what Dr Reid himself has acknowledged was a too higher dose of diamorphine.

Q What was the marked change?
A She had become very drowsy.
C

Q She had been drowsy before, had she not?
A On the MST, and she had had a substantial increase in dose and had become much more drowsy. So one could say the deterioration looks most likely to be due to the marked increased in the diamorphine dose she has had with the commencement of midazolam.

Q Forgive me, she had been very drowsy before any subcutaneous analgesia. What is
D the marked change?
A Well, clearly Dr Reid had thought there was a marked change, or else he would not have reduced the dose.

Q No. He thinks she is on too much, but this marked change which you say was brought about by the administration of diamorphine, it is just making---
A Sorry, you said to me that Dr Reid said there was a marked change, she was
E deteriorating and now dying, so that is the marked change I thought you were referring to. Sorry if I have---

Q It is not your fault, it may well be mine, but I do not think I said anything to you about Dr Reid saying a marked change. What I put to you was that he had said she was terminally ill, he would not consider a referral back to Queen Alexandra Hospital, her prognosis was awful.
F A Okay.

Q Just so you can be clear what point I am trying to make, you said there was a marked change which was clearly due to the subcutaneous analgesia on that day, and I am putting to you that there is no sign of a marked change; she had been very drowsy, for example, the day before.
A I was taking the marked change you were referring to that Dr Reid had described as
G an indication that she had deteriorated substantially, certainly since he had last seen her.

Q That is what your understanding---
A But to answer your question, again we are back to the notes do not record very clearly the exact conscious level and status of this lady across these few days.

Q Well, we will be repeating the same points if I continue with any other aspect of that.
H In terms of drowsiness, can I just ask you this---

A A Sorry, can I just say if she was drowsy, it is very difficult to understand why the midazolam infusion was commenced. I mean, what would be the rationale for commencing the midazolam infusion if she was drowsy? It is a sedative. So there was no point in giving a sedative to a patient who was already drowsy.

Q Well, you have the position, for example, showing that "Enid denied pain when left along, but complaining when moved at all" on the 11th.

B A Yes. In fact, I quote that in my report. So that is an indication to give analgesia, but there is no indication from that to give a sedative, diazepam, at the dose that was given.

Q May I just ask you one other thing about a cause of drowsiness. Would the septicaemia from her infected hip, if that was the case, cause drowsiness? It might well?
A You would expect it to in a patient like this.

C Q Thank you. You will remember that Dr Reid concluded, although it cannot be definitive because no X-ray was seen by him, that the deep-seated wound infection in his view was the most likely cause of this problem?
A We seem to always be trying to conclude that the drugs which we know cause drowsiness are not the cause of the patient's drowsiness that we are looking at. I would say about that there was no clear evidence presented in the notes that she was septicaemic in terms of having an elevated temperature or having a low blood pressure. It is fully

D acknowledged she may have had chronic sepsis in that hip joint, and there are a lot of factors pointing to that, as were discussed.

Q Professor Ford, please do not misunderstand me. I am not suggesting for a moment that diamorphine and midazolam will not have that effect of causing drowsiness. It is a question of whether the opiates were causing the marked change in the sense that we are talking about here.

E A I understand what you are saying. There has not been a marked change in the issue of infection in the hip. This has been a concern since very shortly after surgery with a continuing pain. You were asking me if she was septicaemic and had systemic infection would that make her drowsy, and my response would be it definitely would. What I am saying is there was not clear evidence presented in the notes that this lady was septicaemic as opposed to had a chronic infection of her hip. I am not saying she could not have been septicaemic, I am saying I could not draw any conclusion from the notes about that.

F Q Fair enough. May I just ask you about one other thing to do with this patient, please. In terms of midazolam, Dr Reid, though not an expert, thought that if midazolam was playing a part in bringing about this patient's death, and we are talking about something other than double effect, it would take effect in about two or three hours, you would expect to see--
A I believe he is incorrect in that, because the midazolam would take much longer to accumulate than two or three hours when it is being infused.

G Q It would take longer in your view?
A Yes, it would take at least a day or two before you have maximum effect.

Q As he said, he indicated that that is the time limit he thought would apply for it to be starting to take its real effect?
A Again, I reiterate, this is a high dose to give a frail, older lady.

H

A Q That is all on Patient I, thank you very much. (To the Chairman) Sir, there are a couple of documents to go in. Might they go in now, if you are thinking of taking a break, just before we do?

THE CHAIRMAN: Yes to both.

MR LANGDALE: Mr Jenkins has got them.

B

MR JENKINS: Sir, before you and the Panel close the file, can I distribute these three pages. (Same handed) You should have been handed earlier on today three documents. I hope they were vaguely helpful if you could understand what they were.

THE CHAIRMAN: Up to a point.

C MR JENKINS: I understand. Can I just take you through them.

THE CHAIRMAN: Yes.

MR JENKINS: There should be a one page document which is an alphabetical list of witnesses that you have heard from.

D THE CHAIRMAN: Are we talking about what we were given earlier today?

MR JENKINS: Yes. You should have been given seven pages. The first is a one page document which is an alphabetic list of witnesses and what day you heard them.

THE CHAIRMAN: This is the document that is unheaded but begins "June Bailey" and ends "Dr X, Day 11."

E

MR JENKINS: That is right. The intention with that document is that if the Panel think "When was So-and-so called?" this should tell you which transcript to go to. In addition to that, there was a three-page document, copied on two sides of paper, which is an expanded version of the same thing, so that if the Panel want to know "Where do we find our questions of Dr Reid?" let us say, they should be able to find the page number very quickly.

F THE CHAIRMAN: Yes, we understood that, and in the light of that, we wondered why we had been given the first document, since everything within the first document is included in the second.

MR JENKINS: That is because it is quicker sometimes just to look at the one page.

G THE CHAIRMAN: Do you have particular views as to where we might lodge these various documents?

MR JENKINS: No, I do not.

THE CHAIRMAN: An unfortunate invitation!

H MR JENKINS: File management is always a matter for the Panel.

THE CHAIRMAN: It is a matter of whether we should give them an exhibit number.

MR JENKINS: You can. You may want to put them at the start of bundle 1, the generic bundle, with the other documents – as a plan, as it were.

THE CHAIRMAN: We will discuss that, Mr Jenkins.

MR JENKINS: The third document, again, should be on three sides of paper. You have an incomplete schedule of references for Dr Barton's statements. You have seen statement for Patients A and B.

THE CHAIRMAN: That is page 1 of 5.

MR JENKINS: That is right. Page 2 of 5 you do not have, because that relates to Patients C and D and you have not seen the statements. Page 3 of 5 should have Gladys Richards and Ruby Lake. You will note there are some amendments in there. For example, Gladys Richards, paragraph 12, I have put in italics "*demented lady*". That is what is written in the note, not what is typed up in the transcribed note. What I have said in paragraph 22 is the entry in the typed statement: "IV morphine at Royal Haslar Hospital." That is what it says, but that does not reflect what the notes say. She did not get intravenous morphine at the Haslar.

I have corrected some typos as well.

When you get to the third side of paper, you should have Mr Cunningham, Mr Wilson and Mrs Spurgin, If you look at the Spurgin entries, you will see a number of numbers in brackets. Paragraph 11 is the first, paragraph 18 has a couple more, and paragraph 30 has a fourth one. The numbers in brackets are put there because those are pages that I understood you did not have. I have those and I am going ask for those to be distributed.

THE CHAIRMAN: That is page 4 of 5. Will there be a page 5 of 5?

MR JENKINS: There will, but I have perhaps given you enough to cope with at the moment. I will produce that over the next day or so, if I may.

I have given you a false reference, apologies. At paragraph 11, it should say "37" not "23". It is Enid Spurgin, Patient I. Pages 38 and 55 are page numbers you have. In paragraph 30, I was suggesting that page 9 was a document you did not have. In fact you already have it in the bundle of material.

That is intended to be helpful. I hope it is. You are just about to be given pages 37, 38 and 55 which I am inviting you to insert in bundle I, the medical records of Patient I. (Documents distributed)

THE CHAIRMAN: Very well. We will resume, please, at 25 to four, in twenty minutes time.

(The Panel adjourned for a short time)

MR LANGDALE: Professor Ford, would you go to Patient J, please?

A A Mr Langdale, would you mind if I made a comment about Patient I?

Q Of course not. May I make it clear that if at any time, having thought about anything, you want to add a comment, please do.
A I find it quite difficult to retain all the details of these 12 cases. You asked me why I thought Patient I had deteriorated after the diamorphine infusion and I wanted to indicate to you why I held that view. On page 27 of the clinical notes, an entry from Dr Reid says – and
B the transcript is not entirely complete in the chronology –

> "Now very drowsy (since diamorphine infusion established). Reduced to 40 mg/24 hours."

It was that entry that I took that there had been deterioration and that Dr Reid appeared to consider it was possibly related to the diamorphine and I certainly did, so it was just to
C explain my earlier statement.

Q Thank you for pointing that out. As I say, if anything else ever occurs like that, please ask to take the time to look it up and we will check. It does not cause me to ask any further question.

D Patient J, Mr Packman. A very large gentleman, trapped in the bathroom and so on. We have been through this comparatively recently. Would you look on page 2 of the chronology, the bottom left-hand box, which is dealing with the opinion of the doctor, Dr Dowse.

> "In view of premorbid state and multiple medical problems, not for CPR in event of arrest."

E I do not ask you to explain "not for CPR" but "In view of premorbid state". What is he really saying there?
A In view of how he was prior to the current admission and I think the issues are about his limited mobility. Obviously he had had a recent dramatic decline in his mobility. He had a number of problems with chronic leg ulcers and limited mobility because of his obesity.

Q We see the further notes that are recorded. Page 4, please, 8 August, halfway down
F the left-hand side. It talks about speaking with his wife, who had problems of her own.

> "Mick [Mr Backman] will probably need rehab/long term care"

is the comment made. Page 5, at the top of that page,

> "Spoke with wife. Informed of what Dr Reid had said. Looking to go to GWMH."

G

Then seeking to transfer him to Dryad on 15 August, page 7, but there was no bed available. A description really of the condition on 15 August with regard to his size and the nursing problems that created, leaking of serous fluid, the sloughing and so on, necrotic areas. A nurse described this patient's sacral sore as being "horrendous." There is no dispute about that.
A Yes.

H

Q It was obviously a real problem and very painful. On page 8, the entry we have already looked at with you in chief, 18 August, when he is reviewed by Dr Tandy, and there is a mention of "Black stool overnight" which you indicated could be an episode of melaena.
A Yes. I think in retrospect, it clearly was.

Q The picture becomes more convincing.
A In retrospect, yes.

Q We can move on, please, to page 10, where he is admitted to Dryad and reviewed by Dr Ravindrane – the registrar, as it were, immediately under Dr Reid, so part of Dr Reid's team. He clerks this patient in. We can see the description there. Dr Reid commented, just to remind ourselves, that he would disagree fundamentally with any suggestion that this patient had been sent to Dryad because there was a potential for mobilisation, as he had no such prospect. Does that appear to be a reasonable opinion?
A I am surprised he is so negative in that. I think this was a man who had been mobile, albeit to a limited extent. He was living at home. There is a statement recorded in the chronology that he had seen the dietician and indicated he wished to lose weight. There is no disputing how difficult it was going to manage to mobilise this man, with both his pressure sore and obesity, but I think the vast majority of rehabilitation teams would have made efforts to attempt to mobilise him, recognising it could take a very long time. But if that is Dr Reid's opinion, that is his opinion.

Q Yes.
A Of course.

Q Then at page 11 on 24 August temazepam prescribed by Dr Barton – just noting that in passing. Moving on to 25 August at the top of page 12, this is the passing fresh blood per rectum, and Dr Beasley saying, in effect, stop the clexane.
A Yes.

Q Totally sensible. And to be reviewed by Dr Barton the following morning. Then we can move on, I think, over the page to 26 August, where Dr Ravi, as he is described in the second box down on the left, was consulted. This is on the telephone.
A Yes.

Q Dr Barton's review we will look at in a moment, but Dr Ravi, when he was contacted about clexane, advised to discontinue.

"Repeat Hb today and tomorrow. Not for resuscitation."

The reading of that is that that is Dr Ravi saying that on the telephone. He said he could not remember saying so and was not able to say whether that was him. Just take it, if you would, that that would be what had happened ----
A I would take it that Nurse Hamblin would have reasonably asked Dr Ravindrane, to whom she was speaking, given that that had been his resuscitation status, "Is he still not for resuscitation?" That is the conversation as I would have imagined it.

Q If I may say so, that makes total sense. Dr Ravindrane would have known that he had been on clexane at the hospital prior to getting to GWMH and would have known that the view there was not for resuscitation.

A A Yes. Certainly if he had not been for resuscitation at the main hospital site, given the resuscitation facilities and team available at the Gosport War Memorial Hospital, it would be somewhat illogical to change that resuscitation status decision at Gosport War Memorial Hospital.

Q That contact between Dr Ravindrane and GWMH would have been an opportunity for him to have said, "If there's a problem with regard to that bleed, maybe he should be referred back."

B A I think it is implicit in the statement to check the haemoglobin, because there would be no purpose unless one was going to take action and the action would have required transfer back, because if I recollect there was a statement by someone that blood transfusions were not given at Gosport War Memorial Hospital.

Q That is right, yes.

C A And I would not expect them to be. We stopped administering blood transfusions at Walkergate Hospital in the early 1990s.

Q All right. Dr Barton's review, if we can move on to that, please, on the following page. We bear in mind that the haemoglobin results come in, and we remember the drop with regard to the haemoglobin. Her review. It says, "Called to see male" but that is "Called to see **pale** ..."

D A Yes.

Q So it reads:

"Called to see pale, clammy, unwell. Suggest ?MI treat stat diamorph ..." –

That is an initial injection of diamorphine there, as it were – yes?

E A Yes.

Q "and Oramorph overnight. Alternative possibility GI bleed but no haematemisis."

Which means what, please?

A "Haematemisis" means vomiting blood.

F Q "Not well enough to transfer to acute unit."

Obviously you did not see this patient – no criticism of you at all. That is obviously the view formed by the doctor, seeing the patient at the bedside, as it were. Correct?

A That is the view written down there, yes.

G Q And we proceed on the basis the view formed.

A Yes.

Q "Keep comfortable ..." and so on. Without seeing the patient yourself, it is very difficult to give any sensible criticism of that view, is it not? That is not a criticism of you, but that is the fact of the matter.

H

A A I would disagree with that. I think I was asked to review the notes and I think it is reasonable to pass a view on what was appropriate medical management in the light of the information recorded in the notes, and that is what I did in my report.

Q When the doctor seeing the patient, experienced doctor, forms that view, there is no basis, is there, for you disagreeing with that?
A Well, I cannot accept that. I think I am looking at this as a geriatrician and a general B physician who manages these types of patients. My view is this was a man where the working diagnoses – which I think were reasonable – were that he had had a myocardial infarct or a GI bleed. I do not think it is unreasonable for an expert who is brought in to comment on a case to comment on what the appropriate management of that would be on the basis of the information recorded in the notes.

Q Professor Ford, I fully accept what it is you are brought in to do and what it is you are C entitled to express by way of your opinion, but when you are faced with this and a doctor forming that view, without having seen the patient and being able to form a proper judgment you really are not in a position to disagree with that, are you? How can you be?
A I do not think that decision should have been made by the clinical assistant without discussion with the on-call acute physician or the on-call geriatrician. As I state in my report, I find this statement "not well enough to transfer to acute unit" difficult to understand. He is clearly very unwell and in my view that argued even more strongly for the case to transfer D him to an acute unit for treatment, unless it had been decided with the patient that he did not wish for additional intervention to reduce his likelihood of future death or disability. So that is how I look at this. Had there been a statement, "The patient did not wish further intervention such as blood transfusion" et cetera, et cetera, that would be a different matter; but that was not recorded in the notes.

Q So if Dr Reid had expressed the view recorded, "I agree, not well enough to transfer E to an acute unit," you would say, "I am in a position to disagree with that"?
A Personally, on the basis of the information I would disagree with that decision, whoever made it. As I said in my earlier evidence, this is a man who is in his late sixties. He has gross obesity. He is cognitively intact. I cannot see, unless he has expressed a wish that he does not require treatment, if he had a GI haemorrhage why one would not consider transferring him back for at least blood transfusion if he required it.

F Q In relation to his age, do you remember you made the point that he was - you put it very tactfully – just into the older age group at 67. Although his chronological age compared to a number of these patients was comparatively young, his comorbidities were such – is this right – that his physiological age was much older and may well have meant that active interventional therapy would have been futile?
A He is certainly biologically older than the average 67-year old. I think we can all agree with that, but I think a really important issue is that he is cognitively intact. He could G have been engaged with decision-making, and he was living at home. One was not talking about particularly aggressive treatments for him if he had either a myocardial infarction which the evidence would suggest he probably did not, or an acute GI bleed. I think the vast majority of acute physicians, if called about a patient like this, would not have problems with admitting a patient like this back to the acute hospital site to at least have a blood transfusion, particularly if his haemoglobin result had been discussed with them, and to be considered for endoscopy. I indicated that I thought it was most unlikely he would have been a candidate H for surgical intervention to treat his GI bleed, but that is my experience as an acute physician

and as a geriatrician. Unless he had given clear advance indication that he did not wish for further treatment or unless there was a clear indication that his quality of life was so poor and it was inappropriate to do this with the patient, I cannot see it was in his best interest to not at least discuss further interventions that he might have had.

Q I will just remind you of another passage from Dr Reid's evidence, or rather this was my note of it. With regard to the prescriptions – and we are looking at page 15 – he indicated that it was difficult to say what was the propriety of those without having seen the patient. The patient was clearly very unwell on the 26th. We can agree on that?
A We can.

Q In his view – this is Dr Reid's view – to give diamorphine was appropriate. Given his problems, his prognosis was extremely poor. Would you agree with that?
A We know he has had a major gastro-intestinal haemorrhage with the information we have. He is a high risk candidate.

Q Can I interrupt you?
A Please do.

Q The finding is, "Possibility GI bleed" at that stage.
A Yes.

Q Sorry – carry on.
A And I was going on to say, if he has had a myocardial infarction and an ECG was, again, not obtained, which I would be critical of, again he would be at high risk of having death from the myocardial infarction given his obesity and other problems. We can agree he has a high risk of death, but the situation is not hopeless. This is not somebody who is definitely going to die if they have an acute myocardial infarction or an acute GI haemorrhage. Even if we felt the prospect – this would certainly be my practice – that he had an 80 per cent risk of dying from either event, and I do not think it would be as high as that with treatment, one would transfer back from the twenty per cent, and the possibility of a good outcome with active treatment unless the patient did not wish, or had previously indicated he would not wish such treatment. Just because he may have a poor outcome does not impact on offering what we are talking about, a relatively limited treatment in terms of aggressiveness such as blood transfusion or monitoring on a coronary care unit.

Q His prognosis was "extremely poor" were the words used by Dr Reid.
A Well, it is extremely poor without treatment, as obviously we have seen. I do not think the situation for this man was completely hopeless. In my view, I do not think he was destined to die. I am commenting as a general physician. If one is going to pursue this line, I think one would have to ask a gastroenterologist how they would view his risk, and a cardiologist if he had a myocardial infarct. I think at the least there should have been a discussion with the acute physician at that point.

Q May I move on to the Oramorph first of all. Is Oramorph appropriate in these circumstances?
A I think the difficulty here is the decision has now been made he is for end of life care. I have indicated that was not appropriate. Therefore I would not think the morphine was appropriate, but if one accepts he is on end of life care, if he has pain, certainly an initial dose, if one thinks he is distressed with a myocardial infarct, then an opiate is appropriate.

Q We can see that the history on 27 August. The nursing note says:

"Some marked improvement since yesterday. Seen by Dr Barton this am – to continue with Oramorph 4 hourly – same given, tolerated well. Some discomfort this afternoon, especially when dressings being done."

Then the remaining history over the next few days – Oramorph, poorly but comfortable, very poorly, condition remains poor and so on. If you look on 30 August, please, on page 17, on the left hand side there is a note by Sister Hamblin:

"... left abdominal pain. Condition remains poor. ... No further complaints of abdominal pain."

Also:

"Syringe driver commenced at 14.45."

Then:

"Very small amount diet taken, mainly puddings."

So he is taking something. All right? Just register that fact. Then, over the page, please, to page 18.

"Appeared to have comfortable and peaceful night. This morning has passed a large amount of black faeces."

Then can we move on to the review. That is the day after that by Dr Reid.

"Rather drowsy, but comfortable. Passing melaena stools. Abd [abdomen] huge, but quite soft. Pressure sores over buttock .... Remains confused. For TLC – stop frusemide + doxazosin. Wife aware of poor prognosis."

At that stage, bearing in mind the situation there,, any criticism of that?

A I think the difficulty here is, there is a course of management being taken. He has been put on end of life care. Four days later, not surprisingly, he is no better. We know his haemoglobin, when it was last checked, was 7. It has almost certainly dropped even lower at this point. The patient will look extremely ill and unwell, and he is on that pathway. It has been decided. Of course, at that point he could have been referred back. There could still have been attempts at resuscitation but of course the outlook now is even bleaker because we have had four days of no active treatment for his underlying GI haemorrhage. Sometimes one finds oneself in a position managing patients where you have got to a position you think you should not have got to with them, but you have to take a decision at that point. I do not know what I would have done if I had come across a patient at this point. He is clearly very sick. You would have to decide do you take heroic measures. If you come in and look at this afresh, this is a man with a massive GI bleed. At this point do you transfer him back? Your chances are certainly far less for a good outcome than they were four days ago.

Q We have heard the evidence of Dr Reid about that, and you have already told us.

A I am giving you my view on what I see presented in the notes.

Q Exactly. That is all I think I need to ask about Patient J. Can we move on, please, to Patient K, Elsie Devine. This is the lady with the renal problem, nephrotic syndrome and so on. The lady also where we have to take note of creatinine levels and so on. I am just trying to move on to a page where it makes it sensible to start – perhaps page 3 of the chronology. Date, 20 July 1999. There she is reviewed by the SHO to Dr Stevens.

B

> *"Remains well on current treatment with no new problems. Creatinine slowly worsening – 192 on test sample. Albumin low. Symptomatic treatment only."*

The significance of that, please: "Symptomatic treatment only"?
A In that context?

C Q Yes.
A Where they are looking at a renal function, I would think it means, if her renal function deteriorates, she would not be for dialysis or other intervention. That is how I read it.

Q Within the context ---
A Yes.

D Q --- of that problem?
A Yes.

Q Thank you. Page 4, on 9 October 1999:

> "Admitted to Queen Alexandra Hospital with episode of acute confusion.
>
> *Confused, aggressive and wandering. Diagnosis: Multi-infarct dementia, CRF."*

E "Multi-infarct dementia"? Is that the same thing as vascular ----?
A Yes. There are three main types of dementia. Alzheimer's is the commonest and vascular dementia is the second commonest.

F Q We carry on with that picture and then we can move on, please, to 21 October on page 6 of the chronology. Dr Barton's review here. You indicated, I think, if my note is correct, in relation to the MMSE 9/30, you said, "Quite low, in keeping with severe dementia"?
A Yes.

Q So that figures in terms of that?
A Yes.

G Q Dr Barton says:

> "Get to know. Assess rehab potential. Probably for rest home in due course."

That is the assessment?
A I agree with that, yes.

H

A Q We do not have any problem with the drugs prescribed, which we see on page 7 except, I think, the Oramorph. The thyroxine and so on, no difficulty. Oramorph being prescribed for ---
A You were asking me about the morphine prescription.

Q Yes, please.
A I could not see any indication for this patient, who is not recorded to be in pain, and
B we would not write a patient with dementia and behavioural disturbance up for PRN morphine.

Q The Panel in due course will hear Dr Barton's evidence. That is your view?
A Yes.

Q I shall not raise any other issues with you because we have already dealt with those
C one way or another. Can we move on, please, to page 8, where the review by Dr Reid can be seen on 25 October. In any event, Dr Reid did not query the prescribing of Oramorph?
A No, he did not.

Q And in his evidence, he indicated what his view was and his view fortified by his review of her on 1 November on the same page, where we can see:

D "Quite confused and disorientated. Unlikely to get much social support at home, therefore try home visit to see if functions better in own home."

The situation continued. There is no criticism by you about the subsequent administration of the various drugs, including the drug that was later discontinued. Can we move on to page 11. 15 November:

E "Seen by Dr Reid. Request for review by Dr Lusznat.
Very aggressive at times. Very restless. ..."

At the bottom of the page:

"Referral to Dr Lusznat by Dr Barton."

F We need not do anything other than notice that as part of the history, and I want to go on, please, to page 13, on 18 November 1999, when there was a review by Dr Taylor. Again, deterioration, more restless and aggressive. Refusing medication, Not eating well. Towards the bottom of that same entry:

"*Aggressive, wandering, moving other people's clothes...*"

G and so on.

"... *poor appt* [appetite]."

On this day we have to bear in mind there is a difference, according to that note, in relation to the behaviour in the early part of the day and the behaviour later on.

H "*Reviewed on ward. Happy, no complaints. Waiting for her daughter.*"

It appears by this time the fentanyl was having some effect, would you agree? Because the fentanyl is administered at 9.15 that morning.
A I would agree her behavioural disturbances vary and I would agree at this point she has a fentanyl patch. I am not sure I would agree that that establishes that the fentanyl has improved her behaviour.

Q Is it not a bit of a clue that that is what has improved things and made her happier?
A As I indicated in my report, opiates are not a treatment for behavioural disturbance in dementia. It is a treatment for pain in people with or without dementia.

Q Is that not a clear indication that in fact this lady was happier, better, in a better frame of mind as a result of the administration of fentanyl?
A But she has had variable aggression, is my reading, throughout her stay. This is not a dramatic change.

Q No. It may not be dramatic, but it is a bit unfair, is it not, to say, "Well, in my view, that has nothing to do with the fentanyl," is it?
A I did not say it had nothing to do with it. I said one cannot conclude that the fentanyl is the reason why her behaviour has improved. I said something slightly different.

Q All right. I accept the criticism of my phraseology, but in fact it would be perfectly reasonable to conclude that it was the fentanyl, would it not?
A It may have but, again, as I indicate in my report, it is not a standard treatment. If it is, you still have the issue of having to monitor a patient like this very carefully because it is a very large opiate dose. It is 90 mg of morphine equivalent over 24 hours, and there is a high risk of significant adverse effects.

Q We have heard the evidence from Dr Reid about the propriety of using fentanyl, which I think I have already put to you in the past, and I will not repeat. Over the page to page 14, on 19 November:

> "Review by Dr Barton.
> *Marked deterioration overnight. Confused, aggressive. Creatinine at 360. Fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs SC subcutaneous analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death.*"

A Can I comment on that?

Q Please do.
A Because I think this is the problem, if one hypothesises that the pensioner was improving her behaviour, she is now on it a bit longer and she is confused and agitated again, so that is why I think it is very difficult to conclude that the fentanyl improved her behaviour.

Q Yes, indeed. It may be one or the other. It may be both. "Marked deterioration over the last 24 hours" is the description given in the nursing note there, the "Significant events" section, "extremely aggressive", and this is the incident in the morning which the Panel has heard about when there was considerable difficulty in dealing with her, "taken 2 staff to special" and so on. Chlorpromazine – no problem with that you have told us?

A A No. Sorry, can I just make another comment---

Q Yes, please do.
A --- on an earlier comment by the nursing records:

"Needs [subcutaneous] analgesia with midazolam."

B I think again that raises concerns that the nurses did not understand the role of midazolam, because of course it is not an analgesic, it is a sedative for restlessness.

Q Yes. What was actually administered was diamorphine and midazolam, as we can see over the page on page 15.
A Yes.

C Q Dr Reid indicated he would have been more cautious in his use of diamorphine and midazolam, but in his view they were within a reasonable range. You say that they were not appropriate.
A No, they are not appropriate standing alone, the diamorphine infusion, it is too high a dose and it is not appropriate when you are adding it in to the continued effect of fentanyl, which will be circulating for a considerable amount of time. We discussed that in my earlier statement.

D Q Can you just help in the particular circumstances of this case: the fentanyl commenced on the 18th, and again I am not trying to ask you to do some impossible calculation, but administered at 9.15, if we go back to page 13, if you see in the bottom left, fentanyl administered at 9.15 on the morning of the 18th.
A Yes.

E Q Then moving on to the 19th, when you are talking about the administration of the diamorphine and midazolam at half-past 9 in the morning, assume the fentanyl patch is removed, what---
A Yes. So the lady has had the fentanyl patch on for 24 hours, so she will have absorbed 90 mg morphine equivalent, but the issue, to go back to our discussions beforehand, because fentanyl has a much longer half-life, so it persists much, much longer than morphine, and the *British National Formulary* of 1998, whichever one we are referring to around that
F time, states it may be 17 hours or more for it to disappear, so---

Q Can you help with what therefore we are talking about in this case, twelve hours later?
A So whereas before, if you are giving regular doses of oral morphine, after four hours the morphine is going down and you are replacing that with the subcutaneous diamorphine, here you have got a position when the fentanyl is persisting much, much longer with its effect and you are adding in the diamorphine, so that in that period, the first 24/48 hours, you are
G exposing the patient to much more overall opiates when you replace a fentanyl patch with a subcutaneous infusion of diamorphine than when you replace regular oral morphine or MST with a subcutaneous infusion of diamorphine. So you have to bear that in mind when you are looking at the treatment and the response of the patient. So when I say that the dose of 40 mg over 24 hours of diamorphine was excessive, it is even more excessive in the context of the fentanyl, which is still having an effect.

H Q What I am trying to get at, and it may be impossible to get a precise---

A A Is what is the equivalent---

Q What sort of amount---
A Well, I think conservatively you would have to add on at least 20 or 30mg---

Q All right, something of that order.
A ---of morphine equivalent. I mean, because it is changing hour by hour, so you cannot B give a simple answer to the effects.

Q Well, I think that is as far as one can take it exploring that issue. Thank you for that. It gives us an idea of the sort of thing we are talking about. Then on 21 November the diamorphine at 40 and the midazolam at 40 continues, and the family are aware of the position, and so on. I do not think there is anything else I need to ask you about that case. Thank you. Then Patient L: this lady admitted to Royal Hospital Haslar, and the second C page of the chronology:

"after experiencing chest pain and collapsing at home. CT brain scan conducted."

She had had a fall, chest pain and so on, "MI x 2 – AF", atrial fibrillation, and so on, all those other things recorded. You indicate that there were signs therefore of a stroke, is that right?
A Yes, she has a severe stroke.
D

Q The consequences one can see being recorded. "Analgesia" on page 3 "needs reviewing", some given with fair effect. This lady was on a nasogastric tube for quite some time, and I am going to come back to that when we are at Gosport, if I may.
A Yes.

Q She is transferred to the coronary care unit, and we can see the history, and obviously E there were significant problems in relation to this case, is that right?
A Yes. I mean, she has had a stroke and there is a question about whether she has had prior to this a myocardial infarct, and she has had a clot form in the heart and that go to the brain to produce the stroke.

Q Then on to page 7, 5 May, when she is referred to Dr Lord, and the comment on referral, at the bottom of that box on the left hand side:
F

"Nothing more we can for her on acute medical side."

Over the page, she is "Treated with oxygen and diamorphine for respiratory failure".
A Which is rather in contrast to the previous comment, one might say.

Q I was going to ask you, but that is what occurred, right, and "small doses of G diamorphine to keep comfortable", is what is said in that same box on the left hand side at the top, at Haslar. Is that something you are critical of?
A It would not be generally my approach for patients who are in respiratory failure due to aspiration pneumonia, we would not give opiates, so that is my comment on it. It was done, but it would not be my practice, and it certainly would not be the practice of the vast majority of stroke physicians who look after these patients.

H Q It seems to be what was---

A A It was what was done, yes.

Q We cannot go into it---
A I mean, it may be there was a thinking she has had a myocardial infarct and there may be elements of left ventricular failure, if one is trying to find a reason to justify it.

Q Yes. On the left hand side:

B

"Aware of poor prognosis. Remains for 444. Condition remains very poor."

Then over the page on page 9, 6 May:

"Discussed with consultant. Not for resuscitation."

C Reviewed by Dr Lord, and she sets out the situation, four lines into the body of that:

"Extremely unwell."

A little bit further down:

"Swallow not safe. On intravenous fluids. Too unwell for transfer to GWMH.
D Overall prognosis poor."

We do not need to go into that again. Then she suggests, at the bottom of the page:

"[Lower the] Total [or bring down] Total fluids to 1½l/day".

Is that what that means?
E A Yes, because she thought she was fluid overloaded.

Q "Salbutamol [nebulisers] if wheezy ..... Diamorphine if distressed".

So there is another indication of a consultant in this case thinking that diamorphine was appropriate to cope with distress.
A Yes, I note that. It would not be my practice, but clearly that is being confirmed
F there, yes.

Q Then over the page, at the top:

"Remains poorly .....[Intravenous] diamorphine given as px."

Sorry, it has gone out of head as to what that means, "px" – as prescribed. Further
G deterioration on 7 May, some improvement on 10 May, and then---
A Sorry, I read that as no further deterioration, but that maybe that is---

Q I beg your pardon.
A I am not saying that is what it is, I am just saying---

Q I think you are quite right, it does appear to indeed improve three days later. Then on
H page 11, a review by Dr Tandy:

A

"Appeared to improve over weekend. Barthel is zero."

She gives a further description as to the position:

"she developed further central chest pain. Don't think stable enough to transfer to GWMH at present."

B

So this is the second occasion where the view was not right for transfer at this stage.
A I think this is not uncommon. We see stroke patients who are in need of rehabilitation at this stage, but they are very sick and they are not appropriate for transfer to a rehabilitation ward.

Q Thank you, and I think it follows that it may be, it can arise in such cases, where
C somebody sees what may be a window of opportunity, but it turns out after transfer not to have been a window of opportunity. It is very, very difficult to decide.
A Yes. I mean, people have looked at this in terms of stroke patients, and if you have an off site rehabilitation unit there is a necessary transfer back of around 15 per cent of patients who turn out not to be stable enough to stay on the rehabilitation unit. So this is a well recognised problem in stroke patients.

D Q Because I am going to suggest that that may in fact have been the case here, where she was---
A Yes, absolutely.

Q I do not think you disagree?
A No, I do not disagree with that.

E Q Bottom of page 11 on the left:

"Pain settled. Further escalation in treatment appropriate."

Then still before she gets to Gosport War Memorial, on page 12, on 12 May, bottom left hand side:

F

"Reviewed on ward round.
Feeding well through [nasogastric] tube. [Complaining of] chest pain, relieved by GTN .....
Spoke to Mrs Stevens' husband and daughter. Explained prognosis and rationale behind why [patient] would be allowed to die naturally, rather than be resuscitated or put on ITU, if she had a further MI or respiratory failure/arrest."

G On to page 13, 13 and 14 May, she is reviewed by an orthopaedic specialist; no intervention needed. Bottom left hand side:

"Very uncomfortable this evening. Diamorphine [given subcutaneously] to assist settling".

That is on to the same point we have discussed already. Over the page, on the 15th it says:

H

A "Diamorphine ..... [given subcutaneously] with good effect."

On the 16th, on page 14:

"Settled and slept very well without diamorphine. Feed continues as per regime."

Reviewed by SHO the following day. Paracetamol given, we can see at the top of page 15. Then liaising with GWMH on 18 May. They are happy to take her with the above results, in other words the situation as it appeared to be at that time. I do not think I need trouble you with the next lot of notes. Can we move on to page 17, when the transfer to Daedalus Ward actually took place. The transfer record sets out the position. On transfer the patient was receiving aspirin, enalapril, digoxin, isosorbide, mononitrate and subcutaneous diamorphine. So that is continuing---

A Yes.

Q ---for the same reasons as the hospital gave.

"For rehab at Gosport".

She is admitted. The nursing referral sets out the position. We can go over the page, I think, without missing out anything important, to page 18, to the review by Dr Barton. So this is still on 20 May and she sets out the position. I just want to ask about the significance of aspiration pneumonia. So is it right that in any event she had chronic lung disease, chronic obstructive pulmonary disease?

A She did have. The aspiration pneumonia we would consider probably somewhat separate from that, in that it is a problem that occurs in stroke patients because of their swallowing difficulties and dependency. So in patients with severe stroke, a fair proportion develop, as the name says, aspiration, they have an ineffective swallow and they get infection on the chest. Now, that occurs in patients both with or without chronic obstructive pulmonary disease, but clearly grand lung disease makes the problem worse, because you start off with poorer respiratory function.

Q May I just ask you a further aspect about this question of aspiration pneumonia? I think it probably follows from what you have just told us, but if you have had an episode of aspiration pneumonia, the chances of having a second or subsequent episodes are high?

A Increased. A lot depends on your swallowing function, and I cannot remember if this lady had a formal assessment of her swallowing undertaken.

Q I am going to come on to another aspect of that which I think the records show. It is an increased risk?

A It is an increased risk undoubtedly.

Q It is not going to be a surprise if it happens, in other words?

A Yes.

Q Would it be also the case that that risk would be increased if a nasogastric tube had been pulled out by the patient?

A If it is half pulled out and you end up with feed going into the top of the pharynx, yes, it can, but in general it is thought nasogastric tubes have a neutral effect on aspiration pneumonia in stroke.

A

Q I rather think in this case that had happened, what you have just described.
A I think at one point she did have a misplaced tube, but I am not sure if any feed had been administered through it.

Q If you go back to page 6, we can just pick this up in case it is of significance, page 6, top left hand box, towards the end of that entry:

B

> "[Chest X-ray]: No NG tube seen but NG tube in! On RO NG tube this was found to be in nasal cavity, therefore feed has been placed directly down nasopharynx therefore can't exclude aspiration."

Is that---
A Yes. So I think in this case it is very clear that her pneumonia, a precipitator, or at
C least a major contribution, was the misplacement of the nasogastric tube.

Q We can see, in relation to the---
A She did have a swallow assessment, I see on the next page.

Q Yes, but in relation to the situation with regard to the history at Gosport, pursuing the same point for the moment, would you move on to page 19, which is still dealing with entries
D relating to 20 May.
A Yes.

Q I need to ask everybody, please, you included obviously, Professor Ford, to look at a particular page in the records, medical records, in the file, page 1334. On that page the handwriting is reasonably clear. At the bottom left hand corner can you pick up the date 20 May.
E A Yes.

Q "NG tube repassed c/A"---
A I think that is "O/A", on assessment.

Q Sorry. "[On assessment] this a.m. as Jean pulled it out." Then can you make out the rest?
F A "Bolus fed this pm" I think it says "55mls/hr due to"---

Q "[patient]"---
A Yes, which does not seem quite right, "pulling out NG tube".

Q ---"pulling out NG tube. Also due to recent history of aspiration pneumonia for referral to dietician".

G

So it looks as if that problem had occurred on that day as well?
A No, I do not read it that she had had feed down the tube as before. I mean, there was a very specific description before that the tube was found not to be in the stomach and feed had been commenced. It is usual not to commence feed until you are sure where the tube is placed. I think what had happened here, a common problem with nasogastric tubes, is that the patient had pulled it out, because they are uncomfortable, and this happens, and I think
H what this is saying is that they had replaced the tube and they have given her some bolus feed

down the tube. That is how I interpret that. I think they are not saying there had been a clear instance of feed being given to the wrong place---

Q I see what you mean.
A ---is how I interpret it.

Q You are quite right, the note does not say, but there is obviously a problem with this tube.
A Yes.

Q In the sense we were just talking about. That was something obviously anybody would have to have an eye to, this risk in relation to aspiration pneumonia.
A Yes. It is quite difficult to manage nasogastric tubes in a unit such as a ward at Gosport War Memorial Hospital. Again, we do not transfer patients with nasogastric tubes to this environment because of they problem. They are pulled out, they are difficult to replace, you need to get X-rays, so managing a patient with a nasogastric tube in this environment is difficult. I am not saying it was wrong to transfer the patient but I am just explaining these patients who often were transferred in the 1990s are difficult to manage because of the issue of having to check the placements and you do not have medical staff on site all the time.

Q Looked at the picture as presented on the day of her admission, 20 May, would it be sensible to view it in this way, that really this patient's chances of successful rehabilitation were very small indeed?
A I think we have to go into more detailed definition of what we mean by successful rehabilitation and what we mean by very small. I am sorry to be pedantic.

Q Do not hesitate, just explain what you say.
A She is currently stable but she is an older lady with a severe stroke. I think I have said in my previous statement she is not very elderly, she is in her seventies. We would expect to be able to manage complications now with modern stroke care in an acute rehabilitation unit. The patient is more likely to survive than to die – let me put it that way. They will leave hospital but they will be left with severe disability. As I indicated in my earlier statement, this is not a lady who is going to be living independently. The options are either a nursing home or a considerable support package to manage this lady in her own home, with the help of her relatives and also formal carers going in – and that would be after a period of two to three months in hospital, anticipating slight improvement. But there is a high possibility of further aspiration pneumonia, pulmonary emboli, or in this lady additional cardiac problems that she has maybe had. The approach in these patients is you start a rehabilitation programme when they are stable, although you are anticipating there may be medical complications, but you still give the same intensity of rehabilitation that the patient can tolerate and that you can provide – and I recognise there was a limited therapy input from what I have heard from the statements at this unit. Again the situation is not hopeless but the outlook is poor. This lady is going to be left with long-term disability and in this context now we would have a range of discussions about the appropriate level of care. Some families might indicate that the patient would have expressed a wish not to receive treatment for active problems if they developed another pneumonia and one might withhold antibiotics. There is a range of approaches which would depend very much on what one thought the patient's view was and what they had to look forward to. Again, the discussions we have now are much more explicit and open with families and relatives than they were in the 1990s

A and so decisions were often made "in best interests" so one has to not apply the standards we apply in practice now to what we did back in the 1990s.

Q Of course. Thank you for that general picture. If we can look at the remaining history here, on page 19, still on 20 May, we can see:

> "Pain: Not controlled. Complains of abdominal pain due to history of bowel problems. Oramorph given."

B

We can see that she is given 5 mg, as is shown halfway down that page. Dr Barton had prescribed 5-10 mg PRN. Your view is that you would not use opiates in this situation.
A No, and I think it I worth explaining why, because opiates are not good in terms of patients engaging and effectively recovering rehabilitation. There are studies which have shown they impair people's ability to recover, so we do not favour them. I am critical of the
C use of morphine because this problem of abdominal pain, as far as I could read from the notes, was not a new problem. It was a chronic problem that had been investigated, as I indicate in my earlier evidence, by at least one or two other specialists, and opiates have not been deemed to be an appropriate strategy to manage it. In general that is the case with chronic pain: one would not use opiates.

Q As we have seen, in fact opiates were used.
D A Yes.

Q In the hospital before she got to Gosport.
A But not for abdominal pain is my understanding. It was an ill-defined distress.

Q It appears not.
A For breathing problems.
E

Q It appears to be to settle her.
A Yes.

Q Or various other descriptions. That is all I need to deal with in terms of the Oramorph. The prescription with regard to diamorphine and midazolam written anticipatorily, you have indicated that in terms of the administration of diamorphine and
F midazolam on 21 May, on page 21 of this same document, at 20 minutes past seven in the evening – and we can just look at the history on that day in the bottom left-hand section:

"11.30L: To have GTN spay PRN. Now on regular (4 hourly) Oramorph."

Philip Beed, the charge nurse, at six o'clock in the evening:

G

> "Uncomfortable throughout afternoon despite 4hrly 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 outlook but anxious that medications given should not shorten her life."

Then the syringe driver commenced at 7.45 that evening.

H

A Perhaps we could just do the calculation again. She had had, in terms of Oramorph, I think 35 mg in the preceding 24 hours. Is that right? That is the note I have, but you had better check it.

A Yes, that is correct. In my corrected report I thought she had had three doses of 5 mg and three doses of 10 mg, so it was 35 mg.

Q If it is 35 mg, divided by two we have 17-18 mg ----

B A 12-18 mg, I had, yes.

Q Call it 18 mg for the sake of the calculation. Without increasing the strength of the analgesia, diamorphine 20 mg is 2 mg above.

A Yes.

Q But it is more or less a straight swap.

C A I said that if you were looking to continue opiates – and of course my view was that they were not appropriate, but if you were doing a straight conversion – that was an appropriate dose to start with.

Q It looks as if the nurse did what he said he would do.

A Yes, in terms of the diamorphine.

D Q Yes. The diamorphine and midazolam.

A Well, I am critical of the midazolam.

Q I appreciate that every time we look at this you say you have to take into account the midazolam. That is the drug in a number of these cases that you particularly focus on in terms of saying it is inappropriate.

A Yes.

E

Q Then another doctor comes into the picture on 22 May, page 22. This is Dr Beasley. He is not suggesting there should be any change to the administration of the drugs. If we look down on that same page, at the bottom left-hand side,

"08.00: Condition has deteriorated. Very bubbly. 10.20: Still very bubbly."

F Dr Beasley was contacted and there was a verbal order to increase hyoscine to 1600 micrograms. Again, is that indicative of aspiration pneumonitis?

A I think you just cannot tell at this stage. I mean, I was critical of the discussion of her being uncomfortable. There was no description of what the pain or the problem was that was being treated here and in the context we are at now, where she is deteriorating for reasons that are not clear and she has secretions, the prescription of hyoscine is reasonable.

G Q In this case, it may well be, in fact, that the recurrent aspiration pneumonitis essentially played a principal part in her death.

A Well, we are making an assumption that she had recurring pneumonitis and there is no evidence presented in the clinical notes to support that that was the cause of a deterioration or pain at this point. There is no information which allows us to determine what the cause of her deterioration and this description of pain was at this point.

H Q Would very bubbly be consistent with aspiration pneumonitis?

A I think the difficulty is that once patients are deteriorating and particularly if they are less alert, you often get this as a pre-terminal problem, a problem impairing secretions.

Q It may be a pre-terminal problem of the kind.
A Yes. Also, of course, you do get a problem with secretions in people with active chest infection.

B Q I think we have covered those topics as far as we can. Just in case you think that is absolutely the end of my questioning, I have two more matters. They are both very short, but we have got through the bulk of the papers. Just to go back, if I may, to patient Elsie Lavender, Patient B. This is not, as it were, challenging your evidence or seeking further explanation but I wonder if I can ask you to consider a particular point. Elsie Lavender, Patient B, the lady who fell at her home address and went down a flight of stairs.
A Yes, I remember.

C Q You will remember the lady in terms of the immediate problem in particular presenting itself at Gosport, the pain in the chest and arm.
A Yes.

Q We have been through that history. This is to do with the diagnosis or possibility of brain stem stroke. I want to try to get something clear with you as to where we are on this.
D Would you look in the file, looking at the medical records, page 242. We have the letter from Dr Tandy, writing to Surgeon Commander Taylor at the Haslar, talking about the patient having a fall, unable to stand, a bit battered and complaining of pain across her shoulders and down her arm.
A I am missing this page.

Q Your bundle has not been adjusted. Perhaps you could turn it up at page 935. You
E have the same document there.
A Yes, I have it now.

Q On the second page of that letter, page 936, it says,

"I think the most likely problem here is a brain stem stroke leading to her fall."

F I want to try to get this clear. At the end of that paragraph she says,

"I do not think her brain stem stroke would show up particularly well on a CT and we're now 11 days post-ictus."

A Yes.

G Q There are two things. The brain stem stroke may well have been the thing which caused the fall.
A I think it is unlikely, because I do not think the symptoms she had are typical for a brain stem stroke.

Q What I am trying to get at is that the symptoms that she had in relation to the pain, shoulders, chest and so on, may well be the result of the fall.
H

A A Yes, at this point I entirely agree. I can understand why that was being thought and that is not unreasonable.

Q The fall may have involved some kind of cervical fracture.
A Yes: To be clear, she has had a fall. Everyone is pretty confident she has fallen all the way down the stairs. She could have fallen because of her poor vision, she could have slipped. She does not necessarily have had to have had any new medical event to account for having had a fall, or she could have had a new event like a faint, or a seizure, or a stroke for that matter. That is another thing that is possible. My view was that the clinical signs that she had after she was examined over the next week or so were not typical for a brain stem stroke. But I can understand why it was thought she might have had a stroke, because she has got diabetes, she has atrial fibrillation, she is elderly, she is at high risk to have a stroke. That was not an unreasonable working diagnosis. When she is first seen with all this bruising – and I think she is described as being fairly battered at one point – it is quite hard to assess whether there is true weakness because the joints are so painful. Patients are difficult to examine and so the picture is often difficult to assess. Clearly, as we have indicated, there was thought about whether she could have injured her neck.

Q Yes.
A Even at that point.

Q Yes.
A So, yes, the fall is what would have produced the neck injury, the cervical spine injury, if she had it.

Q Yes.
A Which I think is likely but we do not know because we do not have the X-rays and we have not had an MRI scan.

Q It is just a question that one has to divorce symptoms exhibiting themselves which may be the product of the fall.
A Yes.

Q From what it was that may have cause the fall.
A And I think the point is that two or three weeks later you would not expect this continuing pain, and, more importantly, you would not expect from having some force and bruising that the lady could not use her hands to feed herself. That indicated she had true neurological weakness, which must have been due to either a cord injury or a stroke – and I have indicated that the pattern was much more typical for cord injury.

Q The note in terms of her admission is:

"Fell down the stairs. Large pool of blood at top of stairs. ?hit head at top of stairs and fell down the stairs."

A These patients are difficult to assess. I have seen many stroke patients as a stroke physician. I had a case of a man who fell off a ladder. Initially we thought he had had a stroke, but we thought we had better look at his neck. Sorting out whether people have had a stroke or a cord injury in this setting in the early days is not always straightforward. Dr Tandy is quite right about the CT scan. It would, in my view, have been unhelpful, so one

would have had to decide whether one wanted to get an MRI scan – and you have discussed the issue of the cervical spine X-ray and whether that was obtained and whether it showed anything.

Q Thank you for that. The second and I really do hope last point is this. When I was putting to you the situation with regard to Dr Barton and her workload, and you were saying that you still would have thought there would be time to do this, that and the other, as to the degree of excess pressure and excess workload, would you regard it as a matter of some significance that, when Dr Barton left, a Monday to Friday all day medical presence was thought appropriate to replace her? It is a rather significant increase to cover the same amount of patients and the same situation. Might that perhaps not be an indication that, indeed, the workload on Dr Barton was excessive?

A It could be. Determining what is the right level of medical support and nursing support into units is always a vexed issue. One always has to argue quite strongly for additional resources for these services. The other issue to consider is that the workload and the nature of work were continuing to increase. I think one has to take account of that. I looked at it from comparison to the support we had in our own service, but I think one would need to look at what was then required to provide a proper service afterwards. As I said, there is no doubt the workload was changing and was increasing. That would mean at some point there would have to have been increase in input. As I said to you, a lot depended on the input from the consultants so I do not think I can be definitive in my comments about this. All I could do was describe a comparable set-up and the input we had. But yes, to answer your questions; clearly the amount of support that was required afterwards, if it was the same level of workload, is a factor that would support the contention that Dr Barton had an excessive workload.

MR LANGDALE: Thank you. That is all I need to ask.

THE CHAIRMAN: Thank you very much, Mr Langdale. Mr Kark, I am not going to ask you to start today.

We shall break now, and start again at 9.30 tomorrow morning, please, ladies and gentlemen.

MR KARK: Can I just convey that Professor Ford did indicate earlier today that he certainly would be content to start at nine.

THE CHAIRMAN: Unfortunately we will be testing the video at nine o'clock.

MR KARK: I was going to say, in any event I do not think for my part that that will be necessary. I will be about thirty minutes, or I hope less.

THE CHAIRMAN: I think we are making good time, and there is a pre-existing appointment for the video link to be tested at nine as a consequence of poor results in this morning's test before we started.

MR LANGDALE: Without detaining Professor Ford at all, it is simply an administrative matter in terms of Friday. I wonder whether the Panel would consider rising on Friday afternoon no later than three o'clock. The reason for that is that Dr Barton has to have some [redacted] which is best done on that Friday afternoon. If, of course, we are at the stage of evidence where the evidence does not require her to be present, then there is no

difficulty. It may be that we will have reached a stage where she is giving evidence or about to give evidence. I wonder if the Panel would have that in mind because that is what I shall be asking to happen on that Friday.

THE CHAIRMAN: Should we be at a stage on Friday when the doctor is giving or is about to give evidence, then of course that must take priority and we would in those circumstances rise at three.

MR LANGDALE: I am grateful.

THE CHAIRMAN: Nine thirty tomorrow, then, please, ladies and gentlemen.

(The Panel adjourned until Tuesday 14 July 2009 at 9.30 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 14 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWENTY-FOUR)

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.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning, everybody. Welcome back, Professor Ford. I think you are on the final run now. Mr Kark.

GARY ASHLEY FORD, Continued
Re-examined by MR KARK

Q Professor Ford, I am going to follow the same pattern, as it were, that Mr Langdale chose, which is to deal with general questions first and then very briefly, I think, to each individual patient. I want to start, please, if you could turn up the file 1 and turn to tab 6. This document, we understand, was written by a doctor, we were told, called Dr Logan, I think it was. It is page 27 of tab 6. I just want to re-examine with you where you agree, as it were, with the sentiments expressed and where you depart from them. If you look four lines down in the second paragraph, you can see the words:

> "I felt when there was any question that the patients had pain then they should be given the benefit of analgesia. Unfortunately there were no really very useful middle range drugs between Codeine and Dihydro-codeine and Diamorphine. I also explained that, besides their pain relieving properties Diamorphine and Morphine had very useful psychological effects producing some psychological detachment and euphoria which can do much for a patient's tranquillity."

Now, just pausing there for a moment, the beginning words were "I felt when there was any question that the patients had pain then they should be given the benefit of analgesia", and the words that I noted down from your evidence were "significant concern".
A Yes. I think the problem with saying "any question" is any question by whom, and after what assessment? In my view, some of the patients, there was an interpretation that their agitation was likely to be due to pain, when, from the information that was found in the notes, to me I thought that was not likely, because they had dementia, previous history of behavioural disturbance. So I, for example, would not consider that "any question" of them being in pain: I think one would have to have a reasonable possibility that they were in pain; that is you identify a cause of pain, or you cannot identify another cause for their behaviour after observation. So I think the problem with "any question" is it potentially leaves it open almost to anybody, a nurse or any doctor who sees the patient, after any assessment to think, "Well, they might be in pain. Let us try strong analgesia", and I would depart from that view. The reason for that is there are, as we have seen in some of these patients, adverse effects of opiates, so one has to take a balanced approach, weighing up the potential benefits of treatment and the risks of treatment. So I get back to, which is the general practice of good medicine, which is emphasising good medical practice, which is one requires an assessment of the patient to make a judgement. So he is right, Dr Logan, to emphasise that you should be looking to see if patients are in pain and seeking to relieve it, but I think it is a question of what one interprets as pain, and I think there was in my view over-interpretation of symptoms as being likely due to pain when there were other causes.

Q It is a question of setting the hurdle---
A Yes.

Q ---and you say this is setting the hurdle rather too low?
A I think one would have to ask Dr Logan himself what he meant by that phrase. I do not think he would have meant it as liberally perhaps as it might be interpreted by some, I think is my point.

Q You also, I think, dealt with the words:

"Having established that and being content that the patient was distressed and probably in pain, then one should not hesitate to use opiate analgesia if necessary."

I think your comment was that the challenge is identifying if the patient is in pain. So if you have an agitated and distressed patient, that may be for a number of reasons.
A Yes. I mean, I think my view was that a trial of analgesia is a reasonable approach, so the point is it does not end with the decision to give the prescription. What one has got to do is see does the patient's behaviour that one is interpreting is pain improve, and is the treatment that is started tolerated without adverse effects. So part of good management is not so much the decision to try to treat pain with opiates, it is how that is monitored and the response that is taken to the treatment. I think we have had a lot of discussion about was it appropriate for this patient to be started on opiates at that particular point in time, and I said good practice is to go through the ladder, but in a way the key issue is the response that is taken when that decision is made, and I think the problems were that the dose was excessive and then there was not proper monitoring and consideration given, rather than just focusing on the decision to start opiates themselves.

Q On a similar and perhaps related issue, we have heard a lot in this case about how experienced Dr Barton was and how experienced her nurses were, and you said this on Day 22/43:

"One does not necessarily gain expertise alone from having exposure to a patient group. It has to be accompanied by specific training or working with peers and developing one's skills interactively in that context."

I just want to examine that with you for a moment. "Working with peers and developing one's skills"; in Dr Barton's case, in her particular position of Clinical Assistant, who were her peers?
A Well, by peers I mean not necessarily the parallel group of other clinical assistants. I mean in this context consultants in geriatric medicine, it could be consultants in palliative care if that is a key area of what one is looking at, and also, I think, registrars are often highly competent. I do not know to what extent Dr Barton might have had exposure to registrars.

Q We heard from one. We heard about Dr Ravindrane. There may have been others.
A I think, however experienced one is, it is important to have, I mean we now give it a proper name, continuing professional development, and one goes to meetings, one has audit meetings where one discusses cases, one keeps up to date, and these are absolutely critical, however good you are. I mean, they are critical in my case to maintaining the expertise in where I practice, and I do not know to what extent Dr Barton had that framework. I get a sense that maybe there was not a very strong framework of training and support in terms of interaction with her peers and continuing professional development in elderly care.

Q There is no question that Dr Barton certainly had very long term exposure to a particular patient group.
A I agree.

Q From what you have just said, that does not necessarily lead to gaining in skill?

A No. I think the other thing is practice changes over time. I mean, what was considered good medical practice when I qualified in 1982 would in many instances, I think, now not be considered good medical practice, and so practice evolves and changes and the standards and expectations change, which is why continuing professional development is so important.

B Q I want to ask you about another area of your evidence dealing with inadequate staffing, and this question is put to you by Mr Langdale:

> "Would you agree with this? Where good nursing care – and I stress this – with adequate staffing ratios and regular patient supervision is lacking, the use of drugs earlier and at a higher dosage to control symptoms can help to ease the distress of patients and indeed their relatives."

C You gave a long answer to that, starting with "I do have trouble agreeing with that". This was Day 22/48. You said during the course of your answer:

> "The problem with that is of course the problem of inducing unnecessary adverse effects ..... if you have an environment with a low level of nursing time, you will not get equally the monitoring for that and so you are ending up with a situation where you are having to use potent drugs in a very undesirable, one can say more risky
D way."

Now, let us take that scenario, that you are perhaps under-staffed and perhaps under-managed, as it were, from above: first of all, can you continue to practise in that way over a lengthy period, or should you?
A Well, I think there is an obligation, a professional obligation, to highlight, if that is
E one's response, and I think many doctors' response would be more conservative and might say, "Actually, if there is inadequate nursing environment you have to be more cautious with dangerous potent drugs", because the risks are too high, even accepting that you may not be able to fully relieve patient's pain, what I am saying is there are different approaches to this, but the key issue is if one genuinely believes there is inadequate staffing, one has to raise that with whoever is responsible for managing the unit, both at a clinical level and a managerial level, and point out what one is having to do which one considers is suboptimal practice.
I mean, if we take thrombolitis, for example, generally very powerful treatment, if the
F appropriate monitoring is not in place we simply do not provide it to patients and patients are denied an effective treatment, but we will do that because we put doing no harm to patients as a first priority.

Q You spoke about the importance of adequately being able to titrate the drugs you are using to the best response. Does that mean continuing assessment of the patient once you have started the patient on analgesia?
G A Yes, and we talked about the sort of standard of care laid out now by the Liverpool care pathway, but I do not think it was very different in the 90s of, for example, four-hourly observations of a patient's behaviour and whether they appeared to be in pain and whether they are restless or agitated. I think that would not be an unreasonable expectation of nursing staff. I mean, I am not a nurse so I have to be a little bit wary about what I comment on, but as a doctor that is the sort of level of observation I would expect for patients who are deteriorating and dying as a minimum.
H

A Q Just to finish that topic, how do you regard the suggestion, if this is what was being put to you, that because there is inadequate staffing levels, or inadequate time, it is legitimate either to use more drugs or to use the drugs earlier?
A I may not have directly said "No", but in my last answer, which I still hold to, I said I could not agree with that as a justification for undertaking prescribing what is acknowledging a suboptimum.

B Q I want to turn to another broad topic, about which you were questioned on a number of occasions in different ways, and that is the concept of using opiates for agitation, or for some other symptom other than pain. I am afraid I have not got the reference for this, but my brief note of what you said at one stage was a reasonable body of medical opinion would use opiates for purposes other than pain, and I just want to re-explore with you what limits, if any, there are to that answer.
A Yes. We did not go through all the indications for opiates. They are used for reasons
C other than pain relief. I mean, one which we have not talked about, I do not think it was a problem for any of the patients being discussed here, was terminal breathlessness, and that is a well recognised indication, using opiates to relieve breathlessness. In a completely different setting, one uses potent opioids to induce anaesthesia, and also for long-term sedation in an intensive care unit setting, but again that is not relevant to this setting. It is also used, and we talked a little bit about this, for the treatment of left ventricular failure in acute pulmonary oedema, and again I think that was only a potential indication in one or two
D patients, but usually one is giving it intravenously or intramuscularly, not orally, in that setting.

Q I wanted to pause on that for a moment, because you were fairly specific about how morphine could be used in those circumstances. Would a long term infusion by syringe driver be an appropriate response to MI or something like---
A It is not an approach I have ever used with myocardial infarction or heart failure, and
E it is not an approach I am aware that cardiologists use. I mean, there are many other approaches to manage end stage heart failure. I think opiates may be used in the final stages of intractable heart failure to treat breathlessness, but again I think that would be the limit.

Q The limits on using morphine for agitation: agitation is one of the constant themes in this case – agitation, restlessness, bad behaviour, if you like to call it that.
A Well, it is covered, I think, by the Wessex protocols, which talk about the
F management of agitation, and they do not list opiates as a treatment, and this was apparently the basis for practice that the Gosport War Memorial Hospital staff referred to. So it is helpful in patients who are in severe pain in reducing their agitation and giving a sense of euphoria, that is well recognised, a sense of detachment, but opiates, I stand by my statement, are not a treatment for agitation per se, and all the palliative care guidelines then and now use other approaches, predominantly antipsychotics, and other non-drug measures, and sedatives as an alternative if antipsychotics do not work.

G Q During the course of your cross-examination you were asked about a particular report from 1987, Wilson J A et al on palliative care.
A Yes.

Q Certain figures were put to you. Did you have an opportunity of checking that report at any stage?

H

A I was only able to get the abstract. I could not get the full article. So I have read the abstract, which indeed looked at practice in 150 or so – I have it printed off somewhere – patients who died, elderly patients in a continuing care setting, and, as Mr Langdale indicated, showed opiates were used in just over 50 per cent, and usually in single repeated doses at that point in the 1980s.

Q Because at that time they were not using syringe drivers to that---
B A Well, there were syringe drivers, but it mirrored what appeared to be the practice – obviously I did not look at the drug charts – and I went round and looked at the practice in our own unit over the last year, where most patients were clearly getting low doses, as I indicated, and the highest dose received over 24 hours of diamorphine was 20mg, and most were receiving 2.5, 5 or 10 mg, and the doses were likely to be single doses.

Q Were those end of life patients?
C A These were all patients who had died, and this was prescribing in the last few days of life, but it did agree, which was my estimate, that I thought about a quarter to a third of patients, and we found a third of patients had some need for opiates and were given opiates towards the end of life.

Q I am sorry to come back to file 1, but could you turn back to file 1, tab 4, please, the *Palliative Care Handbook.* You were being asked about version rates and particularly
D paragraph 7 under the heading "Use of Morphine".

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

A I am sorry. What page is that?

Q Page 6.
E A I have it.

Q Paragraph 7:

"When oral administration is not possible because of dysphagia, vomiting or weakness, consider changing to diamorphine by subcutaneous infusion using a syringe driver. The conversion from oral morphine to subcutaneous diamorphine
F (total daily dose) varies between 1/3 – 1/2 allowing some flexibility depending on the requirement for increased or decreased opioid effect."

We have been, I think, taking it as something of an assumption that the one half conversion rate is an equivalent?
A Yes. I was trying to be generous, if that is the right way of describing it, in interpretation, but the implication there is that would be an increase in dose, yes.

G

Q So that the flexibility between one third and a half, the half appearing on the face of that to be allowing for an increase if pain is not controlled?
A If one accepts that it is a third conversion, that is what other sources point to in terms of equivalence of subcutaneous infused diamorphine to oral morphine. Doing a half conversion is equivalent, 33 per cent to 50 per cent is equivalent, to doing the 50 per cent increase which is the recommended increase step to make if you want to increase the dose of
H opiates if you do not have symptom control, so the half is not a standard conversion, then there is implied here to be incorporating an increase in dose. Yes, I would agree with that.

MR KARK: I was going to deal with this when we deal with specific patients, but since we have this file open and this page, it may be appropriate now to put in another page of the BNF. This comes from – and I should have written it on the top – the 1999 BNF. I have given one copy to Mr Langdale already. I am going to suggest that we just slip it into the back of our tab 3 and this is dealing specifically with co-dydramol which I think is one of the very few pages of the BNF we have managed not to copy already in the file. I think this should go in.

THE CHAIRMAN: Do you want us to give it a page number?

MR KARK: Yes, it could do.

THE CHAIRMAN: It goes in at the end of three. It would be 51.

MR KARK: Yes. It might be worth keeping it out just for the moment, though, while we look at the page in the *Palliative Care Handbook*. (To the witness) This, in fact, if we look at the top of the page, comes under the heading "Non-opioid analgesics". Co-dydramol: if we look to the right hand side, the first entry there is co-dydramol. Before that we can see "co-codamol" in the third column along.

A Yes.

Q There are three types of co-codamol in differing packs, I think, with differing strengths of drug, but can we just look at co-dydramol first of all at the right hand side. They contain dihydrocodeine tartrate 10mg and paracetamol 500 mg. Would you put these into an opioid category?

A They are mild opioids. Mr Langdale asked me yesterday about how they compare, and they are very mild. I am not sure. I think it is wrong to call the combination non-opioid analgesics. I think the paracetamol is a non-opioid and what they have done is, they have put the combination in. This is the sort of change of heading under which they have put the drug in, but I think you would find dihydrocodeine and codeine, when they are listed separately in this BNF, being described as opioid analgesics, I suspect. I was asked the question yesterday, "Do you take account of it?" I said "No", and the reason is I had a look through, before starting again this morning, what level of doses of co-dydramol and co-codamol the patients had received. I think the most patients had received was eight tablets a day, which will be the standard. In the case – maybe you are going to ask me this – of dihydrocodeine it would amount to 80 mg of dihydrocodeine and it is about a one to ten conversion. Mr Langdale was pressing me on this.

Q A one to ten conversion of what?

A Equivalent to morphine over 24 hours. I said we did not usually take account of that. The reason is, it is so mild that a patient who had eight tablets a day of co-dydramol would have had an 8 mg morphine equivalent over 24 hours, which would be equivalent to about 3 mg of diamorphine over 24 hours. That is why in practice we do not take account of it, because it is such a small amount of strong opioid equivalent. It does not alter the dose that she has got to infuse with. The only exception, I think, would be if the patient had an adverse effect to mild opioids at that level one would be very cautious about moving to stronger opioids. I think that would be the only way it would work.

Q You can put that away. Finally, while we have this file open, page 2 of tab 3, which is the beginning of the BNF, *Prescribing in Palliative Care*", this phrase was put to you. This is, in fact, where it came from. Look at the left hand side of the page under the heading "Pain":

> "Analgesics are always more effective in preventing the development of pain than in the relief of established pain."

Again I just want to explore with you the limits on that. Is that an opening, as it were, to prescribing opiates to patients without pain?

A It is a surprising statement in a way in a palliative care section because to my knowledge palliative care specialists do not pre-emptively prescribe strong analgesia. The principle is very important if you are going to undertake a painful procedure on a patient such as surgery or a joint manipulation. You would always give analgesia before that rather than wait for the pain and then give it. But there is animal work that suggests that is true in terms of animal models and also experimental human models. I am not a pain expert, and it is also a well established principle that if you treat pain early you can get on top of it and prevent some of the secondary problems that patients may get. But I do not think it acts as a justification to give opioids to patients who do not have pain because you think they might develop pain.

Q I am going to take a very quick canter, as it were, through some of the patients. I think I have possibly one or two questions to ask you first of all about Patient A. Again, I am going to stay entirely with the chronologies. Can we turn to page 13, please. You agreed with Mr Langdale, if you look at pages 13 and 14, that there came a time when this patient was on 30 mg of Oramorph. I just want to explore with you when in fact this came about chronologically. Will you just find it in your report?

A Yes. I make a statement in my report that he was receiving 30 mg of oral morphine over a 24-hour period on 14 January. That was the information I had extracted.

Q If we go back to page 12 and 13, we can see the date is 10 January 1996 and then, if we go to page 13 in the middle, we can see that Arthrotec is discontinued?

A Yes.

Q And the suggestion is that because you are taking Arthrotec away, you need to replace it with some sort of analgesic. If the result of taking Arthrotec away is to leave the patient in pain, no doubt you agree with that?

A It is slightly more complicated, if I can answer that. He was started on Arthrotec just two days beforehand, I think, and the question would be whether he had had any benefit from that. I actually suspect, since it was discontinued, there was no obvious benefit, in which case it is no different from if he did not have it. Again, the notes do not record, I believe, whether he had an improvement or not with the Arthrotec, but he had not been taking this long-term, so the relevance would be had he had any symptom improvement for the two or three days he had been taking the drug.

Q On 10 January, therefore, the patient is started on Oramorph. The prescription is to be given five times daily, but on 10 January he receives 5 mg in fact.

A That night.

Q At night. The last dose given to him at night?

A A Yes.

Q On the same day he is prescribed diamorphine starting at 40-80 mg and over the page we can see then on the following day, 11 January, Dr Barton changes the prescription to increase the prescription at night of Oramorph and it remains as it was during the day, four times 5 mg daily?
A Yes.

B

Q That is, in fact, administered on that day and that is where we get our 30 mg starting. Yes?
A Yes, although I note here it only records... Yes. If it includes the six o'clock dose the following morning – yes, that is the 30. That is where I obtained the 30 mg a day from, yes.

Q In terms of prescribing I do not want to go through the whole list of them again, of
C converting from Oramorph to diamorphine and all the rest of it. Is there any legitimacy to the approach to prescribe a patient 30 mg of Oramorph and, at the same time, to prescribe a conversion dose of diamorphine – ignore the rates for the moment?
A I answered this, I think, around some of the patients. I would view it as reasonable, if the prescription clearly specifies it, to prescribe subcutaneous morphine or diamorphine as an alternative to the oral morphine where the patient was not able to swallow. But no, it is not appropriate to be putting a prescription for subcutaneous infusion of diamorphine as well as
D oral morphine. Of course, all the evidence I have heard was that everybody understood on the unit ---

Q There would not be a ---
A --- it was to replace. But as I indicated, I think I consider the prescription of a 24-hour subcutaneous infusion is not the right approach in this setting. If one is concerned that the patient may be unable to continue receive oral doses of morphine, an appropriate response is
E to have an alternative route which the prescription could specify "for administration if patient unable to swallow," for example, and to give a PRN dose of subcutaneous diamorphine equivalent to the oral dose that is being administered at that time point. That could be given then at a nurse's discretion, under clear instructions, when a doctor was not available. If it was felt that this was very uncomfortable, to have repeated injections, in my view there was on-call medical cover that could reasonably be expected, except under exceptional circumstances, to attend within four hours to write up that infusion. The idea that one has to
F write up, even if it is the correct conversion, a 24-hour infusion of diamorphine because there is not a resident doctor there, I do not accept. I do not think it is best practice.

Q I am not going to delve yet again into the amounts that were prescribed, and I will move on. You can put that one away, please. Patient B: can we go to page 7, please, Elsie Lavender. This was the lady "? [query] fall, ? [query] stroke".
A Yes.

G

Q Can we remind ourselves of pages 7 and 8 of the chronology. I think your comments that I have noted in relation to 22 February was that it is too early here to say that her chances of recovery are small; she has a reasonable chance.
A Yes. I think the situation was certainly not hopeless.

Q At page 8, we see the entry on 24 February by Nurse Joines.

H

A "Pain not controlled properly by D.F. 118"

Is that dihydrocodeine?
A If I remember correctly, yes; that is the trade name for dihydrocodeine.

Q Your comment was, "The pain should not be getting worse at this point". I just wanted again to explore this very briefly with you. Is that on the premise that she was being
B treated for a stroke?
A No. This was on the premise, because stroke rarely present with pain. If it does, if you get post-stroke pain, it is certainly not a problem one would treat with mild or strong opioids or standard analgesics. It is usually neuropathic pain, so one uses carbamazepine, amitriptyline or other agents to treat neuropathic pain. Initially my reading of the notes was, it was thought the pain was due to her having fallen down the stairs and sustained considerable musculo-skeletal injuries, to the extent that she had an X-ray to check whether
C there was a fracture, or a number of X-rays to check whether there were any fractures. My point was that if the pain was thought to be due to that, by this point it should be getting better if it is simple bruising in the absence of a fracture. I think with the benefit of hindsight, and looking at this, that is why myself and, I believe, a previous expert thought it was much more likely the pain was related to cervical cord injury. That was the point. The pain should be improving by now if the working diagnosis was that it was musculo-skeletal injury.

D Q If it were a stroke, there should not be the sort of ---
A There should not be this sort of pain, and if it is post-stroke pain it is the wrong approach to use opioids to it.

Q And if there is continuing pain and one's assessment was, therefore this cannot be a stroke, or it is unlikely to be a stroke, it must be a cord injury, what is the plan for treatment, if any?
E A I think the pain should have ideally prompted a re-examination of the patient and documentation. It was not just pain; she had weakness as well in her hands, which I think had been attributed to the stroke, but I think that was incorrect. Then if one had thought there was a cord lesion, one would have had a discussion about imaging and one would have had to have done an MRI scan.

Q All of which would be ---
F A There would have had to have been a discussion about it and one would have looked very hard to check she did not have a neck fracture and of course we have not seen the cervical spine x-ray or the result of it. We do not know if that was a fully adequate view of the cervical spine, assuming it was obtained – there is some question about that; we think she had it. So there are a number of issues and a different approach one would have taken and one would almost certainly have tried immobilising the neck with a collar. These may have helped.

G Q This comes back to the issue we have discussed frequently. When faced with a patient in pain, it is important to identify what is causing that pain if you can.
A Yes. I think this lady was a difficult case. If there was a weekly consultant review happening, I would have expected that was the opportunity to look at what was happening and for the consultant to think, "Why is she still having pain?"

H

A Q We can put that chronology away. Miss Alice Wilkie, Patient D. I only have one question to ask you about this. You can turn it up by all means if you wish; it is page 8 of the chronology, but it is quite a short point. This patient was started on 20 August on 30 mg of diamorphine and 20 mg of midazolam. The basis of that appears to have been – this was suggested to you – that her daughter had said to one of the nursing staff that her mother was in pain. If a relative comes to a nurse – I think it was Phillip Beed in this case – and says, "My mum is in pain. Can you do something for her?" obviously that should not be ignored,
B but what is the proper approach? What should happen then?
A If this is a new symptom, it should be reported to a member of the medical staff and evaluated. Obviously if it is known what the pain is due to, appropriate analgesia should be provided, but I think the response has to go beyond providing PRN analgesia that has been written up, particularly when it is very potent analgesia.

Q This patient had been on no painkillers at all during this course of her visit to hospital.
C If she was in pain and the relative said she was in pain and believed she was in pain, would it in your view in any circumstances be appropriate to start at this sort of rate for those two drugs?
A No. Older people are the same as the rest of us. They deserve the same level of medical care and attention. If you went to your GP, saying, "I have pain", you would not expect to come out without a history and examination with a prescription for an opiate; you would think that was not appropriate care, and the same principles apply to the care of older,
D frail patients, as I have indicated. The medicine and medical practice of looking after these patients is more difficult and more challenging, but the same principles apply.

Q We can put that chronology away. Can we turn to Patient F, please, Ruby Lake? In relation to this patient, your comment was this, as we noted it from yesterday: in retrospect it is easy to say she should not have been transferred. Again, I just want to explore that with you. Why are you saying in retrospect it is easy to say she should not have been transferred?
E If we go to page 12 – and obviously if you want to start earlier, please do ----

MR LANGDALE: Sir, I hesitate to interrupt, but there is an issue as to whether this arises out of cross-examination. My friend will recall that in chief the witness said that he concluded that she was not really fit for transfer on reflection. I do not see how this question arises out of cross-examination.

F THE CHAIRMAN: Mr Kark, perhaps you can answer that question.

MR KARK: I am not seeking to undermine the evidence in any way, but it is right that it was raised in chief. It is right also that it was raised in cross-examination and I simply want to explore with the Professor what his basis for saying that has been. I am not suggesting there is not a good basis for it, but it may assist the Panel to know what it was about this patient
G that made her on reflection less stable than she otherwise would have been.

MR LANGDALE: I still think my point is right, but I do not want to be over-technical. If my friend wants to go over the same ground, please do so.

MR KARK: I do not think the Professor has covered this ground, in the sense that he has not given the specific reasons. (To the witness) I am not going to ask you to spend very long on it.
H

A A Just to elaborate on my response to Mr Langdale yesterday, my view – it was put to me that she was an unstable patient and I think the medical notes from the Royal Hospital Haslar indicate that. Then she appeared to be stable for a period of days. As I indicated, you really want to try and avoid transferring patients who are medically unstable and then having to manage a deterioration in a suboptimal environment. The point I was trying to make was that it is easy to recognise in retrospect who should not have been transferred. It is very difficult when you are placed with patients to judge when they are ready to transfer. If you B are too conservative, you never transfer anybody, because you are worried something might happen. The reason I said "in retrospect" was because after she was transferred to Dryad, she then I think developed chest pain on the 19th. So what I was saying was that she was transferred on the 18th and then within 24 hours she developed chest pain. One does not like to see this happening, but the point I was trying to make was that this is part of what one sees in geriatric medical practice. You cannot get it right perfectly all the time.

C Q On 17 August – and really this is what I was seeking to clarify with you – at the top of page 13 we can see, "Well, no chest pain". But then we see at the bottom of the page there is what you referred to as a "spike" in her temperature.
A Yes.

Q Then over the page, we see, "Well, comfortable and happy. Last pm spike temp, now [normal]." Then she is transferred, but despite the fact that it might appear that her issues D have resolved, it is possible they are going to recur.
A No. I think for example if someone had discussed this sort of lady with me immediately prior to transfer and said, "In the last 24 hours she has had a spike of temperature and she has been more breathless", I would have said, "Well, let's just wait a couple of days and see how she is." I do not think there is any suggestion that that information was fed through to a senior consultant on either the medical team or the geriatrician. So I am not critical of the transfer in any way. These things happen.

E Q Can I move on to Arthur Cunningham? Again, I am going to be very brief, I hope. Could you go to page 7? It is the issue of this patient's anti-psychotics. I have added in to my page 7, I do not if anybody else has, that on 14 September 1998 the patient was on something called risperidone.
A Yes. That is an anti-psychotic which has less Parkinsonian adverse effects.

F Q And carbamazepine?
A That is a mood stabiliser, I suspect it was being used for. Or it can be an analgesic in neuropathic pain or an anti-epileptic drug, but I do not think he had epilepsy, so I think it was probably being given as a mood stabiliser.

Q If, when he gets to the Gosport War Memorial Hospital, he is no longer receiving those anti-psychotics, I just want to explore with you again what is the proper approach. First G of all, if those who are treating him at the Gosport War Memorial Hospital know of that background and the patient does become agitated, does that affect the proper approach to take with this patient?
A I think you have to re-introduce the anti-psychotics, because any other approach is unlikely to be effective. Sedatives, for example, are not an appropriate approach for behavioural disturbance in dementia. They are not the preferred approach, anti-psychotics are not, because of the adverse effects and because they are not as effective. Opiates are not H

A an appropriate approach. Both sedatives and opiates in particular may make the problem worse, may make people more confused and agitated.

Q That is what I wanted to ask you about. You said this is a man who has had agitation, therefore diamorphine could make it worse. Do you say that because the man had previously been on anti-psychotics? If he has dementia of some form or another, is the effect of diamorphine any worse or is it the same?

B A Any drug that produces confusion as an adverse effect is more likely to do so in the elderly and is much more likely to do so in older people with impaired cognitive function and most likely to do so in people with dementia. So they are an at risk group. It is common to see systemic illness such as infection and drugs produce acute confusional states in people with dementia.

Q At page 14 of the chronology, Mr Langdale reminded you of this entry:

C "Became a little agitated at 23.00, syringe driver boosted with effect."

Again, I just want to explore with you very briefly how quickly one would expect to see the effect of a boost of the syringe driver in these circumstances.

A Not very quickly. Again, in someone with dementia the initial approach to agitation would be better with an anti-psychotic drug, but if you are increasing the rate of midazolam,

D it will not work immediately within half an hour, because it takes longer to get a significant amount of drug in. I am very critical of the very large increase in midazolam in this man.

Q I want to explore this with you. It may be important. On the side of the syringe driver – I have not looked at it for a while, but the Panel have it – there is a button which I believe says "Start boost". So you start it with a button and you boost it with a button. You may not be able to answer this. Do you know what happens when you press the boost

E button?

A I do not and I did not think it was used actually, because I am not sure how one controls the boost button to give an extra loading dose. There is no suggestion from any of the nursing administration charts or of course the prescribing charts that, if you like, what we call a bolus dose was given, but having looked at that pump, but not having read the instructions or personally used a syringe driver to give opiates, I would not know how to use boost function. Clearly in patient-controlled analgesia, patients give incremental boost doses

F in that setting, but I did not gain the impression that these patients were being given at any point booster doses.

Q That is why I have raised it in this context. If we look at the following page, the top of page 15, we can see that the diamorphine in relation to this particular syringe driver was – the original syringe driver at 9.25 was discarded and the same amount of diamorphine was put into the syringe driver and that was restarted at 2000 hours. Midazolam was in fact

G increased from 20 mg up to 60 mg. I am not going to ask you again about that; you have given lots of evidence as to what you think about that. That is also done at eight o'clock. We can see also that the hyoscine remained the same. Coming back to our note on page 14, if this reflects what actually happened:

"Became a little agitated at 23.00, syringe driver boosted with effect."

H That does not seem to indicate that that is a fresh syringe driver. Can you comment on that?

A I had not looked at that specifically, but I take the point you are making that the syringe driver appears to have been boosted before the report of agitation.

Q You cannot take that any further.
A Well, the syringe driver it appears was boosted before the reports of agitation, but maybe the recording of the agitation is incorrect by the relevant nurse. It is difficult to tell.

B Q Or the boost may, I suppose, refer to something else.
A I do not believe using these drugs that there would have been an increased dose given without that being recorded in the prescribing chart for a drug like midazolam.

Q We can put that chronology away. Enid Spurgin. I do not think we need to turn up the chronology for Patient I, but the issue arose in relation to infection. My note of your evidence was – and I just want to confirm this with you – in relation to septicaemia, was there
C any evidence of septicaemia for this patient and what is septicaemia?
A Infection in the joint would be confined to the joint and would produce pain and swelling and inflammation and a temperature. Septicaemia is when you get infection and bacteria actually replicating in the blood stream. It is a very serious condition. That is usually manifest by circulatory collapse, low blood pressure, patients look very unwell and often, but not always, have a high temperature, occasionally a low temperature. So it is a much more marked clinical picture. I think in my response to Mr Langdale, I said there was
D no evidence recorded in the notes that she was septicaemic and the chronic infection which we are postulating may well have been there would have been there for some days and weeks.

Q Can I just ask you this? Can a chronic local infection kill you without it turning into septicaemia?
A I think it certainly can. Chronic infections can cause a patient to waste away; they do
E not eat, but it is not an acute, sudden death. But it can lead to secondary problems. If you have a chronic infection in your hip and you are immobile, you are at very high risk of developing a pulmonary embolus, which can kill you quickly. So there are consequences of a chronic infection, depending on the nature of it, which can lead to death without septicaemia, but related to immobility and other problems.

Q Thank you for that. Finally, can we turn to Patient L, please. I am aware that I have
F doubled up on my timing, but I am almost there.
A I have doubled up on my response, I suspect.

Q Jean Stevens: you have told the Panel that there was, I think you said, a 15 per cent transfer back rate of stroke patients. Have I got that right?
A There was a paper that looked at this in the 1980s or 90s, it was in Orpington Hospital, and they had an off-site stroke rehabilitation unit, and we have had that in
G Newcastle for many years, and it reported the extent to which patients who were transferred for stroke rehabilitation developed problems which required management back on the acute District General Hospital site in about 15 per cent of patients, and I think that would accord with our own experience, they develop problems that you cannot manage effectively in an off-site hospital.

H

A Q Mr Langdale was examining the issue of aspiration pneumonitis with you, and if we go to page 15 – well, no, sorry, we should start earlier than that: we have looked at the note which indicated that her nasogastric tube appeared to have gone wrong.
A Yes.

Q If we look at page 12, and we can go earlier certainly if anybody wants to, she is being reviewed on 11 May, she is then being fed through a nasogastric tube; on 12 May the
B same. Then page 14, we can see at the bottom:

"Tolerating feeds without any problems."

I am afraid foolishly I have not recorded where we saw that note of what the date was that the nasogastric tube had gone wrong.
A On the first or the second occasion? There was one entry, which Mr Langdale took
C me through---

Q Sorry, I have got it, it is page 6, I think, top of page 6, when we have looked at the X-ray, and the nasogastric tube did not appear on the chest X-ray but it was in, which indicated that it had been pulled out to some extent. So that is back on 30 April---
A I mean, just to comment on that, usually nurses do not start feeding through a nasogastric tube until they have had the X-ray back and it is confirmed it is in place, so
D slightly surprising that there was feeding, and it is possible the house officer had assumed there was feed going down it when it had not, but his record certainly suggests that there was feed going down the tube, and then the end of it was found to be in the nasopharynx, and you would certainly expect the patient then to have an aspiration pneumonia if feed had been placed---

Q Which she did, and if we go to page 12 we can see complaints of chest pain, and that
E is on 11 May and 12 May; are those indications possibly of pneumonia?
A Well, nitrates were given, so the assumption here was the chest pain was angina, but it could be what we call pleuritic pain due to infection. You can get chest pain related to the infection. You do not commonly do so. She could have had other causes for chest pain, which I think we discussed.

Q We did. Come back to page 14. This is where I had started. Feeds continuing on 16
F May. 17 May "[Patient] no real change", and then it is:

"[No] further pyrexia since 14/5. Creps L base".

Is that crepitations?
A Crepitations left base, which is where she had infection on the X-ray.

G Q Does that mean that there is still some infection?
A Well, when a patient improves from pneumonia, the temperature goes down and their breathing improves, you can still hear signs at the left base for quite some time, and the X-ray takes often quite a period to clear. It does not mean there is anything not consistent with her improving from her aspiration pneumonia at this point.

Q Page 15, on 18 May, we can see:
H

A "Liaised with GWMH. Happy to take Mrs Stevens with above results. Tolerating NG feeding well. Seems to have recovered from aspiration pneumonitis."

If we go over the page, because we should not stop there, on 19 May she is:

"Referred by physiotherapist.
Referred for collection of sputum sample, but no added sounds and has poor cough."

B

Now, is that an indication that that is a continuing problem of pneumonitis?
A No, I do not think the poor cough is evidence of continuing infection, but the physiotherapist must have been asked, and it says here that she was asked, to see if she could obtain a sputum sample to send for culture, and one would assume at this point, I cannot recollect, that she was off antibiotics – one would not normally send sputum cultures until the patient had finished antibiotics, or they were not responding – and this reports that there were
C no secretions to suck out to send for culture, which again would be consistent with that things are improving.

Q Then on page 17 we can see that she is transferred to Daedalus Ward. We can see the nursing referral note in the middle of the page:

"Has had aspiration pneumonia, now resolved."

D

A Yes. This is now almost three weeks since the initial aspiration pneumonia, so that seems entirely reasonable.

Q Then we have the entry, if we go to page 19, and there are two entries here which may be relevant, and these are on the day of transfer, on 20 May:

E "[complaining of] abdo pain due to history of bowel problems. Oramorph given".

Then below that:

"Oramorph ..... given. [Complaining of] pain in stomach and arm."

I just want to explore with you, first of all, is there any relevance between abdomen pain in
F this case and pneumonitis?
A No. I certainly did not think there was. She had a history of chronic abdominal pain, and so the assumption I would work on seeing this lady was this was her chronic abdominal pain recurring that she had had for some years.

Q If the patient was suffering from chronic abdominal pain, are opiates an appropriate response?
G A I believe Mr Langdale asked me that question yesterday and I said since she had been assessed by a consultant gastroenterologist or surgeon, and it was thought to be irritable bowel syndrome or adhesions, no, opiates had not been considered then, so the situation has not changed because she has had a stroke.

MR KARK: Professor Ford, that is all that I ask you. Thank you very much.

H

THE CHAIRMAN: Thank you, Professor. We are at the time now when you would ordinarily be invited to take a break, and I am going to do just that, but we are also at the time when, following that break, it would be time for the Panel to ask questions, if they have any, of you, and we normally take some time, as you are probably aware, with a major witness to consider what questions we may have. I think that on this occasion the areas of questioning have crystallised dramatically, and we probably will not need as much time in camera as we normally have. So I am going to say we will break now and parties will be informed as soon after the break as we have finished our discussions and we will ask you to come back. Thank you very much indeed.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Professor, as I indicated a while ago, we have now reached the point where Panel members have the opportunity to ask questions of you. I am going to ask first of all for Panel members who have general questions rather than patient specific questions to put those, and I am going to go first of all to Dr Roger Smith, whom you will recall is a medical member of the Panel.

Questioned by THE PANEL

DR SMITH: Professor Ford, on the subject of syringe drivers and their prescriptions, we have discussed diamorphine and midazolam at some great length, and touched upon hyoscine. Can you just remind us what hyoscine does, what its indications are?

A It is an anticholinergic drug which is prescribed to reduce secretions, and in the context it is being prescribed here it is being prescribed to reduce the unpleasant rattle and retention of secretions patients can have in the upper airways. So it is a commonly used treatment in patients at the end of life who are on opiates and other sedative treatment, and also in people, who are not on opiates and sedatives, if they have got problems swallowing secretions or producing a lot of respiratory secretions.

Q In ten of the twelve patients that are the subject of the inquiry, either the anticipatory or the first prescription for the syringe driver drugs has included hyoscine. So there have been three drugs – diamorphine, midazolam and hyoscine – at the very first prescription. Can you help us as to what might be the purpose of that?

A The assumption I made in looking at those prescriptions, and I have not commented on them very much in my report, was that this was anticipatory prescribing for end of life care, anticipating that these patients may develop problems with swallowing secretions, and that the nursing staff could then commence hyoscine if that problem developed. That was how I interpreted the prescription of the hyoscine in these patients.

DR SMITH: Thank you very much.

THE CHAIRMAN: Thank you. Mr William Payne is a lay member of the Panel.

MR PAYNE: Good afternoon. I only have two or three small general questions. Staying with the syringe driver, and I am not going to take you specifically to any specific patients, but I think in your evidence that you have given you said that the best way to formulate the level of analgesic required would be to start by giving it either orally, or injection every four hours, till you get to a base, and then go on to a syringe driver to maintain a level. Am I right?

A A Yes, that is the standard approach which is recommended in most guidelines.

Q Well, can I just direct you to this: I mean, it is only a small thing and---

THE CHAIRMAN: Let us make sure that the Professor has a copy of it. This came with the syringe driver, which is our exhibit C16, and the Panel were all given copies of the document, which is headed "Me and My Syringe Driver".

B A I do not believe I have looked over this document before.

Q I think there is a copy coming to you now. (Same handed)
A Thank you very much.

MR KARK: Are there copies for counsel as well?

C THE CHAIRMAN: It is a very small point. Perhaps I can assist and just ask if counsel can look at, on the central pages – I think Mr Payne's question is in relation to point number 2.

MR KARK: It is could be copied in the meantime, I am sure Mr Langdale and I can – (Inaudible as microphone not switched on).
A Do you wish me to carry on?

D Q Certainly. I did not mean to delay the questions. It is just so we can look at the document in due course.

MR PAYNE: This is a very simple document. The lay members on the Panel can understand this, so can everyone else, but in the middle, and it says "Am I getting worse?", it says:

> "[There] are three reasons why the syringe driver is used. Not all of these reasons
E will apply to you."

Number 1 is:

> "cannot take pills ..... and difficulty swallowing",

which we have heard a lot about. The second part is:

F

> "It may be used if the Doctor is having difficulty finding the right dose of drug to control pain, sickness or another symptoms".

Now, that seems to be the opposite to the evidence that you have given us.
A It is. You can adjust the pump, the dose of drug being given. I have indicated that the effects of that, the final adjustment, will not be apparent for what we call five half-lives of the
G drug. It is not a strategy most doctors would use in finding the right dose of drug. The intermittent dosing and varying the dose to begin with is a better way of doing it generally.

Q Okay.
A I mean, I do not know who wrote this document, what advice they sought, and obviously there are no references, but you can certainly adjust the dose that is infused of any drug in it, but it is not in the guidelines listed as an indication for using a syringe driver. That
H is the only comment I think I can make about this.

Q Thank you very much. Another question I have; can you place me somewhere in the hospital hierarchy where the title of Clinical Assistant comes? I am not quite sure where I can pitch it, if you understand me.
A Well, it is a sub-consultant grade. I mean, clinical assistants can be key posts in delivering high quality services. The key point is they are non-training posts, so they are often occupied, like consultants, by people for many years. So they are an experienced clinician who is trained, generally as a general practitioner, who would not necessarily have had specialist training in the areas they work, under consultant supervision. In terms of what sort of level of expertise would the average clinical assistant have, you would expect them to be at registrar level, but they bring a whole experience of primary care, which a registrar in hospital would not have, so they have a different experience, which can be very valuable.

Q Thank you. That is helpful. So it is around registrar level, is that what you have just said?
A Yes, but they are not directly comparable. The registrar would have usually had more specific specialist structured training in the specialty they are working in than the GP, although not necessarily, but the clinical assistant would usually have had a broader medical experience, and, if they are general practitioners, working obviously in a primary care setting, which a registrar would not have, but they both are below consultant level.

Q Yes, I understood that. My other question for you and, once again it is not a specific patient but I have pulled this in, it is in regard to the drug charts. The front page of the drug chart – if you want to look this is K, page 279A.
A Yes.

Q That is the start of it. It is a prescription sheet. I have asked this question to someone else before, but as you are the medical expert I will ask you it again. At 9 it says:

> "Put date prescription needs to be reviewed in 'review' box of Regular Prescription Section."

If you turn to "Regular Prescription Section", which is page 281, it shows a review date, but there is no date filled in. I am wondering how critical that is, how critical the review date is, and whether it should be filled in and whether it is good practice to fill it in, and whether it is done regularly?
A I think it is true to say not all drug charts used in other hospitals would have a review date entered, so that is my first comment. I am trying to recollect if our own does. I think there are additional comments you can make, but I do not think all drug charts have a review date. You certainly in my view would not expect that to be routinely filled in. It really acts as an opportunity to act as a reminder, for example, with antibiotics, after a certain time period to review. Is the antibiotic still needed? I understand where your question is coming from – should it have been used before giving analgesia. I do not think it should necessarily have been used. I think it acts there as an opportunity to prompt the clinical team to look at an individual prescription at a specific time, but it does not override the general need to do so in individual circumstances for that drug, depending on the patient.

Q It is not a mandatory thing?
A I certainly would not view it as such. Let me put it another way: I do not think it is a failure of good medical practice to not complete it.

MR PAYNE: That answers my question. Thank you very much.

THE CHAIRMAN: Thank you, Mr Payne. We now go to Ms Joy Julien, who is a lay member of the Panel.

MS JULIEN: My question relates to my colleague's previous question relating to the role of the clinical assistant. Could you tell me – in Dr Barton's case – where her responsibility, you think, would have started and ended, firstly generally in terms of the structure and the general quality of care?
A I think I would go back to the job description because that does define the individual clinical assistant's role. I think that does, for example, have a phrase – and we could refer to it if necessary – saying "responsible for the day to day care of patients on certain areas." In fact, I believe the job description is not correct in reflecting the wards that Dr Barton was actually working on.

THE CHAIRMAN: Could I interrupt you just for a second? Mr Kark, I am not sure that this is a document that the Panel have been directed to.

MR KARK: It is tab 2 and it starts at page 1. It is not a document we spent any time on. Strangely, the last statement that was going to be read to you was going to be producing this document.

THE WITNESS: I think that should be the starting point in discussing it, because of the clinical director's job. I do not know if it is necessary for me to read through this: to visit the units, to be available on call.

MR JULIEN: No, that is fine. Really I was thinking in terms of their shortcomings or any sort of inadequacies, where would her role start and end?
A Consultants are responsible for what happens to the patients under their care. I think you cannot hold consultants responsible for every single action that happens. If you employ a locum doctor, you do not know them or the hospital does not, and they work for you and they do a single incompetent incident, it is difficult. You are not directly responsible as the consultant. But if there is a pattern of practice that goes on over a period of time, I think you have a responsibility for that practice. There is an issue about how aware you are of practices, which is a broader issue. Around prescriptions, I think it is more complex. The law is clear. Prescribing is a key privilege given to doctors and the prescriber takes primary responsibility for their action, and we are looking at a lot of issues around prescribing here. I do not think the consultant takes all the responsibility for a prescription.

Q I am sorry. When you are saying the "consultant", are you talking about Dr Barton specifically, or are you talking about ---
A No, sorry. Dr Barton is not a consultant. I am talking about the consultant staff that she worked for, if you like, or with on the elderly care service and unit. For example, particularly with trainees, consultants are expected to exercise considerable oversight to ensure that trainees are acting responsibly. You would expect less oversight for a non-training post, clinical assistant post, but for example if the consultants were aware of Dr Barton's prescribing practices my personal view is they do take some responsibility even though the legal responsibility for that prescription lies with the person ho wrote it. That is my view and it is the nature of consultant responsibility. I did indicate in an earlier comment

in my evidence, that when things go wrong with patient care, and if that is the final judgment that is taken here, it is rarely the fault in hospital settings, certainly, of a single individual. There is usually a system of things that have happened that have allowed that to happen, if it has happened over a repeated period. That is one aspect. The pharmacist was reviewing prescriptions. I think – I believe – many pharmacists might have questioned the nature of the prescriptions. It is difficult to be certain. Obviously the pharmacist at Gosport War Memorial Hospital did not. Nursing staff could have questioned. They might have said, "We are not clear what this prescription means." They might have said, "Where is the protocol by which we operate these prescriptions?" The framework that doctors work in is that the person who writes the prescription, because it is a privilege one acquires being a registered doctor, you do take a heavy responsibility for that prescription.

Q So when you were giving your evidence, on quite a few occasions you would say, "I am critical of that prescription" or "that sort of prescribing," when you are saying that, are you laying most of the blame at Dr Barton or would we need to always bear in mind the context which you have just described?
A I would like to use the word "responsibility". I would lay responsibility with the prescriber, yes, but for example – I am not saying this happened – but if consultants had said, "We think we need a policy of writing up prescriptions of diamorphine 20-200," or whatever, and then Dr Barton and other doctors on the unit did that, if a clinical assistant is implementing an approach, a policy, that has been put forward by the unit, I think it would be hard to hold that individual responsible if there was a policy or protocol there.

Q If there were situations, as we have heard, of a clinical assistant working in an environment that is a very difficult environment with staffing levels and other issues, how far in your view should that clinical assistant go in terms of trying to redress the situation?
A I think any senior qualified doctor in a non-training post who is in a role, if they have concerns about the environment they are working in, they have a duty and obligation for the benefit of their patients to raise those concerns with the senior doctor or consultant they would report to. That could be the individual consultant or it could be the consultant in administrative charge of the unit or, indeed, it could be a senior member of management.

Q To raise it in a formal way or to.... I am just trying to think how far.
A I think it should be. If one is concerned about patient care and the actions one is taking, I think one is obligated to raise that in a formal way. I think having a corridor conversation saying, "I'm a bit worried that we haven't got enough staff and patients are suffering," is not in my view an adequate response because of the sort of problem you get when people say, "What did you do?" You need to lay these things down in a clear way.

MS JULIEN: I think that is all, thank you.

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

MRS MANSELL: I think it is just going to two aspects of your evidence, really, and I want to understand why on the surface they look somewhat different. If I have a look at Day 21, we were talking about end of life care. I think we were talking about the best interests of the patient and sedation therapy. You were saying that the quality end of life experience for many people might be to be alert and to be able to hold a loved one's hand, et cetera. I could understand where you were coming from. You were talking about the potential problems with sedation therapy. When I actually then looked at some answers that you gave under

cross-examination, you were actually saying, this was talking about drug dependency in terminal care. You were saying you do not have to worry about the adverse consequences of necessary opiates, in people who are dying, to control symptoms. Part of what we have been looking at is that part of that package of opiates and prescribing may have actually contributed to that sedation, et cetera. I was trying to say, "Okay. How do I actually interpret these?" What are you actually saying?

A Yes. I am sorry. I do not think my responses are contradictory. What I was trying to outline was what you are trying to achieve at end of life – a patient whose symptoms are palliated, who is not in pain, who is not agitated, who is not distressed and is alert and able to communicate with their family and friends. Of course, that is not always possible to achieve. Sometimes patients do have pain and they need control, and they may have agitation which would usually require anti-psychotic drugs, or are very restless and would need sedation therapy. What I was acknowledging, and I think this is generally well acknowledged, is you do not withhold treatments that are needed to treat pain and terminal restlessness because you want to keep the patient awake. You have to accept that you may not be able to achieve that. I think I also mentioned that the key issue is, you have to use these drugs judiciously. It is not like giving a very high dose of antibiotic to make sure we kill the infection where the antibiotic is quite safe. You do not have to adjust the dose. We give a standard dose which we know will be effective if the organism is sensitive. There are clear adverse effects here and it is incumbent, particularly because sedatives, the literature shows, can be abused to result in a shortening of life. So it is incumbent that you have to have good reason to give them; you have to document, as in good medical practice, contemporaneous notes as to why you are giving them and there should be evidence of adjusting and optimising the sedative treatment. We spent a lot of time talking about the use of diamorphine but in many ways I would actually be more critical of the midazolam where there was often not a clear indication that the patients, at least in the notes, from my reviewing it, had terminal restlessness or other severe distress that merited it.

Q Thank you. That is very helpful. Just from my perspective, when we are talking about terminal restlessness – and I am looking at the patients and I am looking to see around terminal restlessness – what are the characteristics I am looking for?

A You have a patient who is moving around in the bed, may be flinging their limbs, may be actually alert and obviously distressed – it covers a range of descriptions. The key point is that those symptoms are present when you have given analgesia and you think you are controlling pain. It is another symptom. The Liverpool Care Pathway in Palliative Medicine, and you see it in the Wessex Protocols, separates out pain from agitation and they actually talk about restlessness separately.

Q What you would be looking for, then, is a very clear description of what is generating the agitation. So if you have the pain control but you still have agitation?

A No. I think the terminal restlessness can occur in the absence of pain. It can be a distressing symptom at the end of life that may be unrelated to pain.

MRS MANSELL: Thank you very much.

THE CHAIRMAN: Professor, finally it is myself, and I, as you know, am also a lay member of the Panel. I would like, if I may, to go back to the area of questions that we had from Ms Julien which I suppose is the wider picture, if you like. You have, to use your own words, been critical of a pattern of practice in the prescribing of Dr Barton over a number of years, and you have indicated that one might expect a variety of different persons to have

views on that pattern of prescribing. You have mentioned nurses, for example, and I know you are aware of the series of meetings that were held in the early nineties as a result of nurses indicating concern. You have indicated also that there is a pharmacist who is regularly involved. I think you just told us that many might have questioned the nature of the prescriptions. We have heard absolutely no evidence one way or another on that. We have heard that there was a pharmacist looking at these, but we have not heard from any pharmacist and we do not have anything to assist, but from you today we heard that pharmacists, or many pharmacists, might have questioned that. Then, of course, there is the whole issue of the consultants and over this number of years, and over two wards, there were a number of consultants. Would you have expected those consultants to have been aware of the pattern of prescribing practice of which you yourself are critical?

A I am trying to think how I would view this if it had gone on in the hospital wards I had responsibility for. I would have expected to be aware of it, either through myself seeing patients and picking up a drug chart, and my own practice – any doctor's – is that when you see a patient to always look at their drug chart to see what they are taking, to consider whether drugs may be a cause of their symptoms and to understand what their current therapy is, and it is what you think it is. So if one was saying, "Well, how could the consultants not have been aware of it?" that would require that nurses had never, ever mentioned the way that opiate drugs or midazolam were used on the unit to them, that the patients – and these patients did generally die fairly quickly, so that this all happened in between their weekly ward rounds and they were unaware of it. You can postulate a scenario where the consultants were possibly unaware of it, although I think at least in one case Dr Reid saw that prescription and reduced it. I have only looked at 12 cases, but there was at least one case where one of the consultants was aware of the prescribing practice. I think that is clear. I also believe, if I recollect correctly, Dr Reid said that Dr Barton had more experience in prescribing at the end of life, but I would consider that they are his patients, under his care and he would still carry prime responsibility as the consultant.

I have not been asked to do a review, as Mr Langdale pointed out, an inquiry into what happened, but in my opinion there is a broader institutional responsibility for what was happening and where you place that is a judgment. I think in my opinion – and I am trying to be very balanced about this – to say Dr Barton wrote the prescription and therefore that is the end of the matter in terms of responsibility is somewhat of a narrow perspective on the care of patients over a number of years. There were clearly other people that were aware of this prescribing practice. Senior nurses were and a consultant was in at least one case. Pharmacists would have been reviewing the use of diamorphine and midazolam. I think it is worth pointing out that this prescribing – I have never come across such wide and high prescribing of opiates and from talking to other people, I am not aware of it happening anywhere else. So it is not at all a usual practice and you could argue from that that it should have triggered someone to question it.

Q I should make it very clear that I am not for a moment seeking to expand on the ambit of this inquiry, but I am sure you will appreciate we have to look at the allegations against the doctor in the context in which they are alleged to have occurred and it is extremely important therefore for us to understand what the situation would have been on those wards at all levels and you have been very helpful in dealing with the issue of the nurses and the pharmacist. I am going to press you, if I may ---

A Can I just make a comment? I think when I was writing my report, it was quite difficult to give a highly informed opinion on the context, because one does not have all the information about the context. One has the notes which record the patient care. So I think

counsel may have thought my approach was narrow and I think that is the nature of being asked to review a series of notes. I am just explaining my position.

Q That is understood. In terms of where we are now, the Panel have heard a great deal of live evidence and I know you have had the opportunity to follow the transcripts. My question so far as the senior medics, the consultants, are concerned, widening it from just the unfortunate Dr Reid, the consultants in general who would have been responsible on those wards over the years, is it conceivable that consultants operating in the way we are told they were, going on doing ward rounds with Dr Barton once a fortnight, but conducting individual ward rounds once a week, would not have known what the prescribing practices of Dr Barton were?

A I think it surprises me they did not. I can just about see in some instances it might have been conceivable they did not. I mentioned Dr Reid, but also I would have expected any complaint – and I am sorry, I cannot remember when any patient complaints came about the use of diamorphine or midazolam, syringe drivers – that should have prompted an immediate look at what was happening by the responsible consultant. That is one comment I make. I can just about see it is possible, if it was only every two weeks, that one might not have seen that prescribing and if it was never discussed by the nursing staff – I find it difficult, because of the discussions that had been had in the early 1990s. You would think then, as a consultant and you were aware of that, you would ask the nurses, "Are you comfortable with how we are using opiate drugs?" because there was then, unless some of the consultants were unaware of that, that discussion in the early 1990s should have meant the unit as a whole and the consultants were sensitive to the issue. So I find it slightly surprising that there was no discussion of this. All I can say is, I suspect the consultants were very busy doing work on the main site, but in the context of what we now call clinical governance, which was not such a strong concept then, you would expect the consultants and the senior nursing management to be aware of it, mainly because it was clearly a very contentious issue in the early 1990s.

Q That was the one other category you had mentioned of parties who might be expected to have had an interest. You referred earlier to senior members of management. Given what we know about the events in the early 1990s, would it be a fair reading of those documents that senior management were also aware of the situation at that time?

A They must have been, would be my view. There is also – I forget at what point, was there not an independent review that I believe took place? I do not believe I have looked at the details of that, but at some point – I thought in the late 1990s – one of the cases after a complaint was reviewed by an external person and I do not know whether they looked specifically at the prescribing practice. That again should have prompted – if the prescribing went on after that, after that case was reviewed, and I cannot remember, but if the conclusion of that was that Dr Barton's prescribing was not a problem – but again, I have not seen that – management have to hold some responsibility for that if it is now accepted that that prescribing was not appropriate, which is certainly my view.

Q On that subject, I do not know whether you have seen exhibit D4, but it was certainly referred to during earlier evidence. Exhibit D4 is a Portsmouth Healthcare NHS Trust memorandum dated 27 October 1999. Do you have that in front of you, Professor?

A I do.

Q If I could direct you to paragraph 3(d), near the bottom, "Good practice in writing up medication".

A I am surprised, because there is a statement that it is an agreed protocol, but I do not believe we have seen the protocol. A statement that Dr Barton can write up doses of between 20 to 200 mg of diamorphine – I note there is no mention of midazolam – is not a protocol in my view. I am not sure if this was the protocol that Dr Reid talked about that he developed and was then changed.

B Q No, it is not. This specific one Dr Reid says he was not aware of. When he was shown it, he said he had never seen this before and had known nothing about it.
A The question is, who has agreed it? I would be fairly dissatisfied, let us say, as a consultant that a protocol was agreed and I was unaware of it about prescribing. You would expect any consultant to be aware of important prescribing protocols on a ward.

C Q That is very helpful. We are getting some picture through all the evidence we have heard what the practice and procedures were and to an extent what the knowledge was at that time. We have heard finally that in your view a doctor in the position of Dr Barton who might be feeling that they are in a situation where they are under-resourced, under-staffed, expected to do far more than is reasonably possible for them to do, should take the matter up formally and make formal representations. I understand that.
A Maybe that is – I think certainly you would expect that now. I would expect there to be a clear conversation with the responsible consultant. That would be the starting point. Should that be written at that point? No. But I think if there were then repeated
D conversations and there was no improvement in the situation one was concerned about, I think one is obligated to then raise it formally. I do not think one would immediately write a formal letter to the Chief Executive, for example. One would first of all explore the issue with consultants and other managerial staff responsible for the unit.

Q Would you expect managers, consultants, other senior staff, to be aware of that sort of situation where a unit was in effect under-resourced?
E A Absolutely. The consultants would know what the staffing levels were. They should have a clear idea in their own minds of what staffing was required and they should be reviewing that all the time. As the nature of practice changed on the unit, as was described, which I have indicated was common across the NHS, the continuing care beds were being changed into rehabilitation beds. Those patients were not brought by Dr Barton to those wards for rehabilitation; they were brought by the consultants to those ward for rehabilitation. The consultants have responsibility for ensuring adequate resources were in place to provide
F effective and safe care.

Q You may already have answered this next question in that. Just as you have indicated that in these circumstances you would expect Dr Barton to have done something, would you also have expected consultants and senior management to have done something if they were seized of that knowledge ----
G A Yes.

Q ---- and, if so, what?
A I think Dr Barton is a senior experienced clinician. If a senior experienced clinician on your unit tells you there are problems, that is something you cannot and should not ignore. You take serious note of it. It depends who makes the complaint. If it was a very junior doctor who had little understanding, you might not take it seriously if actually you did not think there was a problem, but that is not the situation I think where you have an experienced
H

clinical assistant working for you. If they have raised a concern with care, you have to look into that seriously.

THE CHAIRMAN: Professor, thank you very much. You have certainly clarified a lot of the issues in my mind. We are almost there. We are at the point now where the barristers have an opportunity to ask any questions that may have arisen out of the questions that have been asked by members of the Panel. I am going to ask Mr Langdale if he has any questions.

MR LANGDALE: I do not have any questions arising out of the matters raised by the Panel, thank you.

THE CHAIRMAN: Thank you, Mr Langdale. Mr Kark?

Further re-examined by MR KARK

Q I only have one matter. It is really to ask for your assistance about the phrase "terminal restlessness", which we have heard before, but you have just come back to. You have described it as "Moving around and a flinging of limbs. The symptoms are present even when under the effect of sedation."
A Maybe I meant opiates if I said sedation. They can be present in an alert patient who is very agitated and restless and they can be present in somebody who has a depressed consciousness level. That may or may not be in the context of receiving sedation therapy, because people who are at the end of life become less alert, even without sedation therapy necessarily. They can be twitching or moving.

Q I just want to ask what I am sure is a very basic question. When you use the phrase "terminal restlessness", the restlessness arises from the patient's illness at a time when they are at a terminal point in their life, or is there actually an illness of terminal restlessness?
A I am using the phrase that the palliative care guidelines use. They are talking about this occurring in a patient where it has been agreed they are at the end of – it has been recognised they are at the end of life. You are not approaching it in the same way as somebody who might be very agitated and restless who is not at the end of life, where you would need to investigate and assess the patient. So it is in a very specific context. The phrase "terminal restlessness" should not be used to describe, for example, somebody with severe dementia who may be unwell, but is not actually at the end of life or on the end of life care pathway.

MR KARK: I am very grateful. That is all that I ask.

THE CHAIRMAN: Mr Langdale?

Further cross-examined by MR LANGDALE

Q This will not take more than a moment, Professor Ford. I wonder if you would take a look at this document. I do not want you to say anything about its contents; it is simply to identify it. (Same handed) You made reference to seeing material relating to a complaint. Is that the document you have had the opportunity of seeing?
A No. I have never seen it. I was aware that there had been an assessment. I have not seen this document before. I was aware that there had been an independent assessment of practice in a patient, but I have not seen the outcome of that.

Q Would you just take a look at the document? I am not asking you what it says, but simply, does that accord with what your understanding was as to the nature of the matter that you were informed about?
A Yes, it does. I understood that a review of the case – it disagrees with my own opinion of course – but that is not what you are asking me.

Q I appreciate you have already said that. That appears to be the matter about which you had heard?
A I believe that is, yes.

MR LANGDALE: That really is it. Thank you very much.

THE CHAIRMAN: Thank you. You have heard it from all three of us now. You have come to the end of your testimony, Professor Ford. Thank you very much indeed for being here to assist us so clearly and ably. We can now release you to get back to that holiday! Thank you very much indeed for coming.

(The witness withdrew)

THE CHAIRMAN: We will break now, ladies and gentlemen, resuming at two o'clock, please.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Mr Kark.

MR KARK: Sir, the very last piece of evidence that the GMC are going to bring before you is a statement to be read from a Mr Richard Oliver Samuel, and I ought to mention that he in fact came in during the opening and then left, but I do not think that will affect his evidence given that it is in written form. This is, I think, agreed evidence as it is going to be put to you.

THE CHAIRMAN: Can I just clarify, agreed that we should hear it or agreed that it is evidence of fact?

MR KARK: I believe agreed evidence of fact.

MR LANGDALE: The latter.

THE CHAIRMAN: Thank you.

MR KARK: I am grateful.

Statement of RICHARD OLIVER SAMUEL, read

"I am the Director of Corporate Affairs for Hampshire Primary Care Trust. I have been employed in this position from October 2006 to the present day. This role encompasses responsibility for PCT-wide performance, legal issues and matters regarding the public interest, clinical quality, patient safety and assurance .....

A

My first knowledge of the investigation into events at Gosport War Memorial Hospital was whilst I was employed at the Strategic Health Authority in 2001. I was responsible for liaising with the Police and the Commission for Healthcare Inspection around their respective investigations into the care and treatment of patients at Gosport War Memorial Hospital .....

B

I believe that the first complainant went to the Police at the same time as making a complaint to the Trust, in 1998/9."

I have been asked to make it clear that that was in relation to Mrs Gladys Richards.

"However I am unaware of the outcome of this first Police investigation. I understand that around 2000 a second Police investigation was commenced but similarly, I am unaware of [that] outcome".

C

He says:

"I will now provide some background information regarding Gosport War Memorial Hospital, the role of the Clinical Assistant and of Dr Jane Barton. This background is provided on behalf of Hampshire Primary Care Trust. I do not, however, have direct personal experience of working at Gosport War Memorial Hospital or with Dr Barton in her clinical capacity .....

D

Gosport War Memorial Hospital situated on the Gosport peninsula was opened on 19th April 1923 with 26 beds. In May 1932 an extension including the provision of an Out Patient Department was opened. GWMH was handed over to the newly formed NHS in 1948.

E

In 1963 Out Patient and Accident and Emergency Departments were opened followed in 1966 by new departments for Physical Medicine and X-ray. During the 1960's Redclyffe Annexe was donated to the hospital.

1991 saw the commencement of a two-phase development, including new wards and Day Hospitals for the elderly and the transfer of Maternity Services to a new Maternity ward. More recently GWMH had 113 beds. The hospital does not admit patients who are acutely ill and has neither an A&E department nor intensive care facilities.

F

A full range of outpatient services was provided, although the bulk of these relate to Portsmouth Hospitals NHS Trust. Occupational Therapy, Podiatry, Speech and Language Therapy and Community Dental services were also to be found at the site.

G

In 1998, three wards (Dryad, Daedalus and Sultan) at Gosport War Memorial Hospital admitted older patients for general medical care. This was still the case in 2002.

Gosport War Memorial Hospital is currently undergoing extensive remodelling of the interior lay-out of the hospital and adjoining health centre in order to accommodate services currently located at royal Hospital Haslar including the accident treatment centre (minor injuries) .....

H

A

GWMH was originally under the management of the Portsmouth District Health Authority prior to the formal establishment of Portsmouth HealthCare NHS Trust in 1994. Between 1994 and 2002 Portsmouth HealthCare NHS Trust provided a range of community and hospital bases services for the people of Portsmouth and the surrounding areas of south east Hampshire."

B Then the heading is:

"Dr Jane Barton – employment history

Dr Jane Barton is a GP working at the Forton Medical Centre."

He then refers to a document dated 1 December 1980. If you go to tab 2 of bundle 1, I am C afraid we do not actually have the particular document that he first refers to, but can I just take you through the documents that we do have, because I do not think we have spent any time in any sense looking at these. Page 1, as you will see, was the job description for the post of Clinical Assistant to the Geriatric Division in Gosport, and you will see that at that time (this is back in the 80s) there is reference to the Gosport War Memorial Hospital, the Northcott Annexe and also the Redclyffe Annexe. You can see the job summary is set out and the duties are also set out, which were referred to this morning by Professor Ford. I am D not going to take time to read through those now. If we go to page 5 in fact, this is a document, which I think is dated 17 March 1988 if we look at page 6, and this is the application for the post of Clinical Assistant in Geriatric Medicine. She sets out her qualifications. Her present employer is said to be Hampshire FPC, "General Practitioner (minimum full time 20 hrs) From: 1980 To: Now". If we go over the page, she describes her experience and training.

E "In general practice locally since 1980. We have an average number of geriatric patients viewed nationwide, but the" – I am afraid I cannot read that.

MR JENKINS: "general feeling locally".

MR KARK: I am grateful:

F "general feeling locally is that they are well served and well looked after both within the community, in sheltered care and when they need inpatient care.

It will be a pleasure to extend the care that we as a practice give to our elderly with the support we get from our district nurses and community health nurse/health visitors.

G As a minimum full timer only working 20 hours weekly on practice commitments I am ideally placed to offer continuity of care and my partners have agreed to share the on call cover."

That is dated 17 March 1988. Over the page, page 7, we see the Personnel Officer is writing to Dr Grunstein, who is the Consultant Physician in Elderly Services at St Mary's:

H "Dear Dr Grunstein

A

> I enclose a copy of the sole application for the post of Clinical Assistant in Geriatrics at Gosport which was advertised recently.
>
> Please let me know if you would like me to arrange an interview."

Then if we go to page 9, I am just going to read the first paragraph, and this is dated 28 April
B 1988:

> "Dear Dr Barton
>
> I am instructed by the Portsmouth and South East Hampshire Health Authority to confirm the offer of appointment as Clinical Assistant in Geriatric Medicine for a period of one year commencing on 1 May 1988 and terminating on 30 April 1989.
C The post required attendance at Gosport War Memorial Hospital for five sessions per week."

It deals with remuneration---

MR LANGDALE: Can we have that? Can you read the remuneration paragraph.

D MR KARK: Certainly.

> "The remuneration for this post will be £9275 per annum as laid down in the Terms and Conditions of Service of Hospital Medical and Dental Staff ..... It is subject to amendment from time to time".

That was all that I was going to read from that letter, unless my learned friends would like
E anything else from it.

Now, in fact the statement reads, and my learned friends may be able to correct this, but the statement reads that he produces a "copy of a letter from Hampshire Health Authority ..... to Dr Jane Barton dated 1 December 1980". I think these must be wrong---

MR JENKINS: It is 88.

F

MR KARK: It is meant to be 88, I am grateful, "confirming Dr Barton's appointment to the general practitioner medical staff", and I am not going to read the rest of that. He produces the application form and the job description. I am going to read on from paragraph 17, unless my learned friends want anything else:

> "From 1st October 2002" – so this is post these events – "onwards Dr Barton
G voluntarily undertook not to prescribe benzodiazepines or opiate analgesics. Patients requiring ongoing therapy with such drugs were transferred to other partners within the practice with their agreement so that their care was not compromised. Dr Barton elected not to accept any house visits if there was a possible need for such drugs to be prescribed. Medicines Review Management has reviewed this on a regular basis since 2002 providing the PCT with ongoing auditable assurance. No breaches or problems have been evident throughout this time and the review process continues."

H

That deals with his statement, again unless my learned friends want anything else out of it, and that concludes the GMC's case.

THE CHAIRMAN: Thank you very much indeed, Mr Kark. Yes, Mr Langdale.

MR LANGDALE: Sir, it may be, and this need not hold up proceedings in any way at all, we will be seeking to agree an admission with my learned friend Mr Kark, and I am not going to trouble the Panel with it now, but it is something which, if it is to be agreed, can be dealt with at any stage, whether it technically forms part of his case or not.

Sir, I appreciate that we are hardly into the afternoon session, but I am going to ask, bearing in mind the stage that we have now reached, that the Panel allow us and sees to it that there is an adjournment until tomorrow morning first thing. I need to consider as to whether it is appropriate to make any submissions to the Panel, and I need a little time just to consider that. I can indicate now that if there are to be any submissions, they will not be lengthy ones, and I have to decide whether it is appropriate to make them at all at this stage if they are not likely to completely remove a head of charge from the Panel's consideration. That is a matter for me to decide, and I would like a little time to consider that. I can indicate to the Panel that if there are not any submissions, the evidence the Panel will next be hearing will be the evidence of Dr Barton, and I would like a little time with her before she gives her evidence, for obvious reasons. So for those reasons if none other I wonder if the Panel would consider adjourning until tomorrow morning.

Perhaps I can indicate in terms of overall timing, subject to the problems we have with video link and so on and so forth, we anticipate that the evidence called on behalf of Dr Barton will occupy not only the remainder of this week but all of next week. Quite how long thereafter I am not able to say, but it is going to be more than just a day or two, and there will be an amount of evidence, apart from the evidence of Dr Barton, about which the Panel will be hearing.

THE CHAIRMAN: Very well. So far as the request is concerned, I think general approbation from the Panel. Mr Kark, do you have any observations?

MR KARK: No.

THE CHAIRMAN: No. Very well. Then we will with pleasure accede to that request and look forward to starting bright and fresh tomorrow at 9.30.

MR LANGDALE: Thank you very much.

THE CHAIRMAN: Thank you very much indeed. Thank you, everybody.

(The Panel adjourned until 9.30 a.m. on Wednesday, 15 July 2009)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 15 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWENTY-FIVE)

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.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning, everybody. Mr Langdale?

MR LANGDALE: Sir, thank you for the opportunity yesterday afternoon for us to take stock and to see whether it was first of all justifiable and, secondly, whether it was appropriate to make any submissions with regard to the charges as drawn.

I have considered the matter with the assistance of Mr Jenkins and Mr Barker very carefully. I hope I have made the right decision. The decision is, I am not going to make any submission on any matters relating to the charges at this stage. May I just say this. There are certain allegations contained within the charges, say, for example, an allegation with regard to the prescribing of a dose of Oramorph in a particular case, just by way of illustration, where it may well be that there would be a basis for submitting that the evidence at this stage does not support a prima facie case in relation to that aspect of the charge. That may be wrong but there are certain instances where, in my view, there is a proper basis for making a submission. However, none of those alters the radical nature of the case. In other words, if I were to make the submission to the Panel and the Panel found in our favour, it would not fundamentally alter the structure of the case and the nature of the case that Dr Barton has to meet.

A disadvantage with approaching it in that way, if there is a justifiable basis for a submission, is that it creates a problem for the Panel in trying to separate out a particular part of a charge and might warrant an awful lot of consideration – consideration which might result in a judgment that there was a prima facie case or a judgment that there was not. At the end of the day, the Panel would have spent quite a lot of time dealing with a specific bit of a charge without it really affecting the general course of the proceedings. I am confident that even if some of those submissions at the end of the case turn out to be justified, it will not affect in any way the presentation of Dr Barton's defence. That is my cardinal objective and the thing I have to bear in mind more than anything else. I am confident it will not in any way disadvantage the presentation of her case if we do not seek to take those matters up now.

Those are the reasons why I am not going to pursue it. Whatever submissions there are on the evidence at the end of all the evidence no doubt I will be able to advance to the Panel in due course.

THE CHAIRMAN: Yes, indeed. Thank you very much for sharing that with us. It is very helpful.

MR LANGDALE: I had obviously indicated what the position was to Mr Kark. It follows from that the Panel will now be hearing evidence from Dr Barton. I will ask her to be sworn and we can deal with her evidence.

JANE ANN BARTON, Sworn

THE CHAIRMAN: You need no orientation from me, so I will pass you straight to Mr Langdale.

Examined by MR LANGDALE

Q Dr Barton, it is Jane Ann Barton. Is that right?
A It is.

Q You are a registered medical practitioner. You qualified in 1972 – is that right?
A I did.

Q Oxford University, with degrees. The degrees being?
A Master of Arts, Bachelor of Medicine, Bachelor of Surgery.

Q I think you joined the GP practice which we are concerned with in this case in January 1980, initially as an assistant for three months, and then as a minimum full-time partner?
A I did.

Q After you had qualified, until the time that you joined the GP PCC in Gosport in 1980 what was the position with regard to any medical work or training that you received after you had actually qualified?
A I did a surgical house job in Reading. I did a medical house job and a medical SHO job in Plymouth. I then had a baby. I joined a practice in Weymouth as what was then called a trainee (but is now a registrar). I qualified on the Wessex GP training scheme. I became a partner in that practice. I then had another baby and we went to Australia on exchange with the Royal Navy for two years, during which time I worked as a partner in a practice in Sydney and carried out family planning clinics in any spare time.

Q Roughly how long when you were in Australia were you in practice?
A Nearly two years.

Q That covers that particular period.
A It does.

Q If any more detail is asked of you, you can give it. Bringing ourselves more up to date with the times we are concerned about, or the years we are concerned about in this case, in general practice as we know at Forton Road in Gosport. Let us take as a starting point the year of 1989, say. At the time, just before you applied for the post of clinical assistant at the Gosport War Memorial Hospital, how many patients were you responsible for roughly speaking?
A I had a personal list of approximately 1500 patients, and I think there were 8000 patients in the whole practice.

Q What I am going to ask you to do is to have in front of you now a statement that the Panel already have, that you made to the police in 2004. This is in the Panel's separate file of Dr Barton's statements. I hope you have that file there. Can we go to the beginning of the file. This is the document that was provided to the police, headed "Statement of Dr Jane Barton". You set out obviously in that who you are and set out your history, which we have covered already. Then, in relation to the third paragraph on that first page, I was asking about patients, which you deal with. Would you just help us with regard to the general practice surgery sessions and so on. Is that an accurate statement as to what the position was – working eight general practice surgery sessions weekly. Yes?
A That is eight half days.

Q Yes?
A House calls on my own; personal patients but also generally house calls if I was on duty for the practice. I had a lower rate of out of hours on-call work than the other partners because of my reduced clinical commitment to the practice.

Q Then in the next paragraph you deal with taking up the post as the sole clinical assistant in elderly medicine at Gosport War Memorial Hospital in 1988. Can we leave that file for a moment. Would you leave that on one side because I want to go to the documents which are contained in file 1. Do you have it there? It may be somehow it is not. Dr Barton, I am going to ask you to keep the statement that you made to the police readily available. Keep that file open because we are coming back to it. Perhaps you can put it on one side for the moment.

MR KARK: I think the witness version of File 1, I am afraid, went off with Professor Ford. It is winging its way back from Newcastle, but in the meantime this is a spare. (Handed to the witness)

MR LANGDALE: As long as Professor Ford has not been writing on it! We can use this volume perfectly sensibly, I think. (To the witness) Would you look in that file, File 1 at tab 2, please, and in tab 2 go to page 5. This is your application in 1988. I am not going to take you through the details you set out about yourself. You have already given evidence about the basic background. At the bottom of that application form you set out your employer, as it were, as the Hampshire FPC, as it was at that time and so on. We move over to the second page of that document because I want to ask you about why it was you applied for the post. We are going to be hearing an awful lot about what you did and the patients you treated. You said in the application form, by way of context:

> "In general practice locally since 1980. We have an average number of geriatric patients viewed nationwide, but the general feeling locally is that they are well served and well looked after, both within the community, in sheltered care and when they need inpatient care."

Dealing with that, what was the general picture in terms of your experience with regard to geriatric patients?
A We were not a South coast retirement home like Brighton or Worthing, with large numbers of elderly people. The feeling locally was that because the population was relatively static, they tended to look after their own elderly people, elderly relatives. They took care of them. We also had the enormous advantage of our own cottage hospital. At that time in the cottage hospital there was a male and a female ward, as well as a little surgical ward and we could look after our own patients at the end of their lives in a hospice type hospital environment, and do it well.

Q And that was?
A The Gosport War Memorial Hospital.

Q Exactly.
A So I felt that with the experience I had already gained in Gosport, looking after my own patients, I was ideally suited to extend that role and look after other elderly patients in a similar background.

Q You went on:

"It will be a pleasure to extend the care that we as a practice give to our elderly with the support we get from our district nurses and community health nurse/health visitors."

A Yes.

Q

"As a minimum full timer only working 20 hours weekly on practice commitments I am ideally placed to offer continuity of care and my partners have agreed to share the on call cover."

Help us please with "As a minimum full timer only working 20 hours weekly on practice commitments...". What does that signify?

A That was what Hampshire Family Practitioner Committee accepted in those days as a minimum full time. It is not 20 hours a week because obviously your administrative work, your house calls, your other business within general practice takes longer than 20 hours a week, but that was what the Family Practitioner Committee recognised as my commitment to the practice. It did mean that I had time outwith what I was doing in the practice to offer to the hospital job, but that was the understanding with my partners; that it was in my own time. It was not to intrude onto my practice time.

Q Then can we look back in that same section of that same file to the beginning of tab 2, we can see the job description – the job for which you were applying. I am not going to read through all of this, but it set out at that stage what the position was with regard to the number of patients. We appreciate, of course, that the Gosport War Memorial Hospital changed physically ---?

A Yes.

Q --- in the early nineties. We will be coming on to that in a moment, but at that stage, that is something like a total of 46 patients, I think?

A Yes.

Q Accountable to consultant physicians in geriatric medicine, liaison with – and I need not trouble you with that. The job summary – we have already dealt with this.

"This is a new post of 5 Sessions a week worked flexibly top provide a 24 hour Medical Cover to the Long Stay patients in Gosport. The patients are slow stream or slow stream rehabilitation, but holiday relief and shared care patients are admitted. An important aspect of this role is for the postholder to be seen not only as a medical adviser but as a friend and counsellor to patients, relatives and staff."

Then there is a mention of consultant physicians and so on. Before I move on, is that indeed the nature, does it reflect the nature, of the patients that you began to deal with as a clinical assistant at the start of this history?

A Exactly.

A Q We will hear about things changing in due course. The two names that are mentioned with regard to consultant physicians are Dr Wilkins and Dr Grunstein. I think by the time we are concerned with in this case in particular with regard to the charges, both of those doctors were no longer in post. Or were they still in post?
A Dr Grunstein is mentioned in one of the cases as providing a locum cover up at Queen Alexandra but Dr Wilkins had certainly retired.

B Q Your duties are set out:

"1. To visit the Units ... be available 'On Call'...

2. To ensure that all new patients are seen promptly after Admission.

3. To be responsible for the day to day Medical Management ...

C

4. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date and reviewed regularly."

We will be coming back to that.

"5. To complete, upon discharge, the Discharge Summary ...

D

6. To ensure the prompt preparation of death certificates ...

7 To take part in the weekly Consultant rounds."

Then over the page:

E "8. To prescribe, as required....

9. To participate ... in multi-disciplinary case conferences and discussions ...

10. To provide clinical advice and professional support to other Members of the Caring Team.

F 11. To identify opportunities to improve services ...

12. To be available when required to advise and counsel relatives.

13. To be responsible for liaison with the General Practitioners with whom the patient is registered, and with other Clinicians and Agencies as necessary.

G There may be a possibility that the sessions can be split between two separate General Practitioners, ideally from the same Practice."

That did not arise, so you are not concerned with that. In that same section, moving on to page 7, having looked at what the post description was, we can see the letter to Dr Grunstein from the assistant personnel officer of the then Portsmouth and South East Hampshire Health Authority making clear – and three is no dispute about it – that you in fact were the sole applicant for this particular job. Correct?

H

A A Yes.

Q And then page 9, please, we see the letter from the Health Authority confirming the offer of appointment of you in that post. All right?
A Yes.

Q We take on board the remuneration for the post will be £9375 per year. Did that
B remain the same throughout the period we are talking about?
A It increased, very slowly.

Q Perhaps you can just help us a little bit more as to what it was – you made mention of it in your application – why take on this job? What was the interest here that you had and what was the attraction?
A I very much enjoyed looking after my elderly patients in the practice. I very much
C enjoyed my visiting rights at Gosport War Memorial Hospital, the possibility of admitting my patients at the end of their lives, and I had a great deal of respect for the nursing staff who worked at Gosport War Memorial Hospital and the visiting consultants who came. So I liked the whole ethos of the job I was asking to take on. I was not asking for the job for the money.

Q That comes to the next point I was going to ask you about, thank you. I think you were a member – would this be right – of the Gosport Medical Committee at that stage?
D A Yes.

Q So you had already admitted patients yourself to Gosport?
A I belonged to what was known as "the bed fund' and we were entitled to admits patients to the War Memorial Hospital.

Q That side of it, the GP ward side of it, in effect was what Sultan Ward became after
E the re-arrangements and rebuilding or redevelopment in 1993.
A Exactly.

Q What familiarity did you have at the time when you were appointed to this post with regard to matters such as step-down care, respite care and end of life care? What experience had you had or what familiarity did you have with that?
A I was familiar with my patients with chronic problems being offered and taking
F advantage of respite care in the hospital. This was a scheme by which every six weeks somebody could be offered two weeks in the hospital to give the carers and the family a break and a rest and recharge their batteries before the patient went home again. We continued doing that until about 1996, when it became too difficult. End of life care I was fully familiar with, both people dying at home and people dying in the GP beds at the War Memorial Hospital under my care. "Step-down beds" was not a term that was used in those days, because there was not the enormous pressure to discharge people from acute beds to
G convalesce somewhere else that began to develop in the mid 1990s. So I would not have used the term "step-down" in those days.

Q We will come on to the change obviously as we move through the history. May I just ask you this in terms of your experience with regard to the administration of drugs in the case of patients who were receiving what we can describe perhaps as palliative care or end of life care? At this time, before you actually start in post as the clinical assistant, had you had any
H experience of prescribing opiates for such patients?

A A Yes.

Q Had that involved at times prescribing oral morphine, Oramorph, or MST?
A Yes.

Q Had it also involved prescribing diamorphine?
A Yes.

B

Q At that stage, at the time you took up the post, were syringe drivers a method of delivery with which you had any familiarity or experience?
A I cannot remember using syringe drivers at that time in the community. I can remember that at the time I started the job the district nurses kept one in a cupboard in the health centre which we could use in general practice, but they were like gold dust. In those days, we were reliant upon the district nurse team going out four-hourly to give diamorphine C injections at home at the very end of life if they were required. I do not remember, before I took up the job as the clinical assistant, regularly prescribing a syringe driver.

Q That gives us the general picture. There is one other particular drug I am going to ask you about, because it features a lot in the later instances we are going to have to look at in detail. That is, midazolam. I do not know whether it is possible for you to remember or not, but had you prescribed midazolam before you took up your post as clinical assistant?
D A I think without subcutaneous infusion, it would not be possible to use midazolam in general practice because it would be very short-acting given as an intramuscular and would not be appropriate for restlessness in terminal care.

Q You have told us about your experience at the time that you applied for the post and were appointed. I would like you to look back in that same section of file 1 to page 4, please. At page 4, there is a letter from Dr Grunstein, consultant physician in geriatrics, as we can see E at the bottom of the page. The letter is dated 19 April 1991 – so you had been in post for two to three years by this stage – and he is saying in that letter:

> "I write to confirm the above-named ..."

In other words, you –

F

> " ... attended the Department of Geriatric Medicine for 10 half-day sessions from 27th-31st November 1989. During this time Dr Barton attended clinical sessions, studied service management and preventative medicine for acute, rehabilitation and long stay patients together with geriatrics in the community."

It is clear what that letter sets out with regard to your having attended that – do we think of it as a period of training in geriatrics generally? How would you describe it?
G A I arranged it. I used that letter in order to gain my postgraduate credits for that year, which involves each year you attending 30 hours of postgraduate education. I set up the week to go and see what happened in the geriatric service in Portsmouth. I needed to know what the wards were, what the different wards did, I needed to meet all the other consultants, I needed to go and see the day hospitals and how they were run. So this was me setting up a week to acquaint myself with what happened in the geriatric service in Portsmouth. It was not a requirement of the geriatric department to give me this. I organised it.

H

Q Would that have involved visiting Queen Alexandra?
A Yes.

Q And Haslar?
A Not Haslar. St Mary's, the various day hospitals and meeting the various personalities who ran these different units, which was terribly important if you were going to be accepting patients from them later on.

Q That is a particular period of time when you received further experience and training, if you like, in the context you have just described. I would like to open up a slightly wider topic before going back to the chronology. In terms of training or anything else that would fall under that broad category, or gaining further experience, apart from your on-the-job experience over the years, what else took place in terms of your attending either meetings or any form of training?
A As I mentioned, we all were required to do postgraduate education. I used to attend something called the Portsmouth Refresher Course, which happened annually, was held in Portsmouth and you would find that at least one session during that course would be devoted to palliative care aspects of work that we were doing in the community, which was often quite relevant to what I was doing. There were also at various times arranged by Dr Lord a series of sessions for clinical assistants to attend. I only ever remember attending about four or five. I remember going up to Salisbury for one and I remember presenting a case, an interesting case, that I had had at a meeting in Portsmouth, but unfortunately I can find no record of the paperwork that I kept at the time. But there was an attempt to draw together different clinical assistants and give them ongoing training in how to do the job.

Q With regard to that phase you are talking about or those events, would that involve the consultants or consultants generally?
A The geriatric consultants came to the clinical assistant training sessions and of course when you are going to refresher courses, you are dealing with consultants from all different walks of your profession coming to talk to you and teach you.

Q We will be coming on to a certain amount of detail with regard to what happened with regard to some consultants in connection with the 12 patients that the Panel is concerned with, but in terms of your encounters generally speaking throughout the 1990s with consultants, obviously matters would be discussed between you during ward rounds or any other time when you might see them in the hospital. Was there any other contact you had by way of gaining experience or learning from others apart from what you have described?
A Not until the end of the 1990s, when I became involved with the health authority and gained a little bit of insight into how the more political purchasing providing side of geriatrics was done. I am not sure that is entirely relevant to my clinical practice, but it was an interesting insight.

Q We may be coming back to the question of resources, but while we are thinking about it, perhaps we can deal with that. That is at the end of the 1990s. Are you able to give us a year for that?
A I think I became a clinical purchaser to the health authority in 1997/98. There was a representative from each of the districts within the health authority area. We attended health authority board meetings, we attended presentations and we of course were lobbied by our constituents about requirements for services and money generally.

Q We have already heard from Professor Ford again very generally speaking about the difficulties of getting funding which was experienced really throughout the National Health Service. That is something you can speak to if we need to go into any further detail.
A Yes.

Q I am going to go back, please, to the statement that you made in 2004, the statement which is in the file. You can for the moment put aside file 1. You have set out in your general statement how you had taken up the post of sole clinical assistant in 1988. Then:

> "GWMH was a cottage hospital. It had 48 long stay beds and was originally on three separate sites, and was resourced, designed and staffed to provide continuing care for long stay elderly patients."

You say in the statement in 2004:

> "The position of Clinical Assistant is a training post, and for me it was a part-time appointment."

We have heard that it was not a training post as such. Can you just help with that?
A There is nothing in my contract which states that it is a training post. I did receive training, in that I attended sessions with other clinical assistants. It did not automatically lead on to a diploma in geriatrics or to promotion in any shape or form. So I suppose in that way it is not a training post; it is a substantive post.

Q We have heard the evidence about it generally and that is not something with which you disagree?
A Not at all.

Q in relation to the three separate sites that you mentioned at that point with regard to your statement, those are the three sites which eventually merged and were organised into Dryad, Daedalus and Sultan Wards. Is that right?
A Dryad and Daedalus.

Q Not Sultan?
A Not Sultan.

Q That is when the hospital was upgraded obviously. In terms of the elderly medicine beds at Gosport War Memorial, those were administered presumably by the local healthcare trust.
A Portsmouth Healthcare Trust.

Q Which would be the forerunner of the Primary Care Trust which we have seen on a number of documents.
A Yes.

Q Sultan Ward was not consultant-led, but led in effect by the local GPs in the way that you have already described. How many beds on Sultan Ward?
A Approximately 20.

Q Those patients, without going into all the details, would involve patients in different categories, but including convalescing patients and also respite care?
A Yes. And end of life care.

Q The people responsible for deciding about the admission of patients to Sultan were GPs.
A Yes.

Q The total number of beds on Daedalus and Dryad was I think 48. Is that right?
A Yes.

Q In later years, just dealing with the general picture, is it right that something like eight beds on Daedalus Ward were allocated to slow-stream stroke patients?
A Yes.

Q The remaining beds otherwise in effect being designated to provide continuing care for the elderly.
A Yes.

Q Coming back to your statement, you set out:

> "Initially the position was for 4 sessions each week, one of which was allocated to my partners to provide out of hours cover. This was later increased, so that by 1998 the Health Care Trust had allocated me 5 clinical assistant sessions, of which 1½ were now given to my partners in the GP practice for the out of hours aspects of the post. I was therefore expected to carry out my day to day responsibilities in this post in effect within 3½ sessions each week. This was of course in addition to my GP responsibilities."

In relation to the sessions, what are we talking about? What was a session meant to be in terms of the time?
A I think in those days a session was three and a half hours. So you are talking about me carrying out the duties within ten and a half hours. That was deliberately divided up to be done in my own time. I did not attend the hospital for three and a half half-days; I divided it up into a daily visit, more than one daily visit, and I always felt that I carried out at least the number of hours that I was contracted for.

Q We will come on to the general routine in a moment or two, but that was the general picture?
A Yes.

Q Did that change? You said "at that time". Did that change in any way, the period of time that was allocated to a session?
A By the Healthcare Trust or by myself?

Q First of all by the Healthcare Trust.
A That as far as I can remember did not change.

Q And yourself?

A I felt that I was needing to offer the job more and more time, more and more of my own time, to do it properly.

Q The next paragraph of that statement sets out matters that we have already covered in terms of the beds and so on on Daedalus and Dryad. Can we come on to the question of consultants and what the picture was there? At the start of your taking up your post as clinical assistant, was Dr Althea Lord there?

B A Dr Althea Lord joined the team just before we moved up from Redclyffe Annex into Daedalus Ward. So she covered both periods of time. She took over from Dr Grunstein and Dr Wilkins.

Q So prior to the time of the changes, 1993 or whenever it was, was it essentially those two consultants who we think of as providing care in relation to the then existing situation?

A Yes.

C

Q Dr Althea Lord became responsible for Daedalus Ward and Dr Tandy, from whom we have heard, for Dryad.

A Yes.

Q You make the point with regard to the consultant that:

D

> "... they had considerable responsibilities elsewhere and thus their actual time at the Gosport War Memorial Hospital was significantly limited. Dr Lord for example was responsible for an acute ward and continuing care ward at the Queen Alexandra Hospital in Portsmouth, and had responsibilities at a third site, St Mary's Hospital, also in Portsmouth. As a result, Dr Lord's presence at the hospital was limited ..."

Can we just deal with Dr Lord? You have set out the picture there. During the period of time

E that we are concerned with in this case, particularly really from 1995 through to 1999, what was the general picture with regard to Dr Lord? She would be visiting every other Monday? Is that how it worked out?

A To do the continuing care round. She would be visiting on a Thursday afternoon to do a slow-stream stroke round. I was unable to attend that because I had an antenatal clinic on that afternoon and she would be in the hospital doing an outpatient clinic on a Thursday morning. So it was possible to contact her, speak to her, on a Thursday morning. I think she

F ran the Dolphin Day Hospital on a Monday morning and so again, it was possible to speak to her or pop in and have a word with her on both those occasions. So she was there in effect for two whole days a week.

Q In any given week?

A Provided that she was not on holiday or study leave or doing something else.

G Q In terms of her actually dealing with patients in Daedalus, how many times would you be with her on the every other Monday ward rounds?

A She would start at half past one, two o'clock. She would go on at least till half past five, six o'clock. She would often have to see families at the end of the actual ward round, so it was a long afternoon for her.

Q Normally speaking, do we envisage you being present assisting with regard

H to that ward round?

A A Yes, if I could.

Q What was the picture? Most alternate Mondays you would be there?
A Yes.

Q Then you move on in your statement over the page, page 3 at the top of the statement, to deal with the position with regard to Dr Tandy. You set out the
B picture there of her taking annual leave towards the end of April 1998, followed immediately thereafter by [redacted] leave, so she did not return to work until February 1999. Just dealing with that position for the moment. Up until the time that she took annual leave, what we can think of is really a gap in consultant care from April 1998 to February 1999, before that what was the picture with regard to Dr Tandy in terms of her presence as a consultant in relation to Dryad?
A As far as I can remember she did not do any other work in Gosport, so her
C presence in Gosport would be limited to her weekly ward round. Initially, when she first started I think she did Wednesdays but she then moved to Mondays, so Mondays were difficult, I had to be with either one consultant or another, and she was not in the building available in Gosport in nearly the same way as Dr Lord was.

Q So in terms of her ward rounds, we think of you being there with her 50% of
D the time spent on ward rounds or less or more? Is it possible to give a general picture?
A No more than 50%.

Q Did you find, so far as Dr Tandy and Dr Lord were concerned, that they were both people with whom you could readily consult if necessary?
A Yes.

E Q No difficulties of communication between you about the matters?
A Very approachable and very helpful always.

Q As you set out in your statement, during the period of time that Dr Tandy was, in effect, really not there for that period of time, the Trust took the decision that her post should not be filled by a locum. What actually happened? Did somebody ask that the post be filled or did it just remain not being filled? What
F actually went on in terms of trying to get proper cover?
A I was not privy to the decision that was made by the healthcare trust. I was not involved with the decision-making but I imagine that at that time it was possibly a cost-cutting measure, because she was on [redacted] leave, not to employ somebody full-time or substantive to take over her job while she was not there.

G Q When she returned to work in February 1999, assuming all these days are spot on, what was the position with regard to Dr Reid? Did he take over?
A He took over her role. He took over Dryad Ward as part of his portfolio within the Trust, but the problem with him was as clinical director he was very busy with other meetings and his other commitments and did not always make his Monday round.

H Q Again, just looking at it in the same general way we were with Dr Tandy and Dr Lord, when Dr Reid was in post in terms of his ward rounds how often would

A you be able to be with him when that occurred?
A Every other week, if he did it, if he was available.

Q Again, with regard to Dr Reid, did you find communication about matters you needed to communicate about perfectly viable, sensible or was the position any different?
A I felt that he was singing from a slightly different hymn sheet in that his
B priorities were already beginning to be the more effective use of those beds. He was already looking at the pressures being put on the acute beds at the main hospital sites and how our beds could be more effectively filled to help with the pressures. He was receiving pressure from the acute hospitals trust into the healthcare trust, "Give us more beds", "Make more beds available", and he was responding to that.

C Q In any event, if you needed to consult with him about any material topic ---
A Not ever in the building, again, as much as Dr Lord was, not on site as much and a very busy man.

Q I think he indicated in his evidence there had been times when you had contacted him to seek his advice or opinion. Is that right?
A Occasionally, yes.

D Q During the period of time then that Dr Tandy was - I am going to use the expression "away", 1998 into 1999, does that in effect mean that there was no consultant cover, if that is the right experience, on Dryad?
A There was no continuous consultant cover. Occasionally senior registrars or locums were sent down but the problem with some of the locums was that they were not from within the hospital trust and they did not really understand the
E infrastructure of the hospital, let alone what we did on the wards, so they were of limited help in looking after patients.

Q You move on in that statement to deal with the situation with regard to the position when you resigned in April 2000, and I think we have really covered the matters that you referred to in the statement there. "The consultant normally in charge of Dryad was also Clinical Director", obviously referring to Dr Reid.
A Yes.

F Q I am going to turn to a topic which you referred to in the statement in the next paragraph to invite you to assist with regard to the general picture so far as your physical presence at the hospital was concerned. You indicated that you would arrive at the hospital each morning when it opened about seven thirty, so we think of that as being the general picture?
A Yes.

G Q About how long, first of all, on the average day, it may be that no day is average but in general, would you be at the hospital in relation to patients on Dryad and Daedalus in the morning at that sort of time?
A I had to start my morning surgery at nine, so I had an hour and a half within the hospital to visit and review both wards; Dryad first and then Daedalus.

H Q In general terms, we will obviously come onto individual cases later, what would you be doing? What is the picture?

A I would arrive on Dryad Ward. They would just be finishing the hand-over between the night staff and the day staff and I would be taken around the patients by the senior day staff on duty and I would ask of each patient a series of basic questions about how they had been since I last saw them and I would be given the information, both given to the day staff by the night staff and from notes from the previous day.

B Q So in terms of information, first of all, from nursing staff, assuming that the night staff had completed their notes and so on, you would be able to see those?
A Yes.

Q You would also get verbal information?
A Yes.

C Q Would that always be through the route of the sister in charge? Let us take Sister Hamlin as an example. Would that always be through her or might individual nurses communicate information about the state of the patient themselves?
A Generally individual members of the day staff would not because they would have already communicated with Sister Hamlin. It was quite possible if there was a particular problem that one of the leaving night staff would have a word about a particular patient because they were still on the ward, but the main communication, the channel, was through the senior nurse with whom I went round on the ward.

D Q Do we think of you as actually seeing every patient, as it were, stopping at the bedside, or just getting information about patients from ---
A At Dryad Ward I actually saw every patient. I walked round through all the single rooms and the four bedders.

E Q If the patient was somebody with whom you could communicate, assuming there were no difficulties in terms of dementia or something like that, was it your practice to speak to the patients?
A Yes.

Q You say that was the picture on Dryad. Just dealing with that aspect of it, what was different about Daedalus?
F A Daedalus Ward, the ward round was done more as a business round in the office with the papers, with the night staff leaving, with the day staff taking over, and I would then go out and see particular patients I had concerns about. I would go out into the ward, having been given all the basic information.

Q What is the reason for the difference?
A It seemed to be the way the senior nursing staff liked to run their ward and
G they were more comfortable with doing it in a business way on Daedalus Ward and in a more informal way on Dryad Ward. It seemed to work equally well and I was happy to do whatever they wished to do.

Q I think in terms of Daedalus, certainly in the latter part of the period we are concerned with, that was Philip Beed who was in charge there.
A Yes.

H Q His predecessor?

A A Sister Joines. She liked to do that.

Q Throughout the period we are concerned with, Dryad would involve Sister Hamlin?
A Yes.

Q Would those meetings in the morning involve you from time to time writing
B up prescriptions in response to whatever situation had changed?
A Yes.

Q What physically would happen? You would write up a prescription, whatever it was for, although we will concentrate very much on controlled drugs. What would actually happen? You would write up a prescription on any given morning. What would then happen with regard to that prescription? You would
C go to somebody? It would be given to somebody?
A It would be given to the senior nurse in charge and she would then action it, deal with it, do something with it.

Q So there would be information provided to you in the way you have described, discussion with relevant nursing staff and your taking whatever the particular actions that you thought were sensible at that stage.
D A Yes. In addition, if I might want to write up blood forms or investigations for a patient in which there was a particular problem, I would have to do that at that time also because the blood lady came round when I was not in the hospital.

Q What would that actually involve you doing? Give us the practical picture.
A Finding the relevant form in the pile of forms and writing out the patients' information and what I wanted doing and signing it.

E Q Would you be getting results which had come in from previous ---
A I would also be getting a clipboard of results to look at, comment on and initial.

Q Once your morning visit was completed and you are back, as it were, in general practice, when would you normally re-visit the hospital?
F A I would re-visit the hospital if I had any admissions to clerk in and I would be told about those as they arrived by the admitting ward. They would say a patient has arrived on Daedalus Ward so I would go back to do that. I would be phoned if they had any particular concerns about a particular patient and they would either speak to me during surgery or if it was not convenient they would leave me a message and I would go back and see them at lunch-time, or if there was a particular family who were available and very keen to see me I would be happy to see them at lunch time.

G Q So while you are back in general practice, as it were, at the surgery, you might be contacted about an admission?
A Yes.

Q Which would require your presence, as it were, to clerk in the patient, we will come on to that in a moment, or maybe a situation had developed which
H needed some advice or attention from you?
A Yes.

Q Were there periods of time when you would not be available if the nursing staff wanted to get hold of you during the morning?
A Yes, and the understanding was that the duty doctor within the practice would cover that for me and they would be asked to visit at lunch-time.

Q Did that always work satisfactorily in terms of attendance by others?
A They did grumble a bit but they generally went. They knew how important it was to clerk in an admission.

Q Yes. Whether it is in response to a need to see a relative or a response to a medical situation or response to information about a new arrival, we can then picture you going back to the hospital at lunch-time. Did the length of time you spent at the hospital at lunch-time vary according to the situation which had or had not developed?
A Of course. It would take a substantial period of time to clerk in a patient or to see a family or, possibly, to organise the management of a particular situation. I was quite often constrained by having to get back to general practice, for example, antenatal or postnatal clinic or a surgery, so my time was tight again at lunch-time.

Q What sort of length of time would you normally expect to be there if your presence was required at the hospital?
A I would have to probably be back in the practice at half past one, two o'clock. I would also have my ordinary house calls to fit in during that time, so it would not be to go home and sit down for a three course dinner. The time was very limited in the lunch hour.

Q Let us deal with a situation where you had gone back specifically, maybe you had gone back for more than one reason, but you had gone at lunch-time specifically because there was a patient who was newly admitted. Would it be right for us to picture that most of the patients arriving, the new arrivals, would be coming from a hospital?
A Yes.

Q We have heard, obviously, just about every incidence here with regard to either QAH or Haslar.
A Yes.

Q Let us take a patient in that sort of category. They have arrived, from one or other of those two hospitals. What is your normal procedure? What would be happening?
A I would hope that their notes had arrived with them rather than just a skimpy transfer letter. So the first thing obviously to do would be to look through the notes and get a clear picture of what had been happening before and what plan the transferring team had for this particular patient.

Q So, in general, were the notes normally coming with the patient or was it 50/50?
A They should have done.

Q How often would you find you had problems?

A We went through a spell with Haslar that they did not like releasing notes from a military hospital, so all you would get would be a rather enthusiastic transfer letter and we would have to ring them up and ask then to send the notes on, but probably 70% of notes from the Queen Alexandra arrived on time to the right place, which made life a lot easier.

Q Yes. So if information was there, you would read through and it absorb it, as it were, to see what the picture was?
A Yes.

Q Then what?
A Then go and apply that information to the patient in bed in front of you.

Q Then what?
A Then a full clinical examination, as you would do with any patient either in general practice or in hospital. Not as full as a junior hospital doctor clerking in, but just a basic general examination of the various systems.

Q Without going into every detail, what, in general, would that involve, so we can get the picture with regard to your examination of new arrivals?
A Cardiovascular system, respiratory system, abdomen, GU system if necessary, musculoskeletal system and a very cursory central nervous system examination. This was after you had said "good morning" and "hello" and exchanged pleasantries with them, if you were able to.

Q Yes. What about things like blood pressure and so on?
A I would expect that those had been done by the nurses.

Q Can we take it that they were done?
A Yes.

Q What would the nurses be doing? Blood pressure; what else?
A Pulse, temperature. Both they and I separately would be trying to get an estimate of the Barthel score. I would probably do that both from the referral letter that I had received and also my impression of the patient lying there in front of me, and they would be doing a similar sort of thing to put on their charts. They had lots of other forms to fill in about the state of the patient.

Q Just pausing there on the Barthel score, I think in one or two instances we have seen you have recorded a particular score, and the nurse or nursing staff recorded a particular score. They do not always tally.
A No.

Q But that is how you might get a difference?
A Yes. But it was a matter of single figures, not a major difference.

Q What about Waterlow? Would that be something that would ---
A I did not do Waterlows. I understood what they were but I was not responsible for measuring them.

Q Can we take it that if a patient had a particular problem, say just by way of an example, a significant sacral sore or ulcer, would that also be something that you examined in the course of your examination?
A They would make me look at them, yes.

Q Having carried out that sort of examination, what sort of periods of time are we talking about? What would that normally take?
A That is going to take you 30-35 minutes with the reading and the examining and then the thinking, and then a very brief recording of what I found and the plan.

Q That is what I want to come onto. First of all, before we come on to your recording of things, what would happen with the nursing staff in terms of any record being made by them, normally speaking, with regard to blood pressure, pulse and so on? Would they make a record of that or not?
A It should have been put in the cardex.

Q The cardex being?
A That thing that they keep in the office that they look at. They should have recorded it in the clinical notes. I am afraid I did not go hunting for it.

Q No, but that is what you---
A I just assumed it would be there.

Q If everything was moving as it should that is what you would expect?
A Yes. It was all being done for you, yes.

Q Then your note-keeping or note-taking. We have seen in the twelve patients we are concerned with in this hearing a variation – some are briefer than others. First of all, why did you not make a fuller note than the note that you in general did?
A Because as a general practitioner by trade, I was used to making very minimal notes, really succinctly putting down my thoughts and feelings about the patient, not recording very negative finding as you would do in a hospital clerking of a patient, for my future information and for the information of my nurses.

Q So you would categorise yourself in general terms, not just in terms of note-taking at the Gosport War Memorial Hospital but in general for somebody who took brief notes? Briefer notes than most? How would you see it yourself?
A No briefer notes than other general practitioners in the same situation. I can think of one or two notable exceptions who write essays on every patient, but most of us did not have the time to do that.

Q I was going to ask you about that aspect of it. One could take any individual patient who has been newly admitted and one can say, perhaps, "Surely" – I have to ask you about this – "you could have spent an extra five minutes making a rather fuller note".
A Yes.

Q What do you say to that approach?
A I could have done, but to me it did not seem like time well spent because that very succinct note covered what I needed to know about that patient. It was adequate.

Q Would it be right to thing that time constraints might also be affected by any other matter that you had to attend to at a lunch time visit?
A Yes.

Q If there is more than one thing to do?
A Yes. It was not a priority to write full and extensive notes about admissions or review of patients by the same token.

Q You have accepted ---
A Yes.

Q --- in relation to the heads of charge that your note-taking, note-keeping, was inadequate. I am not going through every word of it. I would just like to ask you this. Did you ever have or find that there was any problem caused either to nursing staff or medical staff, in the sense of doctors, consultants, whatever, with person in that category having any difficulty understanding what should or should not be done with regard to a particular patient?
A None at all.

Q I think we have already heard evidence about this, so I do not think it is in dispute. Nobody, in the same of any consultant or indeed any senior nursing staff, seems to have approached you or picked you up on it and said, "Dr Barton, your notes are too brief. You should be giving a fuller account"?
A No one.

Q Although we will be coming on to this with individual patients in a while, in terms of the plan for the patient, you are seeing a newly arrived admission. You have checked whatever records there are as to what the history has been – the relevant history. You carried out your own examination and assessment. Was it always possible to think of a precise plan at that time, or provide a precise plan, or did it vary? What was the general picture?
A There were a few patients in which it was patently obvious what was going to happen to that patient.

Q What do you mean by that?
A There was one of our cases that we are considering that the lady had come for palliative care.

Q Yes?
A A diagnosis had been made. She had been on the palliative care ward up at the acute hospital. She was being moved down to Gosport. I was going to continue her palliative care. That is easy. There were a number of patients who had come down with the diagnosis of rehabilitation given to them in which, again, it was patently obvious that they were or they were not going to rehabilitate.

Q Would you give us the sense? When you say it was patently obvious, I appreciate these things may be dealing with feel and experience and know-how.
A Yes.

Q But what does that mean when you thought to yourself, "It's obvious rehabilitation is not really a practical course". What sort of situation would tell you that?

A A You have looked through the notes of what has happened so far during the preceding admission. You have looked at the state of the patient there in front of you in the bed. It is obvious to you, with clinical experience, that that patient is not going to be able to rehabilitate.

Q Again, as I say, we will look at individual patients later.
A Then between those two extremes there were people who were going to get the B chance, if it is possible, to make a limited amount of rehabilitation, and there were those people – there were lots and lots of people – who did. We are not considering any of those particular patients in this list of twelve.

Q That provides a basis, I think, as a suitable moment for me to ask you about two related or associated topics as to what you just described. First of all, patients generally. Can we deal with it at this stage. Over the years, as we all know, we are dealing with twelve C patients here between 1995 and 1999, but over the years – I am sure you were not keeping count – what sort of number of patients were you responsible for as clinical assistant from the time you started to the time of your resignation?
A Thousands. Possibly 3000, possibly more.

Q And in relation to the same topic we have just been dealing with in terms of newly admitted patients, and your trying to decide what is an appropriate course for their treatment D to take, what the plan should be, in terms of elderly patients, very often frail with various problems, no longer on the face of it any need for any acute intervention, what allowance did you make for the fact that the patient was newly arrived? In other words, they had been on Dryad or Daedalus for maybe a matter of minutes or a very few hours. How did that affect your view as to what was the appropriate thing to happen in terms of the transfer itself?
A There was always a degree of deterioration in a patient's general condition having been transferred. However short the journey is, the disturbance of being packed up, the E disturbance of being transferred, meeting new people, new are admitted, there was always a deterioration in their general condition and you had to factor this in to your feeling for how much improvement they were going to make, again, or whether they were not going to improve from that state when you admitted them.

Q So sometimes a patient might settle in a positive way, if you like, in 24 hours?
A Yes.
F
Q Or maybe a couple of days. It may be three days?
A Yes.

Q Sometimes the deterioration would not stop?
A Yes.

G Q How would you judge it when you say that, as it were, always or nearly always there would be some deterioration? How would you be able to assess that there had been a deterioration?
A I think the most obvious one that we have been looking at is the relative Barthel scores – the score that somebody had been given in activities of daily living on the ward they had left bore no relation to what was happening when they got to us. Now, either that was imaginative scoring or it was a deterioration in the condition of the patient on transfer, or it H was both.

MR LANGDALE: Sir, I am moving on to another phase in terms of Dr Barton's daily routine. I can deal with that now, or if it is suitable to take a break, we can take a break.

THE CHAIRMAN: We will take a break. What I would like to do, because I anticipate the doctor is going to be on the stand for a considerable amount of time, is to try to keep around the general view that an hour of questions, then a break, then an hour of questions. It will not be exact. You will be looking for appropriate moments, but maybe we can do that. Of course, Doctor, if at any time you feel that things are getting a bit much, and towards the end of a hard day they can, you only have to indicate and we will always stop and make time.

THE WITNESS: Thank you.

THE CHAIRMAN: We will break now, returning at 11 o'clock, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Langdale.

MR LANGDALE: I would like to continue with the general pattern of the day at this stage, please. You have dealt with the general picture with regard to a lunch time visit. I think it follows from what you have already told us, that apart from dealing with newly admitted patients, clerking them in and so on, examination, there might be other problems which you would have to attend to. Supposing a problem had developed with a patient. The nursing staff report that the patient has been particularly distressed, or whatever it might be, or that they are concerned that the patient has deteriorated and you are on, let us say, a lunch time visit and you receive that information. Would you see the patient concerned yourself if something was specifically reported to you?

A I would.

Q Would that be the case whatever the time constraints were?

A I would.

Q And it might be, I suppose, that you would need to give some further instructions as to what should happen in terms of the patient's care, or possibly write out a further prescription, or something of that kind?

A Yes.

Q Then coming back again to the hospital, you would sometimes be visiting the hospital in the evenings - yes?

A Yes.

Q It is possibly very difficult to say, but how many evenings in a week is it ---

A It would be probably only one evening a fortnight, if that.

Q All right.

A And it would be specifically usually because of a particular family had an express wish to see me, and it was impossible for them, because they were coming from a distance or they were working, to see me at any other time. I would make myself available to speak to them.

Q So sometimes the message might come from the family themselves? Or would it always come through the nursing staff?
A Or from me.

Q You might be saying, "I need to see you"?
A I would like to see this family. If it is not possible at any stage during the day, what about in the evening.

Q And again, if I can ask you this by way of generality to cover another topic that has arisen in this case, that is in relation to seeing the family, relatives, whatever one can describe them as in any given case, what were you trying to do? What is the object of the exercise?
A I was trying to make a relationship with the family so that we could help them through what might well be the last few days and weeks of their relative's life.

Q How important was that in the scale of things that you had to deal with?
A It was desperately important but it was the most difficult thing to do, and it was probably the most time-consuming thing to do, to make a relationship with a family who possibly had not come face to face with thinking about the problem, had been given unrealistic expectations or had their own particular problems to deal with, to try and make them aware of what was going on and help them through the process.

Q And what sort of difficulties – you have already outlined some of them – might you encounter if they had, or had been given, unreasonable expectations?
A One of the previous witnesses mentioned the idea that people were told, "Your relative will have a couple of weeks in the War Memorial Hospital and then be fit to go home." Totally unrealistic, and they would then be quite resistant to the idea that in fact that was not what was going to happen.

Q So what would happen?
A They would be hostile.

Q Yes?
A They would be unwilling to accept and we know in interviews like that, that people only probably are able to take in one piece of information and lose the rest, and that piece of information was not what they wanted to hear.

Q Again, we shall be coming on to certain instances in relation to evidence that the Panel has heard about, but let us take it to the crunch point. You simply cannot reach any measure of agreement with the relatives. They remain hostile to the idea of the fact that there is no acute intervention or something of that kind can be carried out. Their expectations have not changed as a result of what you tried to explain to them. Where might it end up if there was a meeting which had not really achieved any resolution?
A At that point I would probably ask if they could see my consultant – if I had a consultant.

Q Yes?
A And reinforce the picture, reinforce the ideas and support me during that process because I was not making any headway with the family.

Q Do you recall any occasion when you did have to try to bring in a consultant into the picture? Does that ring any bells with you?
A I do not think it is relevant to any of these.

Q Not in relation to any of these ---
A Any of these cases.

Q Of these twelve. But did it ever happen?
A It would certainly happen that I could ask if they would see Dr Lord on her next ward round, and an appointment would be made for them, which would have given them time to reflect and time to think about it anyway, think over what I had said, and I might even have arranged to see them again to try and make more of a relationship. That was also the role of our Pastor Mary who would come in at that point to try and offer a softening of the ideas, support, ways they should be thinking about it. Although she had officially retired, she came back and helped on the ward.

Q And in your experience with regard to the nursing staff generally, did it seem to you that they were aware of the importance of that aspect of things with regard to their responsibilities towards relatives or not?
A They gave enormous amounts of time to helping relatives through this period. It was much – I do not say 'easier' – for them; they saw them more frequently anyway. They were there on the ward with them more often, and I think from that point of view it was easier for them to make a relationship with the relatives as well as the patients and start the process of explaining.

Q Do we see it as being in terms of any evening visits, that that would in effect always be to see a relative or relatives?
A Unless there was a particular problem with a patient. Either I was on call or I had just finished an evening surgery, in which case I would be happy to call in on my way home. It was not very far away, so it was technically easy to do for me.

Q We will be coming on to the question of your availability to provide medical attention of one kind or another with regard to the whole issue of anticipatory prescribing, but I am going to leave that, and that side of it, until a little bit later. Might there be situations where you could be contacted but where you yourself were not able to respond, actually able to do anything yourself? I am trying to see what would happen if that was the case – that you could be contacted but you could not give any practical response, and therefore you would have to pass it on to somebody else. Did that ever happen or not?
A I suppose it could happen out of hours if they tried to ring me at home but I either was not available or was not able to give any help at that stage, then they would contact the duty doctor.

Q Yes?
A The same thing would apply during the working day. There was always somebody who was responsible for covering both the wards, and the same at week-ends.

Q And in your experience, in terms of what you understood to be the position with regard to attendance by other doctors in your practice, did that always work smoothly and on time, or not? Just by way of general picture?

A A They were usually reasonable, certainly about giving advice and verbal orders, and they would then generally follow that up at some later stage by a visit, if only to write up the verbal order and check that everything was then all right. I would not say that they would drop everything and immediately attend. Sometimes in general practice it might be difficult.

Q So apart from your normal routine: morning visit, lunchtime visit and visiting in the evening if occasion demanded it, what other situations might arise where you would be
B contacted or have to go to the hospital? You might be contacted because a problem had arisen and you could give a verbal instruction.
A Yes.

Q If that was the case, you would try to follow that up with a visit yourself, if you were not already going to going in.
A Yes.
C

Q Any other circumstances where you might be called out to attend?
A I think that covers it. If you think of the working day, the out of hours and the weekends, we hopefully had all the eventualities covered, either by myself or somebody standing in for me.

Q Going back to your statement to follow some of these topics through – I am still on
D page 4 of the statement – in the top paragraph on page 4 you deal with the question of visiting in the evening and then you go on to say in the second paragraph on that page:

> "I was also concerned to make myself available even outside those hours when I was in attendance at the hospital."

We have covered that in general terms.
E A Yes.

Q Then I want to move on to another topic which you move on to in the statement with regard to the level of dependency and the changes in terms of the patients. You begin that paragraph by saying:

> "When I first took up the post, the level of dependency of patients was relatively low.
F In general the patients did not have major medical needs. An analogy now would be to a nursing home. However, over time that position changed very considerably."

I am not going to go on reading out the rest; we will cover that later. First of all, what was the situation that you were presented with initially? How would you describe the category of patient who was there or coming into Gosport War Memorial Hospital before the change?
A These were patients who were nursing home patients. They were not at the end of
G their life and they were probably not near the end of their life, but they were sufficiently dependent that they needed full-time care by nursing staff: the sort of bread-and-butter nursing home patients that all general practitioners look after.

Q Would some of those patients reach a suitable state for them to go back home or somewhere else, or what? What is the situation?
A Very few of them would ever go home again and there was not the pressure before the
H changes in continuing care for them to go anywhere else. The health service were happy to

look after them in these surroundings. So they were stable from that point of view. Yes, they were reaching the end of their lives and they would need end of life care, but they were relatively stable.

Q Therefore, just to get the general picture, would those patients be patients who were staying in the hospital for quite a long period of time?
A Yes. For the rest of their natural lives.

Q Which might be?
A Five years, we had. Ten years, we had. A couple of years, we had. There was no pressure to move those sort of patients on anywhere because the health service provided for their care.

Q Then the change, with patients coming in increasingly dependent. We have heard about this already in some instances, but I would like to hear your account of it, please.
A Very ill, very dependent patients, with multiple co-morbidities and not medically stable, moved on because it was felt that there was nothing further that could be done for them in the acute setting and their bed was needed for another patient with very serious needs. So where did they go? They went to continuing care.

Q What is the effect of that in terms of your job and the job of the nursing staff?
A It ceases to be running a very efficient nursing home and it becomes something much more frightening.

Q What do you mean by that?
A Because you have patients who are quite likely going to deteriorate and deteriorate quite dramatically. They are very ill and they are going to need quite a lot of care and attention and looking after. It is not done in a measured, gentle fashion as in an ordinary nursing home. It becomes more like an acute hospital but without the back-up of the acute hospital, without proper diagnostics, without the proper blood tests, without the proper back-up, without blood transfusions, without ECG technicians. It was just trying to do a job in the wrong surroundings.

Q Can we just use this stage to look at what was available at Gosport War Memorial Hospital? We have heard something about the ability to deliver, supply and utilise intravenous fluids or whatever it might be.
A There was none. We had no facilities for administering intravenous fluids.

Q If you had had such facilities or means available, what would that have meant in terms of medical cover, as opposed to nursing cover?
A You would have to have full-time medical cover at least, if not on site, but not very far away.

Q Could you explain why?
A For inserting and re-siting and writing up and dealing with the complications of intravenous fluid administration and drug administration.

Q Was there any facility for ECG?
A When I first started the job, there was a lady in the outpatient department who did ECGs for the consultants, but I think again as a cost-cutting measure, they stopped using her

A and we had no access at one stage during this time to an ECG machine and certainly not anyone to read them if they were done.

Q In terms of x-rays?
A We had a very small x-ray department with a rather outdated imaging unit in it, run by radiographers. A radiologist came down from Queen Alexandra once a week to report films taken for general practitioners and within the hospital during that week. Reports were typed B up and then sent out, either to the wards or to the GPs, depending on where they were supposed to go to.

Q So a patient could be x-rayed?
A They could.

Q And, normally speaking, they would have to be moved from wherever they were on C any particular ward to the x-ray department. Was the x-ray department on the same level, or where was it?
A Down that main corridor and off to the right-hand side in a sort of portacabin arrangement. So it was technically quite difficult sometimes when they were seriously ill to move them down and x-ray. Sometimes the radiographers were not keen to x-ray them if they were seriously ill and you would then wait quite a long time for the report on that x-ray.

D Q I would just like to explore the general picture about x-rays a little more. We will obviously be looking at it in detail with regard to certainly one particular patient. In the normal course of events, if you had decided that a patient should be x-rayed – this is your decision and you want it done – what would actually happen?
A I would write up the form, one of my nursing staff would take it down to the x-ray department and negotiate a time for it to be done, the patient would go down at that time and have the x-ray done.

E

Q The x-ray has been carried out.
A The patient has come back to the ward, but the x-ray does not at that stage come back to the ward.

Q What would happen ordinarily?
A It would be reported on the next day the radiologist came to the hospital.

F

Q That might be the day after?
A Or it might be six days after, depending on what day the radiologist came down.

Q What happens if you, as the doctor, want an x-ray result, you want to actually know what the product is and be able to look at it?
A Then you would take yourself down to the x-ray department and ask to look at the G films yourself. It would be the only way around the problem until they were reported.

Q We remember the situation with regard to Patient E, Gladys Richards, where it appears that an x-ray was taken I think the day after she had had the fall.
A It seems that it was fortunate that was a day when someone was in the x-ray department and it was reported right away and the message was sent back to the ward that there was a dislocation.

H

Q So in general terms, if a consultant decided, having done his or her ward round, that a particular patient needed an x-ray, for whatever reason, what would normally happen? Assuming you, as the clinical assistant, were not present.
A He would write up the x-ray request form in the same way, the nurse would take it down to the department, it would be booked. I do not know whether he was aware of how long it took for an x-ray to come back on to the ward. If he had wanted to see an x-ray urgently, he would have presumably had to make his own arrangements to speak to the radiologist or attend the x-ray department himself or do something else with that x-ray.

Q I suppose a consultant, if you had not been present, had asked for an x-ray to be taken and all the form-filling is carried out and so on, and the consultant wants to know what the result of the x-ray is as soon as is reasonably possible, he would be in a position to ask you, as the clinical assistant, to see to that if he wanted it.
A If he had wanted it, yes.

Q Does it follow then that if a consultant, on his weekly ward round, asked for an x-ray to be taken and the clinician assistant was not involved in that process, the normal circumstance would be what? That the x-ray would be seen by the consultant on his next ward round or what?
A That would be my understanding.

Q Any other facilities in terms of Gosport War Memorial Hospital?
A We had a phlebotomist, a lady who came round and took bloods on weekday mornings. Those were then transported up by van to the Queen Alexandra and processed there. So the results generally came back two days later in hard copy form. There was one occasion when an attempt was made to notify somebody on a ward of a blood result, but they claimed they were unable to get through the switchboard. Normally they came back two days later.

Q Does that cover the facilities available, apart from obviously the basic facilities you have already covered?
A Unless you want to mention physiotherapy and occupational therapy, which were in the building.

Q We might as well deal with those at this stage. Physiotherapy and occupational therapy. What was the position there? We have heard something about it in terms of the availability of physios, but how would you describe it?
A The physiotherapy department in the hospital had mainly been set up for general practice use and I think they offered a certain number of hours to the continuing care wards. More of those seemed to be biased towards the stroke stream rehab on Daedalus Ward and I think we were offered one visit a week by the physiotherapy team girl on Dryad Ward, although obviously if you had a particular concern about a patient, you could always go up and have a word and say could they come down and have a look. Occupational therapy, the same: allocated so many hours, very easy to go up and have a word with the occupational therapist and say, "We have a problem. We need somebody fitting with something. Would you come and have a look?" They were in the building, they were available, but you had to go and be nice to them.

Q When we think of somebody in relation to whom steps are being taken to remobilise or rehabilitate, whatever the appropriate description is, apart from nursing care, you have

physios, occupational therapists available in the way you have described. What else could be done in terms of rehabilitation or remobilising?
A You would also be making overtures to social services.

Q So that they could be doing what?
A Their assessments of the patient and their help in finding accommodation for them, deciding what their future placement might be. We also had of course mentioned in a couple of the cases input from CPNs coming down either from upstairs or in from the community to see their patients.

Q CPN?
A Community Psychiatric Nurses.

Q That would be a particular nurse coming in to see a particular patient?
A And liaising back to her elderly mental health consultant.

Q Perhaps we can deal with anybody in the shape of a nutritionist or dietician. Was there anything of that kind? What was available?
A There was one based at Queen Alexandra hospital. She came down to assess swallows. This is more relevant particularly to the slow-stream stroke patients and management of people with swallowing difficulties, but you could request her, you could contact the department in QA and ask her to come down and assess a patient.

Q I think it would follow from what you have told us that in terms of CPR, there would be no team available, no crash team or anything like that, no defibrillator?
A No.

Q In terms of the changing nature of the patients which you have been giving evidence about and the impact of that upon pressures in terms of nursing staff and indeed medical staff, in the sense of the clinical assistant and I suppose the consultants, how marked was the change?
A It turned the job from being enjoyable for both myself and my nursing staff into something very worrying. We began to feel that we were not able to give appropriate care to a lot of the patients we were looking after.

Q Not able to give appropriate care in what sense? What, as it were, suffered as a result of that change?
A The first thing was, the hardest thing to deal with was the expectations of the relatives. That suffered tremendously. When we were a nursing home serving our local population, with families locally, everyone understood what we did at the Gosport War Memorial Hospital. The community supported us, they had a fete every year, they had a League of Friends. We were part of the Gosport community. Gradually, over this time we were accepting patients who were beyond my skills, beyond the skills of my nurses to look after properly and inappropriately in our beds.

Q Beyond your skills. Would you enlarge upon that?
A Because I did not have intravenous fluids, I did not have resus facilities, I did not have all these things that you take for granted in your district general hospital, as well as the medical support. Instead of doing it by myself part-time, I would have had a whole team of people working with me to look after these patients.

Q I am going to come on to what steps you took or tried to take and indeed the situation reaching the point where you resigned. I am going to come on to that later, but just staying with the same topic in terms of those matters, the hospital redevelopment, Gosport War Memorial Hospital redevelopment takes place in 1993.
A Yes.

Q We have the set-up you have already described with regard to these wards and so on. When about, if it is possible to give a time, did you start to notice the change in the nature of patients who were being admitted under a consultant to Gosport?
A I think about 1996 ...

Q Something like that.
A ... it began to ramp up. Portsmouth seemed to be very slow in getting rid of continuing care. I think it happened more quickly in other areas but I think Portsmouth held on to continuing care and respite care longer in Gosport, perhaps, than in some other areas, but by 1996 it was beginning to become apparent, but not desperate at that stage. By 1998 it was difficult.

Q One further question about that general issue. You have mentioned already, and we have seen cases involving some of the twelve patients under consideration, the fact that patients might be admitted to Gosport who were not medically stable. I will use that as a broad brush description. About what sort of proportion, if it is possible to give any figure, would you say of patients who arrived at Gosport who it appeared really were not in a suitable state?
A It was no more than 10-15%.

Q Something like that.
A Something like that. It was not the vast majority.

Q No. Can we deal with that in general terms before we start looking at individual patients? What do you say to this, "Well, doctor, when the patient was admitted and you formed the view that really it was not suitable for the transferring hospital to have sent them to Gosport, why not send them back?" Would you like to address that, as a matter of practicality?
A The patient had survived the transfer down to my ward. The reason the patient had been transferred down was that their bed was needed for someone else. Had I rung the relevant department and said, "This patient is not well enough to be here", they would have been sentenced to a transfer back and a long wait on a trolley in A&E while a bed was found for them.

Q At the initial hospital?
A At the initial hospital. It was not as if there was a nice cosy spot for this patient to be slotted back into. There was already somebody else in that bed and several already waiting in A&E to be transferred into that bed. I felt that my duty lay with the patient at that point not to put them through further misery and distress to transfer them back, but, if you like, to make the best of what we had got, to make them as comfortable as possible and, in many ways, at that point to accept that they were for palliative care. I could not justify to myself transferring them back again, unless, of course, there was something that could obviously be done, like the lady who had dislocated her hip. That is a different issue altogether.

Q Yes. Again, just dealing with the practicalities, might it also be the case that a patient would arrive at Gosport and one would not know whether they were medically stable or not but it might transpire over a day or a day or two that, in fact, they were not in a suitable state for transfer. Would the same process of thought apply in those cases?
A Exactly.

Q Back, please, to the statement that you made about this on page 5 at the top. You dealt in the second paragraph with the position with regard to 1998 as an example:

> "... the bed occupancy was about 80%. However, the Trust was concerned to increase that still further and it then rose to approximately 90%. There would therefore be as many as 40 or more patients to be seen and/or reviewed by me when I attended each day. There was no increase in nursing staff, support staff, occupational therapy, and physiotherapy, and no support from social services to assist with the increase in patients, and the increase in dependency and medical needs. On a day by day basis mine was the only medical input."

We have covered all those matters. That is the way you expressed it in that statement.

Then we can move on:

> "Part of the list of duties laid down for me, as Clinical Assistant was to be responsible for the day-to-day medical management of patients. My work involved looking after a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. The vast majority had undergone treatment in the acute sector and were transferred to our care for rehabilitation, continuing care or palliative care after their acute management was completed. A major group of these patients were suffering from end stage dementia as well as major organ failure such as renal failure. A lot of my time would be spent attempting to forge a relationship with families and helping them come to terms with the approaching death of a loved one. This aspect of the job was often not helped by unrealistic expectations of the level of rehabilitation available at our cottage hospital or possible in these individuals patients and difficult dynamics within the families. The act of transferring such frail patients also further compromised their condition, sometimes irreversibly."

Again, we have covered those topics in my asking you to speak about them. I just want to take up one part of that last paragraph. You spoke in that section about patients being transferred to your care at Gosport for rehabilitation, continuing care or palliative care after their acute management was completed. I would like to ask you about your understanding of these terms. Continuing care, we have heard about it from other witnesses, but what do you see that as when you talk about a continuing care ward or a patient coming for continuing care? Is that back to our nursing home type situation?

A A Yes, these are patients with a low but stable Barthel score, a low but stable mini mental test score, requiring a level of continuing care day and night from nursing staff and unqualified nursing staff, as you would get in a good nursing home.

Q Palliative care, just looking at it generally for the moment. Again, we have heard evidence from witnesses who might describe it slightly differently and we B have to bear in mind that a distinction can be drawn between palliative care and end of life care, but what would you say palliative care meant in general terms?
A People in which no cure was possible but who were not yet at the end of their lives, they were approaching the end of their lives, you did not know what the time-scale was going to be. You knew that you could not reverse the changes that had happened but that all your care would be aimed towards giving them a reasonable quality of life during that time.

C Q That would also embrace palliation of their symptoms?
A Palliation of their symptoms, entirely.

Q Again, in general terms, if you as a doctor concluded in respect of a particular patient that palliative care was what was to happen, that was, if you like, the plan, what did that signify in terms of whether the patient might ever recover from that?
D A Palliative care does not imply that they will not recover, it implies that they were unlikely to recover. You have not ruled it out but you have not ruled it in, so it is a whole series of interventions in order to keep their dignity, their quality of life, their comfort, as much as you possibly can at that stage.

Q Whilst at the same time controlling their symptoms, presumably?
A Whilst controlling their symptoms.

E Q It may follow on and may not need much explanation from you but we had better just deal with it. Then a patient who is at the end of their life, end of life care, reached a terminal stage, people have different expressions to cover the same thing. What does that signify in terms of your approach as a doctor?
A All their systems are running down. Everything is shutting down. They are losing interest in life, they are sleeping more of the time, they are not interested in F eating, eating is not valuable to them, they stop drinking, they stop interacting with their relatives and they are then approaching the end of their life. Again, you cannot give a time-scale but it is a process with one end.

Q That, in general terms, is the picture in the way you would describe it in the terms we are talking about?
A Yes.

G Q May I move back again to your statement to provide us a framework for these topics? Back on page 6 where we stopped a moment or two ago. You went on to say:

> "In carrying out my work I relied on a team of nurses both trained and untrained to support the work I did. Between us all we tried to offer a
H level of freedom from pain, physical discomfort, unpleasant symptoms

and mental stress, which is difficult to offer in an acute setting and is more allied to palliative care."

First of all, numbers of nurses. Did the change in the nature of the patients who were arriving for treatment at Gosport have an impact on the staff level in terms of the demands on the staff?

A I was not aware of any marked increase in the number of staff on either wards. I was aware that increasing the pressure on these girls made them more stressed, made them have to take more time off sick, made life more difficult for them. I was aware that both wards had a budget for bank staff and they had to always watch their pennies when employing people to replace nurses who were off sick on holiday. So there was constant pressure on them, if they wanted to do the job properly, which they did.

Q In general terms, we have a nurse in charge of Dryad, a nurse in charge of Daedalus, we have covered the particular personalities we have heard about in this case. Was there a number two to the person in charge? How did the structure work?

A Generally, each ward manager had a senior staff nurse and, generally, it worked out that she would be on duty when her senior was days off or on the alternate shift.

Q It may be testing your recollection too far, I do not know, but how many nurses during an average dayshift on duty on Dryad Ward?

A Probably three trained staff and four untrained.

Q Something like that. Daedalus?

A I would imagine comparable numbers.

Q Pretty much the same?

A Whether it increased slightly when the stroke beds came in, I do not know.

Q Then night staff, what sort of numbers, as you recall it, operating on Dryad and Daedalus?

A Two trained, two untrained and one of those two trained might also be carrying the bleep, might be responsible for the whole of the hospital, so she would be going round checking on the other wards as well as her duties on the ward she was based on.

Q So on any given night, whether there are bank staff in or whatever it might be in terms of the lowest grade, as it were, of nurse, would there always be somebody available at a senior level?

A Yes.

Q They might be looking after more than one ward but available if any problems arose requiring their attention?

A And going round regularly, yes.

Q In general terms, how did you find the nursing staff that you had to deal with in relation to both those wards? What is the general picture as you saw it?

A I had the greatest faith in all my nursing staff. I knew that they were not rocket scientists but I knew that, on the other hand, they cared for their patients

A and they cared how they were looked after, that they were fed, washed, turned, seen to and comforted.

Q In terms of the more senior nursing staff, can I ask you, first of all, about Sister Hamlin? Somebody who was at Gosport War Memorial Hospital right from the time you started having anything to do with the hospital or did she come on the scene later?

B A She came to Redclyffe very shortly after I started doing the job.

Q So you had known her, obviously, by the time of your resignation for a number of years?

A Yes.

Q I do not think there is any dispute about this: had developed a close working

C relationship with her?

A Yes.

Q Obviously got on well. Any social life shared by the two of you outside the confines of the hospital?

A None at all.

D Q Would it follow that in relation to nurses, generally speaking, below that level, I will come on to Sister Joines in a moment, depending on how long they had been there you would know them pretty well?

A Yes.

Q Sister Joines, how long had you known her for?

A She had been working at the War Memorial pretty much since I joined the

E practice. I had known her on the male ward before she took over Daedalus ward when the hospital was redeveloped.

Q Yes, so we can think of her there throughout all the relevant time.

A Yes.

Q Again, a close working relationship with her?

A Very. I respected her as a very competent sister and ward manager.

F Q Help us with the sort of balance between you. You would be listening to what they said, they, presumably, hopefully, would be listening to what you said. How did that work out if there was a difference of view as to what should happen?

A Neither would defer to the other simply because of your perceived rank or status but a discussion would go on and, hopefully, the right decision made for that particular patient. I was not really frightened of her but I respected her.

G Q Maybe she was frightened of you. We do not know. In general terms, so far as the nursing staff were concerned, what was the atmosphere like? Was there a build up of a kind of team spirit or was it disjointed?

A I felt we had a very good atmosphere. For example, when the new wards were opened in 1993 we arranged a bed push, I did not actually take part in it, to raise money for the Pegasus Airwave mattresses for nursing these very frail

H dependent patients on. The nurses between the hospital between them raised several thousand pounds to provide mattresses for our new ward. That was the

A sort of camaraderie there was between the nursing teams.

Q I am going to be coming on later to the difficulties that arose in the early 1990s. We have heard some evidence about that and I will come on to that separately, if I may, now you have given us the general picture with regard to the nursing staff. I think it would follow that, obviously, you placed a measure of trust in them?

B A Yes.

Q And would rely on the information they gave you?
A Totally.

Q Just going back to your statement, on page 6 you set out:

> "Over the 12 years in which I was in post, I believe I was able to establish a very good relationship with the nursing staff ... found them to be responsible and caring ... experienced, as I think I myself became, in caring for elderly dependent patients. I felt able to place a significant measure of trust in the nursing staff.
>
> Over the period in which I was in post there was only a marginal increase in the number of nursing staff. With a significant number of patients and the considerable increase in dependency over the period, the nurses too were faced with an excessive workload.
>
> The picture therefore that was emerging, at least by 1998 at the hospital, was one in which there had been a marked increase in the dependency of the patients, and indeed an increase in their numbers. There was limited consultant input reduced still further by the fact that no locum was appointed to cover Dr Tandy's position. By this time the demands on me were very considerable given that I was expected to deliver this significant volume of care within a mere 3 ½ sessions each week.
>
> I raised this matter with management, albeit verbally, saying that I could not manage this level of care for the number of patients, but the reality was that there was no one else to do it. In due course I felt unable to continue. I resigned from my post in 2000."

MR KARK: I am sorry, but before we have an answer to this long question, can I just raise a flag? What Mr Langdale is doing is taking Dr Barton through her pre-prepared statements. I do not know how these were prepared – I expect with the assistance of solicitors. Then he is asking for a comment on it. That is precisely the conduct that he objected to when we had Professor Ford here.

I appreciate you have read these, and I appreciate that Dr Barton has been living this case for many, many years, and I have not taken exception so far. When we come to more contentious elements, particularly in relation to the patients, I thought it right just to raise a flag and warning that I might well have an objection to this sort of examination in chief, which is entirely leading, taking place.

THE CHAIRMAN: Mr Langdale, it is right that you are doing something which you were objecting to in Mr Kark. There is one difference here, though, which is that the Professor Ford reports were not before the Panel, whereas you are taking your witness to, and transcripting, paragraphs that are already before the Panel and put there without objection, I might add. I am not sure of the value in any event of reading line by line what we already clearly have an understanding very clearly the significance of.

MR LANGDALE: Sir, two things. I am doing absolutely, with my deepest respect, what I am entitled to do. The situation is completely different to the situation that pertained with regard to Professor Ford. I would be entitled, and I am not seeking to do this, to take this witness through every line of every statement she has made because that is what is before the Panel and I could do it in that way, and that would be her evidence. I am not seeking to do anything that is improper or inappropriate.

What I have been trying to do is, having arrived at a certain topic in her general statement, is then ask her about it, and then go back to the statements so we can take on board what has been said. I will avoid repeating passages if I think the witness has already covered it in her answers, but it is simply to keep pace with the development of the statement. I have been, with respect to my friend, trying to ask her about a topic in her own words, based on her recollection and response now, and then referring back to the statement where necessary. I will avoid any unnecessary repetition. I bear in mind, of course, that the Panel has read this, quite possibly more than once. I shall try to avoid repetition in that sense, but I am absolutely entitled in my respectful submission to take her through what she has said because it is there in front of you. Professor Ford's report, for obvious reasons, was not. *I* did not object to Professor Ford referring to this report and saying, "In my report I said...". He was absolutely entitled to do that. I did not object. I simply raised a point which had arisen with Mr Kark when he quoted a chunk from the report, without having even introduced the topic. We agreed to continue because it was not contentious. With respect, I am entitled to do what I am doing, as I say, and I will take as much care as I possibly can to avoid reading out any lines where the witness has already covered the topic, albeit in different wards.

THE CHAIRMAN: I certainly was not for my part disputing your entitlement. I was merely questioning the value of significant reading of paragraphs to a witness when we already do have them before us, and they are of importance, and significance has already clearly been flagged up for us.

MR LANGDALE: I will bear that in mind and try and avoid any possible problem with that regards.

THE CHAIRMAN: Since we have, I am afraid, successfully interrupted you, perhaps this would be a moment for us to break and you can resume when we return. We will do that. Fifteen minutes, please, ladies and gentlemen – ten past twelve.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Langdale. Sorry for the interruption.

MR LANGDALE: Not at all. I want to ask about the period of time which we just touched upon in your statement with regard to the increasing pressure on you, your raising the matter

A with management and so on. In terms of management, in case some of these names come up, I am leaving aside consultants for the moment – all right? But in terms of management, was there somebody who was a hospital manager – given that title?
A There was a gentleman called Bill Hooper, who had an office in Gosport War Memorial and who I would see occasionally in the corridor and in passing. I started to mention to him in about ---

B Q It is not your fault. I just want to establish personnel first of all. That is somebody called "Bill" or "Phil"?
A Bill.

Q Bill?
A William Hooper.

C Q Bill Hooper?
A Who was the general manager for the Gosport War Memorial Hospital.

Q We will be seeing the name on correspondence. I just want to get the picture with regard to certain people. There is somebody called Isobel Evans. What was her position?
A She was, I think, the equivalent of the sort of matron for the whole hospital. I am not sure what her official title was.

D Q I think up to about the mid-1990s.
A Yes.

Q Just so we know who she is, because we will see her name on some documents that I am going to ask you to look at. She fulfilled that sort of role. There was somebody called Max Millett?
E A He was the Chief Executive of the health care trust.

Q Which ultimate became the primary care trust. Yes?
A He did not move over to the primary care trust.

Q I see. So when does he ---
A He resigned at that point. 2002, I think.

F Q That is in relation to those names in particular. In terms of Bill Hooper, General Manger of Gosport War Memorial Hospital, was he succeeded in due course by a lady called Barbara Robinson?
A He was.

G Q In terms of your raising the matter, raising the problems that you were facing by this stage, did you have any conversation first of all with Bill Hooper?
A I would have had an informal conversation with him to the effect that I was doing a lot of work for five sessions a week, clinical assistant remuneration, and that it was getting more difficult to do. I would not expect him to be looking at the clinical aspects of this problem, but more the financial aspects of it.

H Q So when you spoke to him about the difficulties in an informal sense, were you actually asking that you should be paid for more sessions to do the work, or what?

A A I was.

Q And what was his response?
A I suspect he laughed. After he had stopped laughing, I suspect he said that the financial constraints on the health care trust were such that they could not afford any more sessions for the job.

B Q Was he the person who actually held the budget?
A He would have been responsible for reporting back to those who held the budget.

Q Was there an indication from him that he would pass it up the line or he was going to do nothing, or what?
A I suspect he would have passed it up the line.

C Q Did anything come of that?
A I do not think so.

Q When abouts, without your being asked to give a precise date, did you have that conversation with Bill Hooper?
A Probably in about 1997 or 1998.

D Q Something like that. He was succeeded by Barbara Robinson. Did you have any sort of conversation like that with her at any time?
A A similar sort of conversation about how the workload was impacting on her nursing staff as well as on me not, probably, with any sort of financial motive in mind at that point in time, but more concern for the nursing staff.

Q Again, what response did you get?
E A I imagine that she passed it up the line.

Q Then consultants: did you ever discuss these issues or raise these issues with Dr Althea Lord?
A I did. Again, informally. I never wrote her a letter, but I would have discussed with her the increase in workload. I was always aware that Dr Lord tried to very carefully select the patients that she sent to Daedalus Ward as being appropriate for us to look after at the
F War Memorial Hospital. She would not accept some patients, because she felt that they were not sufficiently stable. I was aware she was trying to do that for us. I was also aware that she did not have any political clout when it came to asking for more clinical assistant time or more manpower.

Q What was her response when you discussed these matters with her?
A She was sympathetic and she was well aware.
G

Q Did she indicate as to whether she was able to do anything about it herself?
A She indicated that it would be very difficult for her to do anything about it, and she was also feeling the pressure herself at that time.

Q First of all this: when abouts would you have spoken to Althea Lord? Maybe you spoke to her about it more than once, but what sort of period of time?
H A A similar sort of period of time; 1998-1999.

Q And in terms of Dr Reid?
A Basically, as soon as he came to the job. As soon as he became the consultant in charge of Dryad, knowing that he was clinical director. I had an informal conversation with him, probably at the end of a ward round where we discussed the way forward, which he felt was to suggest to me that I might like to do the job full time. I pointed out that I was at heart a general practitioner and therefore that would not be possible, and he intimated to me that the pressure would continue to increase in the job. It was not going to get any better.

Q So it would seem then he was aware of the problems?
A He was very much aware of the problems but he was not going to be able to do anything about it.

Q Was that something you spoke to him about once or more than once?
A Probably only a couple of times, through 1999, culminating in my writing to him.

Q We are going to look at that letter in a moment, which was in January 2000?
A Yes.

Q Can I just ask you this. If you were raising these problems and finding that no one was apparently able to do anything about it, why not just stop? Why not resign in 1998 or 1999?
A Because I felt that I owed an obligation to the patients, to the staff, to my colleagues in the town, none of whom else wanted to have anything to do with the job, and to continue to do my best to do the job to my best ability. It was a very foolish way of thinking really, in retrospect.

Q Then the situation changed. You carried out but there came a point when you wrote to Dr Reid, and I am going to invite us to consider that period of time, in terms of what led to your resignation. Sir, there is a small collection of documents. Dr Barton is the author, if I can just indicate to my learned friend, of a letter I am going to put in, a response from a Dr Jarrett, which she will be dealing with, together with an accompanying document and another letter from Dr Barton to Dr Jarrett about these issues; then a letter from Dr Jarrett to Dr Barton together with another letter from her, and then a letter indicating that she has resigned, "Thank you for all the work..." and so on. Those are the documents I am seeking to put to the witness. I am going to ask that she receives them as a small bundle. There are about seven or eight pages and I will see that the Panel is provided with them and also, of course, Mr Kark.

THE CHAIRMAN: Has Mr Kark seen them yet?

MR LANGDALE: I do not think he has.

THE CHAIRMAN: Perhaps he should before we ---

MR LANGDALE: He may be aware of them in any event because they would be amongst the papers in the case.

THE CHAIRMAN: Mr Kark, are you content for these to go in before you have seen them?

MR KARK: If this is correspondence written by Dr Barton and to Dr Barton, then it is unobjectionable.

THE CHAIRMAN: Then we will receive them now as exhibit D6, please.

MR LANGDALE: I will just double check. I think every one of them is. There may be a letter from Dr Lord, but we will be calling Dr Lord. I think it is a covering letter. I feel absolutely sure there is absolutely no difficulty.

THE CHAIRMAN: We shall mark this D6, ladies and gentlemen.

MR LANGDALE: Mr Jenkins suggests, and I think it is sensible, if this collection could go behind Dr Barton's general statement which we have been looking at in that tab? It is a matter entirely for the Panel.

THE CHAIRMAN: If it is given an exhibit number, it is probably best for it to go with the other loose leaf defendant exhibits, otherwise we might find difficulty in finding it at a later stage.

MR LANGDALE: Whatever seems easiest. This would be ---

THE CHAIRMAN: D6, Mr Langdale.

MR LANGDALE: (Document marked and distributed) Thank you very much. That is for the whole bundle. (To the witness) Dr Barton, I think you have a copy of this as well. The Panel now have that. Would you look, please, at the first document which is a copy of a letter you wrote to Dr Reid. All right?

A Yes.

Q It is dated, as we can see, in the top right hand section, 28 January 2000.

"Clinical Assistant Elderly Medicine Gosport War Memorial Hospital

I feel that this is an opportune moment to examine my post for a number of reasons.

Firstly there is currently a review of the arrangement of Elderly Services and their relationship with future Primary Care Trusts and a future Trust configuration. These will undoubtedly impact on the future use of present continuing care beds throughout the District.

Secondly the Clinical and Managerial Integration between the Hospitals Trust and DSCA and the possible future implosion of acute work at Haslar will have a major effect upon the types of subacute and post acute care offered at Gosport War Memorial Hospital in reconfigured services on the peninsula in the future.

Thirdly and perhaps more relevantly at the moment, the type and throughput of patients who are currently using our beds is completely different from those I looked after when I took up the post twelve years ago. The types of patients and their medical conditions have changed markedly and perhaps this issue has not been looked at comprehensively within the Trust. There is no such thing as Continuing Care

nowadays, and Palliative care is something that I do perforce without a great deal of specialised back up.

At a clinical level this manifests itself in a number of ways, the most strikingly obvious of which is the expectations of patients and their relatives.

In part I feel that this stems from a mistaken perception that Gosport War Memorial is a Hospital with a capital 'H', ie resident medical staff and full on site resuscitation facilities. It is also apparent during discussions that relatives take the word rehabilitation literally and expect a much higher level of care and expertise than the current staffing levels and my time allow.

Whereas as recently as three years ago I would expect to spend a specific period of time with a worried relative over and above the normal consultation process once every few weeks, currently I find myself having to do this on a more frequent than weekly basis, in addition the climate of complaint, litigation and actual prosecution fuelled by intense media interest at present in care of the elderly and the issue of dying makes my position as a General Practitioner attempting to provide day to day care extremely difficult.

I am finding the pressures on me to continue to provide what I considered appropriate care for patients, proper consultation with their relatives and support of my hard pressed nursing staff almost intolerable. The current Police investigation into a charge of attempted murder only service to highlight the almost impossible task faced by a team dedicated to offering seriously ill patients a dignified and peaceful passing.

I would be most grateful if you would give this matter your earliest attention as I feel that the issue is placing considerable stress on the nursing staff and I personally feel extremely vulnerable to litigation for reasons that are outwith my control.

Yours Sincerely"

There is a copy to Dr Lord and a copy to Max Millett. To put certain things in context, what were you referring to when you were talking about the current police investigation, and so on? Had there been any complaint with regard to the treatment of patients prior to your writing of this letter?

A Yes.

Q The short answer is yes. And that was in relation to – do you remember by that stage?

A Gladys Richards.

Q And your reference to "current police investigation into a charge of attempted murder" relates to?

A Gladys Richards.

Q That?

A Yes.

Q I think in terms of the statements that you made to the police, the first statement that you made did indeed relate to Gladys Richards when you were first seen by the police in

2000 --- I am hesitating. It is thought to be 2000. We can check on the date. In terms of that letter to Dr Reid, did you receive any response from him?
A I did not.

Q Can we look, please, at the next page in the bundle, which is a letter to you from Dr Jarrett dated 16 February 2000. Dr Jarrett being whom?
A One of the consultant geriatricians based up at Queen Alexandra Hospital. This was distributed to a whole list of people.

Q You were one of the recipients of this, were you?
A Yes.

Q It begins:

"Dear Colleague

The bed crisis at Queen Alexandra hospital continues unabated. Routine surgical operations have been cancelled now. It has fallen on us to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some underutilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post acute patients. A policy offering guidance is enclosed. We shall trial the flexible use of the beds for a few weeks and I would be happy to co-ordinate any comments.

Thank you for your help."

Over the page I think is the document he refers to in the letter, "Emergency Use of Community Hospital Beds". That is the document, is it?
A Yes.

Q Then he refers, without my reading out every word of this accompanying document, in the fourth line down to:

"Some continuing care beds remain underutilised in Petersfield ... Gosport War Memorial Hospital and St Christopher's Community Hospital Fareham."

Was that correct in your view, that beds were remaining under-utilised at Gosport at that time?
A No.

Q

"These beds have no resident medical staff and weekly, or less than weekly, consultant ward rounds. There is basic nursing care and only minimal rehabilitation staff and facilities.

Therefore patients referred to these beds for post acute care should be:

Waiting for placement ...

A

Medically stable ...

No outstanding investigations ...

No interventional therapy ...

The patient lives near the community hospital ....

B

The patient and family consent to the move

The patient, family and staff ... clearly understand that the placement is in a post acute bed, not continuing care bed ...

GP beds in community hospitals are independent of the department's continuing care

C

provision ..."

Et cetera, et cetera. Did you find that reply helpful to what you had been saying?
A I was very upset to receive that reply to what I had been saying about the pressures already existing on our beds at the Gosport War Memorial Hospital.

Q Did you accordingly write to Dr Jarrett soon after that, the next page in the bundle, on

D

22 February?
A I did.

Q The body of the letter reads:

"I was very disappointed and also quite concerned to be shown a letter from yourself dated 16th February on the subject of the bed crisis at Queen Alexandra and addressed

E

to the various ward managers and Sisters.

Less than a month after I wrote a letter to the Clinical Director expressing my concerns about the situation in our continuing care unit, I find that we are being asked to take on an even higher risk category of patient.

These post acute patients have a right to expect a certain standard of medical care,

F

appropriate levels of therapy and supervision and appropriate out of hours cover during this period of time in hospital.

I find myself without a consultant or seamless locum consultant cover for a period of a further month on one of the wards and the other consultant cannot be expected to provide anything other than firefighting support during this time."

G

What was that a reference to, you finding yourself without a consultant or seamless locum consultant for a period of a further month?
A I think Dr Reid was not going to be available on Dryad Ward for that time and Dr Lord was being asked to cover both Daedalus and Dryad Wards during that time.

H

Q It goes on:

"As a result I am unable to do the clinical assistant job to a safe and acceptable standard which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition, my staff are subjected to ever increasing pressures from patients and relatives, causing stress and sickness levels to rise.

I would also question the term underutilisation in a unit which is handling approximately 40% or the continuing care done by Elderly Services at this time.

I hope you will give this serious consideration."

Did you then get a letter back from Dr Jarrett, which we can see on the next page, dated 7 March 2000:

"Dear Jane

Thank you for your letter dated .... making me aware of your concerns about the use of continuing care wards.

My original letter was an attempt to ease some of the acute pressures at Queen Alexandra Hospital. As you know there are a huge number of elderly patients as outliers who are blocking the surgical beds. There has effectively been little elective surgery from the Christmas crisis period.

A brief survey, a few weeks ago showed that there were some continuing care beds that were unfilled.

After discussion between John Bevan and my consultant colleagues ..."

John Bevan?

A He would have been the medical director of the acute hospital trust at that time.

Q

"... we felt it might help the dire situation here if we used some of those unfilled continuing care beds for patients who are clinically stable and awaiting placement in say a rest home or nursing home. It was envisaged that the patients would require little medical input and that we would only move patients who they themselves and their families were happy to move.

I understand that the continuing care workload at the Gosport War Memorial hospital is quite large certainly in comparison with other community hospitals."

Would you agree with that description?

A I would.

Q Then:

"Gosport is busy in other areas with an ever increasing number of referrals from Haslar Hospital and an increasing need for consultant input to the GP beds. With that in mind we will need to look at ways of trying to improve consultant cover for the Gosport peninsular. I will try and incorporate this into our plans to try and expand consultant numbers.

Thank you for letting me know of your concerns."

Did you then take the step of writing to somebody called Peter King, if we turn over the page?
A I did.

Q He was Personnel Director of Portsmouth Healthcare Trust, as we can see, and you wrote to him on 28 April 2000, enclosing your letter to Dr Reid and your letter to Dr Jarrett. Correct?
A Yes.

Q You say:

"Dear Peter,

Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport ... I have highlighted these worries on two occasions previously in the enclosed letters.

I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example on one of the wards I will only be having locum consultant cover until September."

Which one of the wards was that? Do you remember?
A No.

Q

"In addition an increasing number of higher risk 'step down' patients continue to be transferred to the wards where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.

The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation.

My original contract of employment signed in 1993 indicates I am required to give you two months notice. However, I wish my serious concerns and anxieties to be placed on record during the notice period."

Was that resignation letter setting out everything that was of concern in your mind at the time or not?
A Yes.

Q Then on to the next page of the bundle, please. On 19 May, did you get a letter from Fiona Cameron, who was the Divisional General Manager, saying that she had been passed a copy of your letter of 28 April tendering your resignation and Peter King had apparently formally responded. Is that right? Had Peter King formally responded?
A I cannot remember.

Q She says:

"I am writing to offer my thanks for your commitment and support to Gosport ... over the last seven years. There is little doubt that over this period, both the client group and workload have changed and I fully acknowledge your contribution to the service whilst working under considerable pressure.

Acceptance of the above pressures coupled with your resignation has led to a review paper being produced which outlines the current service at Gosport ... for Elderly Medicine patients, the medical support to this and the issues and pressures arising. The paper proposes enhanced medical input and rationale for that, which is in keeping with current intermediate care discussions.

I hope that you will be able to give your support to this proposal, given your knowledge of the current situation ...

My thanks for your contribution .... and my good wishes ..."

And so on. Then over the page, we have "Guidelines for Admission to Daedalus Ward".
A No. There are no guidelines.

Q One less document for us to be concerned with! It was in the bundle I had received and I am afraid I had not cross-checked. That takes care of bundle D6 and deals with the circumstances leading to your resignation in the way that you have described. When you ceased to work at the War Memorial Hospital in 2000, what replaced you in terms of clinical assistant or anybody occupying a similar role?
A I understand that a full-time staff grade position was engaged to be present on the wards from 9 until 5 every weekday. All of my partners but one agreed to continue providing a proportion of the out of hours care which was not covered by HealthCall completely out of hours in order to provide continuity of care between 5 and 6.30, when HealthCall took over.

Q Some time later – later in terms of years rather than months – was further medical cover provided as you understand it?
A I understand it, but I can give you no details.

Q We will deal with that in another way. I do not think there is any dispute about it. Further medical cover was provided in due course.
A Yes.

Q What do you say to the suggestion that really you were not sustaining an excessive workload? What do you say to that?
A I felt I was sustaining an excessive and dangerous workload by 2000.

Q I have dealt with the question of your note taking and your response to that. I think this refers to something that was given in evidence by Dr Reid. Given the choice between taking fuller notes and devoting your time to the care of patients, which would you choose?
A I would always prioritise taking care of the patient to the detriment of my notes.

Q I am now going to turn to the question of prescribing in terms of what is sometimes described as anticipatory prescribing and sometimes described as proactive prescribing. Before I deal with that specifically as an issue in context, I would like to ask you about the prescribing of certain types of drugs. What I am going to do is ask you about that in general terms without going through a mass of detail, then I am going to ask you about the issues which arose in 1991 and then I will come specifically, having put matters in context, to the issue of proactive/anticipatory prescribing, why you did it and what you understood would happen. First of all, in relation to particular controlled drugs – not in every case controlled drugs, but in general that is what one is dealing with. In terms of opiates – I will come on to the milder opiates in a moment – just dealing with the higher level opiates, starting with Oramorph, what was it that you found from your experience was the need for the administration of Oramorph and what were its advantages? What would create a situation or what sort of situation would it be that would involve ---
A Continuing pain, distress, anxiety in a patient undergoing palliative care. I was well aware of the analgesic ladder, both in general practice and in the hospital setting, and like one of my consultants mentioned in his letter earlier on, I felt that a small dose of Oramorph was much more beneficial to the patient than large does of step 2 analgesics, which were unpleasant to take and had unpleasant side effects associated with them, whereas a small dose of Oramorph would often give a slight feeling of euphoria and well-being to the patient in addition to controlling their symptoms of pain and discomfort.

Q Dealing with the practical problems, if you like, in terms of the administration or provision of a large number of, say, co-codamol tablets or co-proxamol or DF118 or co-dydramol. Just taking those as a group, what is the advantage, assuming the patient is in a situation which requires treatment with opiates, of Oramorph over those?
A Much smaller volume to take. They are large, unpleasant tasting, difficult tablets to swallow and I never felt that their analgesic properties were as effective as the opiates. I think in those days we were not frightened of opiate use in the way that we are now.

Q What would you classify as a small dose in general terms?
A 2.5 to 5 mls, i.e. 5 to 10 mg of Oramorph four-hourly and an extra dose at night to see them through the small hours.

Q That is the general picture.
A That is the general picture.

Q In terms of your past experience of administering Oramorph, prescribing it and seeing to it that it was given to the patient, had you been prescribing Oramorph in those sorts of circumstances from the time you started as clinical assistant at Gosport?
A I had.

Q Had you ever experienced the adverse effect on a patient of Oramorph causing excessive drowsiness or any other problems: agitation or anything of that kind?
A I had come across it causing constipation and it was almost mandatory to co-prescribe laxatives at the same time, because you knew it was going to make people constipated. I had

had problems with it causing nausea in one or two patients, which again could be controlled by another drug or step down, use a different drug for a while and then go back to it.

Q I think we have seen in one of the 12 patients there is a reference by you to the patient being Oramorph sensitive, or something like that. We will see that in due course. In general terms, had there been any problems in relation to your prescribing and administration of that drug?

A No. I found it a very user-friendly drug.

Q May I just ask you this, albeit in the context of Oramorph, but generally. In terms of the BNF, how familiar would you have been at that time with what the BNF said with regard to opiates generally and opiates individually in terms of Oramorph and diamorphine?

A I would have been quite familiar with the passages in BNF.

Q In general terms, were you aware of what the BNF said about the general position with regard to elderly patients receiving opiates?

A I was.

Q In relation to the Palliative Care Handbook, or the Wessex protocols, whatever they are properly described as, were you aware of that document?

A I was. It was usually in my pocket or in my briefcase.

Q Were you aware of what was said in that palliative care handbook with regard to the general approach so far as conversion from morphine taken orally to subcutaneous administration?

A I was aware of the conversion.

Q It would follow from what you said that you were aware of the other general guidelines that are set out in that document?

A I was.

Q Did you take into account any feedback from nursing staff when you prescribed and administered controlled drugs like Oramorph? Would that signify to you?

A It would be very helpful in choosing which drug, which range of dosage, to use on that patient. I could not do it on my own just looking at the patient as a snapshot once a day, I relied on what they told me had happened for the rest of the 24 hours.

Q Did their account of the effects of the administration of Oramorph bear out what you yourself thought or not?

A It did.

Q Did any consultant or, indeed, anyone else ever query your use of Oramorph with regard to any patient?

A No.

Q Turning to the administration of subcutaneous analgesia, and we are focusing not exclusively but very much on diamorphine and midazolam, so I am going to focus on those two. Again, in general terms, what sort of situation would cause or bring about the actual administration? I am not talking about prescribing

in advance at the moment, but the actual administration of subcutaneous analgesia. In general terms what situation would bring that about?
A There were the obvious reasons like the patient was no longer able to swallow or the patient was vomiting continuously or the patient was too frail or unwilling to take oral medication, but there was also the additional consideration that when adding the midazolam I had the help of an anxiolytic mild muscle relaxant to add to the pain relief I wanted to give to control the patient's very distressing symptoms. So it was a tool to control symptoms at the end of life.

Q When a patient was provided with subcutaneous analgesia and diamorphine being, as it were, the lead drug, not always but very often, together with midazolam, what did that signify in terms of the patient's status in terms of continuing care, palliative care, end of life care?
A It signified that palliative care was now moving into end of life care, into terminal care. It was the time when all the other medications the patient had been taking, for whatever reason, were probably stopped, for whatever reason, and you then focused on making the patient comfortable and peaceful.

Q What about the situation where a patient, just in general terms, is receiving analgesia in the form of Oramorph and the reason for the change to subcutaneous administration of diamorphine is that the patient can no longer swallow, not because the patient's condition has deteriorated?
A You could then make a direct comparison of dosage, based on working out from the one third to one half conversion table as to what you would give in the syringe driver. Now that would not necessarily mean that is the patient was right at the end of life, although why had they stopped swallowing? They were probably nearing the end of life anyway.

Q There might be some other problem?
A There might be some other problem.

Q But in the abstract, that sort of situation would not necessarily import a change of status?
A No.

Q When you made a calculation as to what was appropriate in terms of the dose to be administered, I am just talking about the minimum dose prescribed, when you hit on the figure of 20 or whatever it might be, were you taking into account in terms of any calculations that you made what would be the conversion from Oramorph to diamorphine? In other words, were you applying a one third conversion or a half conversion or what?
A In those days I think a half was used more commonly than a third. I was also taking into account that in general practice it would be very unusual to start at 10 mg of diamorphine in 24 hours because that did seem, in practice, a very low dose. It did seem very ineffective. 20 as a starting dose in the opioid naive or not opioid naive seemed a very satisfactory starting dose and I did not ever see any major side effects or problems with that dose.

Q In a patient who was opiate naive, they have not had any opiates in the immediate past, as it were, why not start at 10 to address that issue?
A Because, in my experience over the years of using it, it did not seem very effective in the dose of 10 mg. You would very quickly have to go back and

increase it to 20.

Q We will be coming on, obviously, to particular doses with regard to particular patients in a moment, but may I just ask you about your understanding, still staying with diamorphine for the moment - well, we had better go back to Oramorph, taking that as a starting point. Your understanding as to the effect, the impact, of the administration of Oramorph in terms of when it starts working and when it declines, in effect, that general picture, what was your understanding as to what the sequence would be?
A I am not a professor in clinical pharmacology but in my understanding in those days, by the end of four hours it was pretty much ceasing to be effective and that it would reach its maximum effect at approximately two hours. That is how I used to dose it.

Q Yes. If we imagine a patient receiving a teaspoon full, 5 mg, it would reach its maximum effect, in your mind at the time, when? After two hours?
A I suppose between the two and the four and then be starting to - that was why we, presumably, gave it four hourly.

Q Exactly. Then in terms of diamorphine by subcutaneous, leaving aside intravenous or intramuscular injection but administered subcutaneously, what was your understanding as to how the process would work in terms of controlling pain?
A I was surprised to hear that experts felt it took as long as 17 to 24 hours to build up to a steady state level. I always imagined, using it clinically, that it kicked in more quickly than that, but that you would reach a steady state during the first 24 hours of administration.

Q Perhaps you can deal with that very point because we will need to address it at some stage. Professor Ford was making the point in relation to subcutaneous analgesia, and still staying with diamorphine, that very often a preferred course of action, so you can establish the dose required, is to administer an immediate injection, "loading", I think was the expression he used, and then you wait to see what happens with that before deciding what level of subcutaneous analgesia should be applied. What do you say to that?
A It would be a luxury to be able to do that in a community hospital.

Q What would it actually involve, this process, if you had ---
A An assessment and then the drawing up and the giving by two trained nursing staff every four hours of the relevant injection. Then, presumably, at the end of a certain length of time, when they felt the pain had been controlled, converting that into the amount to go into a subcutaneous infusion. I had never seen it done in the community and I had never used that method in my hospital practice.

Q When you say you had never seen it done in the community ---
A No, that is not correct. Before we had syringe drivers, of course we did it in the community but it was not satisfactory for the patient because they got breakthrough bleeding, it was very unsatisfactory for the unfortunate nursing staff who had to keep going back every four hours and give another injection and that is why we went over to subcutaneous analgesia because it was so much more convenient for the patient and for the nursing staff.

A Q Whenabouts did you start using syringe drivers to administer subcutaneous analgesia?
A I cannot remember but I certainly started using them at Redclyffe Annex, so that would have been 1989. I cannot remember how often I used them in general practice before that time.

Q Perhaps we can just deal with the economics, if you like. How many syringe
B drivers would have been available on Dryad and Daedalus in 1995?
A Two on each ward, if they had not been pinched by Sultan Ward.

Q They were ---
A They were in very short supply and they were like gold dust.

Q Yes. So your understanding as to how quickly the subcutaneous
C diamorphine would take effect would be what? Let us say you are starting at 20: how long would you think it would take for that to be achieving the level of ---
A I suppose I would have thought three or four hours you would be starting to get a significant level in the blood stream, depending on how well the patient was perfusing and where you put the syringe driver and how it was operating. I did not realise it was as long as 24 hours.

D Q In your experience ---
A It seemed to be more than 24, yes.

Q Were you ever conscious of the fact that ---
A Had not worked by the next morning? No.

Q Yes. Did the nursing staff ever report to you that there was a problem with a
E delay in terms of pain control in general terms?
A No.

Q I think we have probably already covered what were the advantages of administration by means of syringe driver and I am not going to go over that again, but may I just ask you one other thing about them generally with regard to boosting the level of analgesia being administered. What did you understand that process would or might be?
F A There was a button on the side of the Graseby syringe driver that increased the rate of administration of the drug. I do not know how long it boosted it. I have to confess that I always felt the nursing staff benefited more from the boost than the patient did.

Q Explain that, would you?
A I could not believe that you would get a significant increase in the amount of
G opiate or drug in the blood just by pressing the button on the side. Otherwise, it would have run out long before the 24 hours and they did not.

Q Yes, I see. How often would that sort of thing happen, or to what degree were you aware of it apparently happening? Was it a rare event?
A With the sort of prescribing of the opiates that I was using in the syringe driver, it should not have needed to happen. I would have chosen an adequate
H dose to cover that 24 hour period.

Q Then just one thing I would like you to deal with, please, with regard to midazolam. I will ask you about it in more general terms in a moment, but can we just note in relation to the *BNF*. This is tab 3 of bundle 1. Would you turn up page 4? There is the section there in the *BNF*, halfway down the left hand column, "SYRINGE DRIVERS", and then moving over to the right-hand side, can we pick up, just below halfway down the right-hand side, "Midazolam"?
A Yes.

Q

> "Midazolam is a sedative and an antiepileptic, and is therefore suitable for a very restless patient; it is given in a *subcutaneous infusion dose* of 20-100 mg/24 hours."

Q Were you aware of that?
A I was.

Q Did it seem to you that the administration of 20 mg, as if you were doing a dose range, was high, bearing in mind what the *BNF* said about it?
A I did not feel in practical usage that it was a high dose to give.

Q In terms of subcutaneous use ---
A In terms of subcutaneous, not as an anaesthetic.

Q I just want you to indicate please before, perhaps, we adjourn, in terms of why use midazolam? It is still in very general terms. You think it right that the patient's condition warrants the administration of subcutaneous analgesia, first of all, diamorphine, to control, essentially, pain, although we appreciate, it has been said already by you and other witnesses, that you were of the view that it was also useful for dealing with anxiety and so on. We will come back to that, but, essentially, pain is what we think of. Why administer as well, it does not happen in every case but in most of these cases at some point, midazolam which has a sedative effect? What is the point of it and what are you trying to achieve?
A I think the professor mentioned this concept of terminal restlessness. I do not know if anybody has ever done any research into what it is but it is a very distressing symptom, both for the patient and those looking after the patient. It was very good at controlling that. I also felt that as a sedative it replaced the antipsychotics and antidepressants and other drugs that had been present in a lot of these patients, particularly the end stage dementia patients, so that it would cover any withdrawal or restlessness they got from not being able to take those drugs any more, and it was a drug that I became familiar with through using it over the years and comfortable with using.

Q I was just going to ask you about that. Is there any guideline or indication anywhere as to whether doctors should be using a wide range of different drugs or not?
A I think the *Wessex Guidelines* makes the point that you should use a small number of drugs and be thoroughly comfortable and familiar with them and the possible problems you are going to get with them, and I had the three that I used routinely really, or made available routinely.

Q Yes. Whenabouts had you started combining diamorphine and midazolam in terms of subcutaneous analgesia, if you can give us any rough idea?
A I would have thought in the early 1990s.

Q Were you aware of the risk with the administration of diamorphine of over-sedation?
A Yes.

Q Did it bring about, so far as you could judge it, over-sedation in the sense that it was not appropriate for the patient's needs and should have been reduced?
A No.

MR LANGDALE: I appreciate we get into an area as to what is happening with a patient who is deteriorating, in any event, but we can come on to that, perhaps, later.

Sir, if that is a convenient moment?

THE CHAIRMAN: Yes, indeed. Thank you very much. We will rise now and continue at five past two. Thank you, ladies and gentlemen.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Mr Langdale.

MR LANGDALE: Dr Barton, I was asking you about your general approach with regard to subcutaneous analgesia. Of course, we will come back to it in a slightly different context later on. I want to ask you now, before I ask you directly about pro-active or anticipatory prescribing, about events in 1991. Here we will need to go back to File 1, please, and in that file the collection of documents put in by Mr Kark on behalf of the GMC, which we find at tab 6. The first document in tab 6 is a summary of a meeting held at Redclyffe Annexe, 11 July 1991. You are not present. There is Mrs Evans, who I think was the matron of Gosport War Memorial Hospital. Is that right?
A Yes.

Q And a number of other nurses – Sister Hamblin, Staff Nurse Giffin, Barrett we can pick up, Tubbritt and Turnbull, amongst the names that are there. Concern about the use of diamorphine on patients; some reservations being expressed about whether it was always used appropriately. Concerns – without my reading through all of them are: not all patients given diamorphine have pain; no other forms of analgesia are considered; sliding scale is never used; the drug regime is used indiscriminately; individual needs are not considered; deaths are sometimes hastened unnecessarily; use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting the dose; too high a degree of unresponsiveness from the patient was sought; sedative drugs such as thioridazine would sometimes be more appropriate; diamorphine was prescribed prior to such procedures such as catheterisation when diazepam was just as effective; not all staff views were considered. Now, I am not going to go through all the detail of that, but we can see that Mrs Evans acknowledged the concern and felt, half-way through the last paragraph, that

A "... both Dr Logan and Dr Barton would consider staffs views so long as they were based on proven facts rather than unqualified statements."

Were you aware at the time that this happened – that is the meeting in July 1991 – that there were such concerns?
A I was.

B Q Were you aware of the concerns being expressed on that first page?
A I was.

Q Had any nurse ever expressed any such concern to you?
A My understanding was that the problems were raised initially by a couple of the night staff and at that time I do not remember ever seeing the night staff very often on the unit when I went there in the morning. So I was made aware indirectly by the trained staff on
C days, that there was some concern by night staff.

Q Did you yourself carry out any inquiry as to what these concerns were?
A I did not.

Q Would you help us why not?
A I felt that it was at that point in time a matter for the nursing staff to take through their
D hierarchy.

Q Is this right? No nurse who was making any complaint about procedures ever addressed you face to face about it?
A They did not.

Q From what you had gathered, were the concerns just the views of some members of
E the night staff, or did it include day staff, or what?
A My understanding was that it was much more a concern raised by night staff. I felt that the day staff were much more au fait with the use of opiates at the end of life, and more comfortable with them.

Q I am not going to go through all the rest of the detail of that meeting, but one can see on page 3 of that section of the bundle, that tab – we might as well deal with it here. One of
F the queries was, is it appropriate to give diamorphine for other distressing symptoms other than pain. What was your view? What would your answer be to that question?
A My feeling was that it was entirely appropriate to use diamorphine for such symptoms as anguish and distress and fear of dying, as well as purely pain.

Q Then over the page to page 4, we can see what the conclusion of the meeting was:

G "To try and find the answer to these questions Mrs Evans would invite Kevin Short...".

Does that name mean anything to you?
A No.

H

A Q

"... to talk to staff on drugs on drugs and ask Steve King from Charles Ward Q.A. if he would be prepared to contribute."

Does that name mean anything to you?
A I know that Charles Ward was the elderly medicine, a palliative care ward, up at Queen Alexandra, and I imagine Steve King was the clinical manager, but I did not know him
B personally.

Q

"This would take time arrange meanwhile staff were asked to talk to Dr Barton if they had any reason for concern on treatment prescribed as she was willing to discuss any aspect of patient treatment with staff."

C First of all, were you? Is that a correct summary of your position, that you were willing to discuss any aspect of patient treatment with staff?
A Absolutely.

Q Did any member of staff after this meeting talk to you about having concern on the treatment prescribed?
A I cannot remember, but I am quite sure, this concern having been raised, that I would
D have been scrupulous to try and explain to the nursing staff I was dealing with why, in that particular case, we were intending to use opiates.

Q Then can we go on, please, in that same bundle, there is another meeting recorded at the end of October on page 6. Thursday, 31 October, the report of a visit to Redclyffe by the community tutor, continuing education – Gerardine M Whitney. Does that name mean anything to you?
E A Yes.

Q The purpose of the visit:

"The visit was in response to a request by Staff Nurse Anita Tubbritt to discuss the issues of anomalies in the administration of drugs."

F We can see that present – just using the surnames – Giffin, Tubbritt, Turnbull, Howard, and that appears to be it. There are certain things that Giffin said and, again, at item 4:

"... concerned that diamorphine is being prescribed indiscriminately without alternative analgesia, night sedation or tranquillisers being considered or prescribed."

Then Nurse Tubbritt recited certain instances and I am not going to go through those. You
G were not present at this meeting, obviously. The conclusion to that meeting:

"1. The staff are concerned that diamorphine is being used indiscriminately even though they reported their concerns to their manager...

2. The staff are concerned that non-opioids, or weak opioids are not being considered prior to the use of diamorphine.

H

A

3. The staff have had some training, arranged by the Hospital Manager, namely:

- The syringe driver and pain control
- Pain control"

which is repeated.

B

"4. Staff Nurse Tubbritt wrote to [the matron] Evans ..."

and there is some literature, and so on. Then we can move on, please, to November 1991 at page 10. Were you aware that there were concerns still being expressed by the end of this year, 1991?
A Yes.

C

Q Had anybody, any consultant, approached you about any of these concerns?
A No.

Q Had anybody from hospital management approached you about the concerns in terms of asking you to do anything?
A No. I was aware of Gerardine Whitney's involvement in their concerns as I knew that
D Anita Tubbritt was doing a course at the Portsmouth Nursing School and had used this subject as the subject for her dissertation. That was why it had come to Gerardine Whitney's attention. I knew that the subject was becoming important to them again, so I knew there was going to be a meeting but I was not directly involved, other than knowing about it.

Q Again, were you of the same frame of mind, that this was a matter to be dealt with through the nursing channels of communication and so on?
E A I think I was beginning to be aware that perhaps there ought to be some medical input, but I did not feel it was appropriate for me to be talking to the nurses about this problem. It was obviously a consultant issue to be dealt with.

Q Is this right – that by the end of the year, that no nurse had actually said anything to you about any of the prescriptions you prescribed?
A Not at all.

F

Q Moving on to page 13, this is the beginning of December. Keith Murray is writing to Anita Tubbritt and he is keeping her informed about what the position would be. I am not going to trouble you any more with that. Then the letter from Keith Murray at pages 14 and 15 to Mr West, the District General Manager, setting out what the position was. The fourth and fifth paragraph down:

G

"... two study days on 'Pain Control'...".

Last paragraph:

"Regrettably the concerns of the staff have once again returned..."

That is the thing we have just been dealing with?
H A Yes.

Q And then over the page, certainly in the view of some people, it was only a small group of night staff who were making waves and so on. But, again, you were not involved in that correspondence?
A No.

Q And I am not going to trouble you with the next page as between Isobel Evans and Nurse Tubbritt on page 16. Can we move on, please, to page 17. This is November 1991, still the year end. This is a note from Isobel Evans. You received a copy of this, we can see at the bottom?
A Yes.

Q

> "It has been brought to my attention that some members of the staff still have concerns over the appropriateness of the prescribing of diamorphine to certain patients at Redclyffe Annexe.
>
> I have discussed this matter with Dr Logan and Dr Barton who like myself are concerned about these allegations. To establish if there is any justification to review practice we have agreed to look at all individual cases staff have or have had any concerns over and then meet with all staff to discuss findings."

Had there been a discussion with Dr Logan and with yourself with Isobel Evans about these allegations?
A Yes.

Q Was that a meeting between the three of you? Do you remember?
A During one of Dr Logan's ward rounds at Redclyffe Annexe, Isobel Evans would have come down and expressed her concerns and asked for his advice.

Q And it says:

> "...we have agreed to look at all individual cases staff have or have had any concerns over and then meet with all staff to discuss findings."

Is that right? There had been agreement between the three of your to look at the cases the staff had concerns about?
A Yes, yes.

Q Did that happen?
A No.

Q Why did it not happen?
A No names were given to me.

Q If they had been given to you, any particular patient that anybody had any concern about, would you have applied your mind to it?
A Of course.

Q The note continues:

"I am therefore writing to all the trained staff asking for the names of any patients that they feel .... [inappropriate administration]"

and so on, saying at the end, because this of course went to every nurse as well as a copy to you and others:

"I am relying on your full co-operation and hope on this occasion everyone will be open and honest over this issue so we are able to address everyones concerns and hopefully resolve this issue in a constructive and professional manner."

Then over the page, just so we can note its presence, there is the letter from Murray to Turnbull, page 18. Then another letter from Murray at page 19 to Isobel Evans and referring to the continuing situation. We can move on, please, to page 21, December 1991. Isobel Evans is communicating to all the trained staff, top right hand corner at Redclyffe, copy to night sisters and that is Bill Hooper?

A That is Bill Hooper.

Q Dr Logan and Dr Barton. So you, it appears, got this.

"Due to the lack of response to my memo of the 7th November Dr Logan will be unable to comment on specific cases, however, we have arranged a meeting for all members of staff at Redclyffe who have concerns .... on ... 17th December ... to discuss the subject ...

It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have...".

That was the situation at that point in December. Can we move on to page 23, 17 December. That is a meeting at which you were present?

A Yes.

Q Isobel Evans, Dr Logan, you, Hamblin, Donne, Barrett, Giffin, Tubbritt, Wigfall, Turnbull.

"All trained staff were invited to the meeting if they were concerned with this issue, no apologies were received."

Then the matron, Mrs Evans, opens the meeting and rehearses some of the history. We can go on over the page, perhaps.

"As Mrs Evans had presented staff's concerns she stated the problem as she saw it and invited staff to comment if they did not agree with her interpretation:-

1. ... increasing number of patients requiring terminal care.

2. Everyone agrees that our main aim ... is to relieve their symptoms and allow them a peaceful and dignified death.

A

3. The prescribing of diamorphine to patients with easily recognised severe pain has not been questioned.

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

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

B

All present agreed with these statements, no other comments were asked to be considered."

Then staff were reminded, this, that and the other. Then Dr Logan spoke to the staff at length on symptom control covering the following points. We have seen what Dr Logan said in his notes of this same meeting. We have looked at that more than once. It is on page 27, but in general terms did you agree with the views expressed by Dr Logan?

C

A Entirely.

Q He indicates at (f) on that page that diamorphine has added benefits of producing a feeling of well being.

D

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

E

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

Then over the page a record of the fact three was general discussion, and answering of staff questions.

F

"Dr Logan stated he would be willing to speak to any member of staff who still had concerns over prescribed treatment, after speaking to Dr Barton or Sister Hamblin."

Did anybody ever approach you after this meeting to say they had concerns about a particular case?

A No.

G

Q Did you yourself feel that any more could be done to try to deal with these concerns than had been done by this stage, in terms of you, Dr Logan or hospital management?

A I felt that by holding a meeting, and by reiterating to the staff that we were available and willing to answer their queries, there had hopefully been the opening of a sufficient dialogue, that this sort of feeling of being excluded and feeling of decisions being made without them and all of those sort of issue which were highlighted by the use of the opiates would not recur, because particularly the night staff would feel more involved in the decision-making, and their opinions perhaps more carefully listened to.

H

Q As I understand it, in general terms, apart from night staff coming off or just about to come off duty in the morning, you would not normally have any contact with them?
A Not at that time.

Q No?
A No. It was easier later on, but it was also a problem of communication between the day staff and the night staff about decisions that had been made or were going to be made that had led to some of these problems. The night staff did not feel that they were consulted.

Q What was the position in terms of the nature of the problem with regard to what day staff had to contend with, in terms of nursing of patients, and night staff?
A There is a lot more procedures have to be done to patients during the day time. There is a lot more potential for the patient becoming very uncomfortable when you are thinking about washing, bathing, turning, dressing, administering medicines than there is for the night staff to do.

Q And the consequence therefore in terms of observance of symptoms?
A You may well find that a particular patient has a greater need for analgesia when assessed by the day staff than was thought to be necessary by the night staff. I think that is where some of that misunderstanding had initially arisen.

Q I am going to come on to matters relating to Nurse Hallman in a moment or two, but just carrying on with this particular phase, after this stage in 1991, did you feel that the problem which you had become aware of, or the concerns, continue or did those concerns appear to have been allayed?
A I felt that the problems had largely been allayed, mainly because two of the night staff mentioned in this were very much on board with what was going on and the other one concerned moved to another ward.

Q The other one being - ?
A Giffin.

Q So the two you are talking about are the two the Panel has heard evidence from: Nurse Turnbull and Nurse Tubritt.
A They felt much more involved, felt more concerned and felt more comfortable with what was going on.

Q It goes on:

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

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

Patients were not always comfortable during the day even if they had slept during the night.

There appeared to be a lack of communication ...

A

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

What do you say to that last point, that it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms?
A Absolutely not.

B Q

> "All staff agreed that if they had concerns in the future related to the prescribing of drugs, they would approach Dr Barton or Sister Hamblin in the first instance for an explanation, following which, if they were still concerned, they would speak to Dr Logan."

C And so on. "No-one felt there was a need for a policy", more about the communication problems between day staff and night staff and I am not going to go through all the detail of what Dr Logan indicated were his views in his record or minute of that meeting at page 27. Did you yourself feel that there was any basis for concern that patients were being given diamorphine inappropriately?
A Not at all.

D Q Were you aware in terms of the night staff, having seen what view they expressed about your professional judgment, having any hostility towards you or having any problems communicating with you or anything of that kind, if they wanted to do so?
A Not that I was aware of.

Q In general terms, how would you describe your relationship with the night staff during the period of time that followed: 1992 onwards?
E A Good.

Q In this context, before we come specifically on to proactive prescribing, I would like to deal with the position with regard to Nurse Hallman. This is probably as convenient time as any, although of course it occurs rather later on in terms of our span of time. The Panel will already have the documents D1 through to D5. Perhaps you could be given copies. (Same handed) The Panel has already heard evidence about these matters when the evidence
F of Nurse Hallman was considered. We see her letter of 24 March 2000, in which she is complaining about the way she is being harassed at work, "almost to the point of leaving my job and the Trust", and she sets out her feeling that an attempt is being made to shift her out to QAH. I am not going to go through it all. D2, the second page, relates to a meeting between Shirley Hallman, Betty Woodland and Rosemary Salmond, who was investigating this on 30 March. We can see what it is that Shirley Hallman was saying. It is right to say – we heard her evidence about it – that she did not actually mention anything to do with syringe
G drivers in either her letter or the notes of that meeting we have just taken on board. I want to move on, please, D3, which is the fourth page in, where there was a meeting between you and Rosemary Salmond on Friday 7 April:

> "This meeting was convened as part of the investigation of a complaint of harassment brought by Shirley Hallman against Dr Jane Barton and Gill Hamblin."

H

A You then set out that you had worked on the ward – I am not going to go through every word of it – and as a visitor to the ward you did not feel it was appropriate for you to be involved with management issues. Does that reflect what your view was?
A I felt that I was being dragged into a conflict between two members of the nursing staff and being used as a bit of pawn and that really was not included in my job description as clinical assistant.

B Q That is the conflict between Shirley Hallman and Sister Hamblin.
A Yes.

Q It goes on:

"In describing Shirley Hallman's manner Dr Barton felt that she could be aggressive in manner and would also have periods of apparent sulking. It was often easier not to C disagree with Shirley's opinion rather than upset her. In consequence changes to treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working. She described Shirley as 'working to her own agenda' and not really a 'team player'."

I will just complete the passage before coming back to that:

D "Asked how Shirley had managed when she acted up for Gill Hamblin during an extended period of sick leave, Dr Barton felt she had managed tolerably well, but the ward had not been as busy at that time ....

Dr Barton described how she had only wanted to give advice and support to Shirley Hallman and had never 'put her down or been beastly to her'. She described how Shirley had asked for her advice before applying for the G grade post at QAH ..."

E And so on.

"Dr Barton described a discussion between herself and Shirley, initiated by Shirley following her return to Dryad. Shirley had asked if there was a problem between them, to which she had replied 'no.' Dr Barton then asked Shirley how she was getting on with the job opportunities at QAH, assuming Shirley was still wanting to F do acute work. 'If I had known she did not work there I never would have inquired ... I bitterly regret offering support.'

She described how the work on the ward had changed. There had been limited consultant cover. Families were increasingly demanding ..."

And so on. In relation to that, what was the position with regard to the third paragraph of this G record of the meeting with you?

"It was often easier not to disagree with Shirley's opinion rather than upset her. In consequence changes to treatment routines particularly relating to opiate administration, would happen on shifts that Shirley was not working."

H

A I would like you to deal with that, because Nurse Hallman said that she had indicated to you she had concerns about a particular patient being given subcutaneous analgesia. What is your recollection of that?
A It was a wider issue than that with Shirley. Shirley had come from a background in which she had not had a great deal of experience in palliative care. She freely admitted that herself. She did not feel it easy to make the judgments about when and what palliative care to be using in certain patients and that was the original reason for suggesting a spell up on the
B acute unit: to give some more opportunity to see how it was done up there, exposure to more patients, more experience, people who were more experienced in doing it. That was the reason for suggesting that she take the temporary post up at Queen Alexandra, to widen her experience a bit. She felt uncomfortable sometimes about making the decision about what sort of palliative care a patient needed.

Q When you say you had formed the view that she was uncomfortable about making the
C decision, can you elaborate on that?
A She did not feel she was experienced enough in assessing a patient and what level of pain relief they might need at that point. From what I can remember of that particular patient, she felt that opiates were not appropriate in that patient at that time from her assessment of the patient, but what happened on the subsequent night shift was that the night staff reported back that the patient was definitely very uncomfortable and restless and needed opiates.

D Q In relation to that particular discussion with that particular patient, or indeed in general, was there ever a situation where she expressed a concern or queried the need for palliative care or whatever it might be, and you said, "All right. We will not go ahead with that" and then later took the steps to ensure that the palliative care was applied?
A On listening to her judgment, I would have made the decision in that case not to go ahead with the opiates at that particular point in time. I would have said to her, "Well, let's wait and see." On subsequently receiving the report from the night staff that the patient had
E definitely required opiates, I had gone ahead with them. It was not a case of waiting until she went off shift and then rushing back on to the ward and saying, "Let's start the opiates"; it was a case of the ongoing assessment of the patient.

Q That is why I wanted to check what you meant by:

F "... treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working."

A Because Shirley was not there, not because we waited to do it when Shirley was not there.

Q Had you had any problems with her getting upset if you disagreed with her?
A Probably. She had a tendency to flounce if you had a disagreement with her.
G

Q Was there any question of you trying to, as it were, get rid of her by helping her to transfer to QAH for a period of time?
A Not at all. My interest was purely in helping her widen her experience and becoming more confident in doing the work on the ward. I thought she was a good nurse, but I thought she had deficiencies in the areas in which she was expert. I had no criticism of her general nursing ability at all.
H

Q That is all I am going to ask you about that, having dealt with that particular nurse. I am now going to ask you about the proactive prescribing, having hopefully set the scene in terms of the history and dealt with that one particular issue that arose during the course of the evidence. Why should it ever be necessary for you to prescribe subcutaneous analgesia in advance of a patient's actual need for it?

A Because, with all the best will in the world and for all that I was available to the ward, either in person or on the end of a telephone, I was not always there and, despite what the professor of pharmacology and palliative care felt, there was sometimes quite a considerable gap in time before a patient who patently needed subcutaneous analgesia was going to be given it.

Q What is the importance of that gap? What are your concerns?

A Because no-one suffering pain and distress and agitation right at the end of their life should be forced to wait more than 20 minutes, not four hours or more. It was quite inappropriate that people should suffer.

Q In practical terms, would it always be only a matter of four hours that a patient might have to wait?

A It could easily be longer.

Q What were you aiming to achieve when you prescribed in an anticipatory fashion?

A I was aiming to ensure the maximum comfort and dignity for my patients. It was not for my convenience, it was not for the convenience of the nursing staff. It was purely done for the comfort of the patient.

Q What was the alternative? Supposing you said to yourself, "Well, I'm not going to prescribe controlled drugs in advance of a patient actually needing them." What would have been the practical consequence of that?

A I do not think there was a practical alternative, because I do not think even with a verbal order from a duty doctor wherever or whenever the nurses were allowed to give opiates. Even with an immediate subcutaneous injection or intramuscular injection, it was only under very exceptional circumstances that you could give a verbal order for that to be given. So the patient could well be waiting several hours to receive adequate relief of their pain.

Q Perhaps you could deal with this. Thinking of alternative courses, why not prescribe a single injection of diamorphine, which would cope with immediate pain

---

A For four hours.

Q For four hours. Explain, please.

A Saturday morning, half past twelve. What are you then going to do for the rest of the weekend?

Q Would it not be realistic – I want your evidence about this – to suppose that a doctor would be able to attend to treat the patient over the weekend, say, after a period of some four hours?

A It was unrealistic to expect some of the doctors that one had providing out of hours cover to prescribe appropriately and sensibly.

Q What is the concern about that, if you would explain that, please?
A The possible calibre of the doctor that you were getting and that they might not be willing to prescribe opiates at all.

Q What sort of reason might prevent a doctor from doing that?
A Unfamiliarity with using opiates, unfamiliarity with palliative care. You were getting a doctor about whose provenance you knew nothing to come and look after your patients.

Q What was your experience in relation to patients before they got to Dryad or Daedalus with regard to adequate pain relief?
A They suffered.

Q How was this going to work, anticipatory prescribing? In what circumstances would you anticipate the need for controlled drugs to be administered?
A Are you talking about oral and then subcutaneous, or just the subcutaneous side of it?

Q Let us break it into two. You are quite right to make the distinction. First of all, anticipatory prescribing for oral morphine.
A I had a very low threshold, as I have explained to you, for anticipatory prescribing of oral opiates because I felt that they were valuable in managing all kinds of post-operative, post-travel, pain on transfer into the ward. They were not sentencing the patient to go down a particular route, but they could be very appropriate and very useful for patients. Some patients would get them prescribed on arrival.

Q Supposing you did not immediately prescribe Oramorph, but you thought, "I had better write out a prescription in anticipation." What sort of patient would that be, in very general terms?
A Somebody who has had their fractured neck of femur repaired and has apparently been on two paracetamol a day is going to have an ambulance journey and a transfer and they are going to be very, very uncomfortable on arrival: they are going to be cold and frightened and in quite a lot of pain. A small dose of Oramorph at that point is a very appropriate prescription.

Q That is immediate administration.
A When the nurses make their assessment of the patient when they admit them and pop them into bed.

Q Would you ever write a prescription anticipatorily for Oramorph in the sense that you were thinking, "Well, it might not be necessary for a day"?
A Certainly. I knew that it was there for the nurses if they felt it was appropriate for the patient. They did not have to get a doctor into the hospital, did not have to call a duty doctor. It was there, it was available and I trusted them to use it at an appropriate time and in an appropriate dosage.

Q So we come back again to the trust you had in the nursing staff.
A Totally.

Q Can we then look at the other side of the coin on this particular issue, which is in relation to subcutaneous analgesia? We are talking essentially about diamorphine and

midazolam. What sort of patient would justify you writing out in advance of the actual need a prescription for that kind of subcutaneous analgesia?
A This is a patient who has been with you maybe a very short time, maybe a very long time, when it becomes apparent to you clinically that they are reaching the terminal phase of their illness. They are reaching the end of their life.

Q When you are thinking, "I am anticipating the need for subcutaneous analgesia", are you envisaging that that will be administered in a palliative care setting?
A It can be palliative if, for example, the patient becomes unable to swallow or is unwilling to take their tablets or has particular symptoms, but it could also be when they have reached that point in your clinical judgment that they have become terminal. Everything is switching off. They are dying.

Q What were you relying upon when you anticipatorily prescribed in terms of the nursing staff, assuming you were not actually going to be there when the situation was reached where those drugs might have to be administered?
A The observations that they make every time they go to the patient's bedside, every time they do something to them, every time they handle them, the awareness that they have of the clinical state of that patient, it is not something you can measure or put into guidelines, it is a clinical impression that your experienced nurses and, to a lesser extent, your doctor becomes aware of dealing with the patient.

Q What was your understanding of the procedure that was to be followed if the nursing staff concluded in your absence that subcutaneous analgesia should be administered? They have the prescription there. What would happen, did you understand, if the nursing staff thought - and we appreciate this is always senior nursing staff making the decision - the time has come for subcutaneous analgesia to be administered?
A The first alternative is that I am going to be there or I am coming in, or I am asked to come in.

Q Can I just pause there? Were there ever instances where you had a discussion with nursing staff, because you were there already, and they said, "Well, I think probably the pain", or whatever it was, "reached such a stage that the only sensible option is subcutaneous analgesia"?
A That would be absolutely fine because I could then examine the patient, make my own assessment as well, agree entirely with the conclusion they had reached and say, "Go ahead with the subcutaneous analgesia".

Q So you are there, there is a discussion, everybody has agreed, having checked and so on, made an assessment, that that is right. Then supposing the need arises in the view of the nursing staff and you are not there.
A Then I can be contacted by telephone. I will have seen the patient within the preceding day, I am aware that they probably already, even at that stage, had concerns about the patient and I would be happy to say to them, "Go ahead, commence the subcutaneous analgesia and I will make a further assessment when I come in again in the morning".

Q So if you are not there ...
A But I have seen them recently.

Q ... your understanding of the procedure was that they would contact you, or endeavour to contact you?
A Yes.

Q You could then give, as it were, a verbal authorisation ...
A Yes.

Q ... for them to start. It might be, I suppose, if it was over a long weekend, a patient who you had not seen for more than a day, you had not seen for possibly two days or maybe even three.
A Yes. In that case I was relying much more heavily on their expert clinical judgment because I had not seen the patient for three days, but I trusted them.

Q In your experience over the years, had you ever formed the view that the nursing staff's judgment about the need to start subcutaneous analgesia was wrong?
A Never. There was only that one nurse whose judgment I felt was suspect, but that was working the other way; not starting it, rather than starting it. The others were very competent, very experienced.

Q Let us envisage the last of the three possible situations when the nursing staff have concluded subcutaneous analgesia is now appropriate. You are there, no problem. You are not there but they contact you. You just explained what would happen. What then did you understand the procedure was if you are not there and they cannot get hold of you?
A Then they would ask a duty doctor to come in. There was one occasion in the cases we are looking at where the duty doctor went in and sanctioned the use of the subcutaneous analgesia.

Q What about the situation when the nursing staff themselves, without being able to contact a doctor, felt it was necessary to start subcutaneous analgesia? Is that something they were entitled to do in the circumstances where an anticipatory prescription had been written?
A It is a difficult one, is it not, because it was written up, "PRN if required", but it was not actually written down in black and white what would be the requirement to start it. I do not know how comfortable they would have felt about doing that without any recourse to speaking to a doctor.

Q We appreciate we are in territory where there is no written protocol, as it were, but was it your understanding that the nursing staff would, in extreme circumstances in the sense that they could not contact a doctor, that they would be acting properly if they started subcutaneous analgesia without actually speaking to any doctor?
A I would have felt that that was their prerogative. I would have been unhappy about it but I would have felt it was their prerogative.

Q Again, does it come down to the same question as to what is appropriate for the patient?
A Absolutely.

Q In general terms, if the decision to start subcutaneous analgesia had to be

A taken at a time when you were not available on the telephone or not actually there at the hospital, what sort of delay might there be before the patient was seen by you if subcutaneous analgesia was started in your absence?
A The minimum delay would be the next morning; the maximum delay would be the end of a long weekend.

Q Depending on ---
B A Depending on where we were in the day or weekend time-scale.

Q Were the consultants with whom you worked aware or unaware of your practice of writing anticipatory prescriptions?
A They were aware.

Q I would like to ask you, please, about the range of dose, in general terms,
C when you carried out such prescribing. If you deal with this question: how could you know what was an appropriate range to write up if this was in anticipation of a patient's need rather than the need being right before your eyes? How could you know what amount to prescribe?
A The only thing you could write up would be the maximum possible range you would need in the worst case scenario, that the patient became seriously ill on Christmas Thursday, Christmas Eve, Christmas Day, Boxing Day, everybody has a
D day off after Boxing Day, and there could be a span of time to three to four days during which time they were only being given medical cover and the nurses would wish to have a sufficient range of doses to cover any eventuality of symptom control in the patient.

Q You have agreed that the dose range, not in every single case, but the dose rage here - and I am just going to focus on diamorphine, but the dose range in your
E prescriptions of 20-200, those dose ranges were too wide?
A They were excessively wide and the situation never arose that we needed them.

Q That evidence has been made clear, but I want you to deal with this: why did you write at that time prescriptions as wide as that which you say were, in fact, excessive? Where does the 200 figure come from?
A It is probably a calculation from doubling up, doubling up, doubling up of
F the dosage of diamorphine that you needed to control the symptoms which would reach 160 mg by the time you got to day four.

Q If the pain increased in that way?
A If the pain increased and they were not able to control the symptoms.

Q Why 200, because, as we have seen in a number of the twelve cases we are
G looking at, it is a sort of standard range.
A I wrote it up purely as a standard range.

Q So it does not depend on the individual patient in terms of that writing up?
A It does not.

Q Again, with midazolam, were you tending to write up a standard range?
H A A standard range as in the *BNF*.

A Q How was it that you would be able to anticipate that a patient would be needing not just diamorphine but also midazolam?
A Because in our clinical experience in the patients we looked after over the years the use of midazolam was very helpful in control of some of the general symptoms near to death.

Q Running in tandem, as it were?
B A Running in tandem with the diamorphine.

Q We have to appreciate, of course, that in some of the patients we are concerned with, although the prescription had been written up for both, in fact, only one was started, the diamorphine. Was there any advantage to you in any way of writing up these prescriptions in an anticipatory fashion, apart from satisfying yourself that the patient's pain and other symptoms would be properly
C controlled?
A That was my prime motive in writing up the prescriptions.

Q Was there any other ---
A There was no other advantage to me at all.

Q Again, so far as you were aware, were all the consultants with whom you
D had dealings on these two wards aware of the sort of dose ranges you were writing up by way of anticipation?
A Yes.

Q I think there was one instance, we will perhaps deal with it now, when Dr Reid spoke to you about the dose range. I think his recollection was that it was - I have forgotten, I am afraid. Something like ---
A 20-200.
E

Q I think the one he could remember talking to you about he thought was a slightly smaller range but it does not matter. In terms of having a discussion with Dr Reid, what do you recall of the discussion about that?
A I would explain to him exactly as I have just explained to you how the situation could arise that the patient's requirement for opiates increase over a weekend or over a holiday period and I wanted to ensure that the nurses had
F available to them appropriate doses for that patient without recourse to using an out-of-hours doctor or waiting.

Q Did he appear to agree with that and understand?
A He seemed quite happy with that as an explanation.

Q I would like to ask you this in terms of your experience of the sort of
G increases that might be justified or expected in cases where subcutaneous analgesia had been administered. Let us say it starts off at 20 for diamorphine. It turns out that that is not controlling the pain or any other symptoms that applies. What in your understanding, and what would you advise, if you were there to advise, would be a suitable increase in the dose?
A I would go to 40.

H Q So doubling up?
A I would double.

Q In general terms, was that the practice that you followed?
A Yes.

Q Can I deal with this: why double up? Why not indicate that, well, if an increase is needed, with the 20 mg dose, why not say this should be increased by 10 if the pain is not controlled?
A Because in my clinical experience that was not adequate.

Q When you, in general, wrote up an anticipatory prescription, were you having in mind, in terms of the dosage, that the patient would, normally speaking, be on some form of opiate, such as Oramorph, before the need for subcutaneous analgesia would arise?
A Usually.

Q Would it also be a matter to be taken into account, or would you disregard it, that the need for subcutaneous analgesia would only arise if the Oramorph was not controlling the pain?
A Or there was another very good reason for changing them.

Q Another reason such as the non-swallowing reason?
A Yes.

Q Were you allowing for that in any way when you set the dosages in your own mind for these anticipatory prescriptions?
A Yes.

Q Because if you convert directly and the pain has not been controlled, you are not going to achieve anything.
A No.

Q In general terms, what was your understanding as to the procedure with regard to what the nurses would do if they decided subcutaneous analgesia was required in terms of the dose that they would administer?
A They would usually, in the vast majority of cases, go for the minimum dose. The bottom end of the sliding scale.

Q We will look at, I think, one or two instances when that did not happen. We will look at those when we look at the twelve. That was your normal understanding as to what the procedure would be?
A Certainly.

Q Would they need your approval, say so, if they decided the patient needed an increase? If a senior nurse decided that 20 mg of diamorphine was not achieving its purpose, did you understand that the procedure was that they could, on their own judgment, their own decision, increase the dose or did they need to check with anybody?
A I would have been happy for them to increase the dose. I suspect they would have been happy to contact somebody, contact me.

Q What normally happened, just to give us the general picture, if the nurses in relation to a prescription of subcutaneous analgesia with a range and they needed

A to increase the dose, would they normally contact you, assuming they could, or not?
A I think they would normally attempt to contact me, yes, just to let me know what was happening, or perhaps if they were changing the syringe driver at the end of the nightshift, knowing I was coming in, they would not bother to ring me then, they would know I was going to be coming in anyway.

B Q Let us also follow that through. In terms of subcutaneous analgesia having been started, let us say during the night and let us say they contacted you or an on-call doctor who said, "Yes, I think it is sensible to go ahead", because of the symptoms, you arrive the next morning, I just want you to explain to the Panel what would happen. You were not there and you did not specifically approve the administration of subcutaneous analgesia, you arrive in the morning, that is what has happened overnight. What would you do in terms of the patient and in terms
C of the nature of the dose?
A I would go and make my own personal assessment of the patient.

Q Is this something you would always do in a patient who had been on subcutaneous analgesia?
A Yes.

D Q What about the patient who is on subcutaneous analgesia when you see them on morning one? When you go in on morning two would you check on such a patient or not?
A Yes.

Q Would that mean seeing the patient?
A Yes, but not recording it necessarily.

E Q I want to get the picture. If you have a patient on subcutaneous analgesia, when you went to the hospital would you always go and see that patient?
A I would always like to check on their general condition.

Q Forgive me. That is not quite... Would you always go and see them?
A I would go to the bedside to check their general condition, whether they are comfortable, whether the drugs seemed to be working, whether they were very heavily
F sedated, whether they were still uncomfortable, whether they were rousable.

Q We think of any patient who is on subcutaneous analgesia, any time you are at the ward ---
A They are at an end of life time.

Q --- you will be specifically seeing them?
G A Yes.

Q As opposed to just relying on the nurse's report?
A Yes.

Q And what did you understand to be the picture? Because we heard from Professor Ford for the need for monitoring and continuing to assess, just the general picture again.
H

A What did you understand the nurses would be doing when you are not there in terms of monitoring and assessing?
A Exactly the same thing. When they are seeing to the patient, when they are giving any treatments, doing any dressings, they will be forming an impression of how comfortable that particular patient is at that time. Again, there is not a form that measures the comfort of a patient at that time of their life.

B Q As you have already told us, when you were there, the nursing staff could always ask you to look at a particular patient in any event if there was something that they wanted to draw to your attention?
A If they were concerned, yes.

Q I am going to turn in a moment, perhaps after we have a break, to matters relating to some documents that Dr Reid was asked to look at with regard to protocols and so on. I just C want you to deal, before we do that, if I may, to cover two points. Would you just explain what the procedure was and how you and the nursing staff worked together dealing with these problems, what you understood would take place? Why not have a written protocol?
A I am always a bit suspicious of whether a protocol has ever been written that will cover all the different eventualities when you are dealing with real people at the end of their life. There would be so many "what ifs", it would run to about five pages and for the nurses looking through all that, would they have time to go and actually look at the patient.

D Q In relation to anticipatory prescribing, why not have a written protocol with regard to that, as to what the nurses could or could not do with a dose range and a prescription that was written in anticipation?
A In retrospect, why not? It would have been a very useful document, but as far as I was aware there was not one at the time, and the suggestion was never made to me.

E Q That I was going to ask you. No suggestion by any consultant ---?
A No.

Q --- or anybody to do that. One question: it is in a separate section but while it is in my mind, and I do not have to keep turning over pages to remind myself, the pharmacist. Can we just deal with that, please?
A Yes.

F Q What was the position with regard to the pharmacist? Was there one who visited?
A Yes.

Q Would that be visiting both wards?
A Yes.

G Q Weekly, we have heard?
A Yes.

Q And what did you understand the pharmacist would be doing?
A She looked at all the drugs charts, she checked whether there were drugs that were interacting or were inappropriate or unsuitable to any particular patient, in addition to all her duties checking the stock of drugs and the dangerous drugs kept in the hospital. So she had a H dual role.

Q Did the pharmacist ever discuss with you or raise matters with you about the prescribing of drugs generally? Was there ever any ---
A There were occasional discussions. I also knew that if I had a particular problem with a drug, I could ring her up or her team up at Queen Alexandra and ask for advice and support. So we knew where they were; they knew where we were, and she would say, "Are you happy to be using this antidepressant with something or other".

Q We have heard that the pharmacist never raised any query about either dose ranges or dose combinations?
A No.

Q Or indeed anticipating prescribing?
A No.

Q Did that give you any comfort in terms of what you ---
A I did not have any discomfort about it, so I felt comfortable about it at that time anyway.

MR LANGDALE: Thank you. Sir, would that be a convenient moment, please?

THE CHAIRMAN: Yes. Half past three please, ladies and gentlemen.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Langdale.

MR LANGDALE: Dr Barton, some further documents that the Panel have already seen, but I need to ask you about. Do you still have that same little collection that you were looking at earlier on, beginning with D1? Can we go back to that, please. Look in that small bundle, a few pages in, to D4. We looked at D3 in relation to the complaint. D4. This is not your document. It is a document that I asked Dr Reid about. It is a memorandum from Barbara Robinson dated 27 October 1999. First of all, it is to Max Millett, whom you have already mentioned.

"Learning Points from the Wilson Complaint"

Again, sir, not Patient H. It is a different matter. (To the witness)

"Thank you for your memo and the copy of Dr Turner's letter."

There is something to do with microfilming/fluid chart. (2b) is nursing care plans. I am not going to deal with that.

"3d) Good Practice in writing up medication.

It is an agreed protocol"

I am stressing those words. Barbara Robinson said:

A

"It is an agreed protocol that Jane Barton, Clinical Assistant, writes up diamorphine for a syringe driver with doses ranging between 20 and 30 mgs a day. The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient."

B

Then:

"Ian"

and Dr Reid indicated he thought that must be a reference to him –

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

C

She described it as "an agreed protocol". Is that a description you would give to your practice with regard to 20 to 200?
A I would agree with it, but I always assume that a protocol had to be in writing, and I never saw anything in writing myself agreeing with what I was doing in practice.

Q And would you yourself have reached any agreement with Barbara Robinson about this, or would it not enter into your discussions with her?
D
A I cannot imagine it would have entered into my discussions with her.

Q In any event, that is what she wrote?
A Yes.

Q I have asked Dr Reid about it. Can we move on please to the next document, which again I asked Dr Reid about, which is a Protocol for Prescription and Administration of Diarrhoea by Subcutaneous Infusion, of which he was the author, although he said that it was never put into practice. In the introduction he points out in the second paragraph how a situation may be created whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met.
E

"To overcome this and also to give guidance to nurses who may be unsure as to how much analgesia (diamorphine) to administer within a variable dose prescription."

F

Does that appear to be consistent with anticipatory prescribing?
A Yes.

Q

"Dosage

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day, i.e. up to 2x 'Xmg' should be given."
G

Again, something that would be in accord with your practice?
A Yes.

Q "Pain Control Chart". As one will see, he suggests it should be completed on a four hourly basis.

H

"Prescription

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 20-80 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

Administration

If pain has been adequately controlled within the previous 24 hours, the nurse should administer a similar dose of diamorphine over the next 24 hours."

Agree?
A Yes.

Q "If the previous 24 hour dose has made the patient unduly drowsy etc., the nurse should use his/her discretion as to whether the dose to be administered for the next 24 hours can/should be reduced, within the prescribing dosage rime. If the minimum dose appears to have made the patient too drowsy, the on-call doctor should be contacted."

Agree?
A Yes.

Q This may be a convenient moment just to deal another facet of the care of patients of the kind that we are talking about in this case – drowsiness.
A Yes.

Q How does one tell with a patient who is drowsy when on subcutaneous analgesia, how do you decide whether it is the subcutaneous analgesia that is causing the drowsiness or either the existing condition of the patient before the subcutaneous analgesia was administered or indeed the patient's deterioration anyway?
A I do not think that you can completely untangle which particular aspect is causing it. I imagine that a major overdose of an opiate would make the patient completely drowsy, unrousable, unconscious; there would be no fluctuation in the conscious state at all, whereas during the normal process of dying there would be a natural fluctuation as there would be possibly with the course of the terminal illness. That is the only way I could think to distinguish between those three threads.

Q Were you aware of the fact that diamorphine and midazolam might of themselves be causing at least some element of the drowsiness?
A Yes, but I was prepared to accept some level of drowsiness in exchange for adequate relief of pain and other terminal symptoms.

Q I wonder if you could just deal with another aspect that we have to consider in terms of a patient who is going downhill in terms of a terminals stage or about to enter a terminal stage. Is this in your experience a sort of static state, where you just keep pain control at a certain level and things do not change? What is the process in your experience over all these years?
A Anything but.

Q Would you explain that?
A There is what the nurses kept recording in the notes as "further deterioration", which would mean that the periods of being less conscious would become longer. The periods of wakefulness would become less. The patient would take less interest in their surroundings. There would be fewer involuntary movements. The whole system, the whole body system, is gradually winding down into death.

Q What is the importance of being able to observe, to see the patient at the bedside, when we are talking about patients in this sort of situation?
A Because, again, it is not something you can measure. It is only something you can make an assessment of by observation and by experience; by being there and knowing what you are looking for. That is what these nurses did.

Q Just to finish off this document, Dr Reid's proposed protocol said:

> "If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose."

Then over the page:

> "Information to Patient and Relatives
>
> Where patients are mentally capable ... they must be told that an infusion of ... (diamorphine) is being started ....
>
> When patients are unable to understand such information ... the decision that diamorphine is being, or about to be, administered, should be communicated to their next-of-kin/relatives..."

and so on.

> "If the relatives express concern about the administration of diamorphine, despite the above discussion, the medical staff should be informed and the medical staff should make every effort to discuss the administration of diamorphine with the patient's next-of-kind/family."

Looking through that document, was there anything there which you would disagree with, or which did not square with your own practice?
A Nothing at all.

Q Dr Reid mentioned to the hearing that there had been an instance where a patient had been taken off morphine, I think by you, and there had been a complaint by members of the family. It did not ring any bells with you? Maybe he dealt with it, and I am not going to ask you any more about that. Then he set out a diamorphine infusion and pain control chart, which we need not trouble ourselves with. That is all I am going to ask you about that part of the matter. Before I turn to the position with regard to individual patients, I just want to complete the history in terms of you and your practice after you had resigned as clinical assistant at the Gosport War Memorial Hospital in 2000. Did you return to practice as a GP?
A I remained in practice as a GP.

Q I am sorry. You returned to full practice, I suppose.
A Yes.

Q My mistake, I am sorry. In terms of police investigation, I think the police were conducting interviews that you were aware of with a number of people. Is that right?
A Yes.

Q And you were interviewed under caution, first of all in relation to Gladys Richards?
A Yes.

Q And then – and I am not worried about the exact sequence – thereafter over a period of time, from time to time, about certain patients?
A Yes.

Q I am deliberately putting this to you in leading form. Were you advised by your solicitor in relation to those matters?
A Yes.

Q And on the advice of your solicitor, it is a matter for you to decide but, taking his advice, did you deal with the police inquiries by way of your general statement and a number of statements relating to individual patients?
A I did.

Q It does not cover all of the twelve because three did not come up in the police inquiries. Did there come a time when you voluntarily limited your prescription powers?
A There came a time when the health authority suggested that I be investigated under the "Failing doctors" procedure.

Q Would you just explain the history briefly, please.
A The Director of Public Health came to see me at home and suggested that there were doubts about my ability to practise in general practice. I objected very strongly to that, because the incidents that had taken place had not occurred in general practice. There had never been any complaints about my general practice and I thought that it was a trifle unfair to be investigated under the failing doctor procedure. There was a meeting held with the Director of Public Health and the then Acting Chair of the PCT, and it was agreed that I would voluntarily not attend the Gosport War Memorial Hospital other than the baby unit upstairs, which was run by the different trust, and that I would voluntarily not prescribe opiates and benzodiazepines until this question was resolved. That carried on voluntarily until a year ago.

Q When I think an Interim Orders Panel made an order which in effect came to the same thing.
A Yes.

Q Is that what it boils down to?
A Yes.

Q In other words, making an order that you should do what you had already been doing in effect?
A Since 2002, yes.

Q That is the reference in Mr Samuel's statement ---
A Yes.

Q --- that the Panel heard about from 1 October 2002 onwards, Dr Barton voluntarily undertook not to prescribe benzodiazepines or opiate analgesics?
A That is correct.

Q I am going to start now to ask you questions about individual patients. I am not going to ask you to go through the remainder of your general statement because we have really covered all the matters that you referred to there. I am going to ask that you have in front of you, in relation to each of these patients, not only the patient file, but also the statement you made about the patient. What I am going to try to do is to use the material in the files, but principally really the chronologies as you go through your evidence. If there is something that you are not able to deal with, or you have forgotten something, or we have reached a position where you are not clear about something, you can always look to your statement made closer to the time (albeit not that much closer to the time) to assist you in your recollection. In relation to your individual patient statements, a lot of them have a general history at the beginning, which we are not going to trouble with, but I do want that available to you when you are giving your evidence. Obviously we start with Patient A, Leslie Pittock. I am going to try to use the chronology. If you need to refer to any particular document inside the file,

please do. In relation to Leslie Pittock, when you made your statement in relation to what you provided to the police in their inquiries, did you have some of the medical records available, or all of them, or what? Do you remember? It does not matter if you do not.

A I think I had all of the medical records available.

Q Because you obviously make reference to certain documents.

A Yes.

MR LANGDALE: Sir, if at various times we need to supply a page reference inside the patient file with regard to your statement, then I will specifically mention it. Mr Jenkins has prepared the lists which give a page reference if one needs to cross-reference Dr Barton's statement to the file. (To the witness) If we go back to this patient, we have seen the history more than once; I do not need to go over all of it again with you. He had chronic depression and so on. You in your statement indicated what had been drawn to your attention in terms of the previous history and so on: Dr Banks, Dr Lord and a number of matters. We can move on to page 9 in the chronology, where the day before he was admitted to Dryad Ward. Dr Lord reviewed the position:

> "Chronic resistant depression. Very withdrawn."

Et cetera, et cetera. She says at the end:

> "RH place can be given up as unlikely to return there."

The bottom left- hand box:

> "Has recovered from recent chest infection, but is completely dependent with Barthel of 0. Eating very little, but will drink moderate amounts with encouragement. Overall, prognosis poor. Happy to arrange transfer to Dryad Ward."

In general terms – we have heard about this from other witnesses, but I need to ask you – when you saw Dr Lord saying about a patient like this, "Prognosis poor", what was that signalling to you?

A It was immediately signalling to me that he was for palliative care and possibly bordering on terminal care. My feeling was that she had assessed him as very poorly, in need of definitely palliative, but quite soon terminal care.

Q In the context of this patient, can we deal with another general issue? It has arisen here and we might as well get your evidence about it. When a patient came into Dryad or Daedalus with, "Prognosis poor", or it looked to you as if palliative care was probably not very far off, that sort of situation, did that mean that everybody stopped trying or gave up on the patient or what?

A It meant that everybody continued to try, but they were realistic about the fact that their efforts were probably not going to bear fruit, that he was going to continue to deteriorate, despite our best efforts.

Q Then we can look at your admission note with regard to this patient:

A

> "Transfer from Mulberry. Immobility. Depression. Broken sacrum. Small superficial areas on right buttock. Both heels suspect. Catheterised. Transfers with hoist. Long-standing depressive on lithium and sertraline."

Then the transfer details say "Poor physical condition" and so on. I am not going to repeat it. Then Nurse Shaw records at the bottom on the left:

B

> "Appears to have settled well ... Has taken a small amount of puree as reluctant to eat sandwiches. Needs to be encouraged with diet and fluids."

Professor Ford indicted that in his view your initial description did summarise the problems. Then we move over the page, where you can see at the top of page 11 the drugs the patient was receiving: sertraline, lithium, diazepam, thyroxine. Of those, which, if any, would you think of as anti-psychotics? Any of them or none of them?

C

A Not any of them are anti-psychotics as such. An anti-depressant, a mood stabiliser, a tranquilliser and a bit of thyroxine.

Q If a patient has been on that sort of medication and that ceases, what effect would that have on your decision as to the correct medication in terms of opiates?

A I would have been well aware that they could have quite an unpleasant withdrawal reaction, certainly to the sertraline and certainly to the diazepam, and I would be allowing for

D

that when I set the initial dose both of the opiate and of the tranquilliser.

Q We can see that you prescribed on the 8th a dose of Arthrotec, a painkiller. Nobody is questioning that. Then on the 9th, there is the note which was added to what was originally on the chronology:

E

> "Reviewed by Dr Barton.
>
> Painful [right] hand held in flexion. Try arthrotec. Also increasing anxiety and agitation. ? sufficient diazepam. ? needs opiates."

Would you explain your thinking there?

A I was thinking that this man was beginning to show signs of suffering pain, generalised pain, as well as this hand held in flexion, and that he was going to need opiates.

F

Q What is the significance to you of the right hand held in flexion? What are we talking about?

A I did not know what was causing it. I did not know whether it was a musculo-skeletal thing or whether it just was an expression of his anxiety, rigidity, immobility. That is why I had a go with the non-steroidal anti-inflammatory in the first instance to see if it would help and it did not.

G

Q 9 January, that same date, we see the nursing note:

> "Stated that he has generalised pain. To be seen by Dr Barton in the morning."

Then over the page, the nursing care. I am not going to go through that. Two doses of Arthrotec were administered. Then on the 10th on page 12, he is reviewed by Dr Tandy and she says "For TLC". What is the significance of that?

H

A A Tender loving care equals what we tried to do with palliative care.

Q

"Telephone call with wife – agrees in view of very poor quality for TLC."

Can we take it that in the ordinary course of events Dr Tandy would have seen your note relating to the previous day, when you had said "? needs opiates"?
A Yes.

Q Would there have been some discussion between you and Dr Tandy about this patient?
A Yes.

Q Obviously after this time it is impossible to remember precisely what, but we can see the nursing note records that you were there:

"Seen by Dr Tandy and Dr Barton.
To commence on Oramorph 4 hourly this evening."

This is a case where Professor Ford indicated that was entirely appropriate. Here we are starting off with an opiate, not a mild opiate, but one on the final rung of the ladder, I suppose. Is that right?
A Yes. In a small dose.

Q Dr Tandy, it appears, either agreed with you or agreed with what you proposed or suggested it herself. Who knows?
A Yes.

Q Indeed, looking over the page to page 13, we can see that you prescribed 5 mg to be given five times daily. The first administration of that appears to be at ten o'clock in the evening. Is that right?
A Yes.

Q Would the discontinuation of Arthrotec have any bearing on your decision as to what level of dose was appropriate with an opiate, or does it make no difference?
A It would make no difference.

Q At some stage – and the position is a little confused here – it may well be on the 10th, you wrote up a prescription for subcutaneous analgesia and also the following day. I am going to treat it as one. What it involves is diamorphine initially written up by you as 40 to 80, if we look on page 13.
A Yes.

Q Hyoscine 200 to 400 mcg and midazolam 20 to 40. Over the page, there is another anticipatory prescription written in relation to those same drugs: diamorphine is now 80 to 120, hyoscine remains the same, midazolam goes from 20 to 40 to 40 to 80, sertraline and lithium, which had been prescribed, were discontinued and we also bear in mind that on 11 January, Oramorph is administered at six o'clock in the morning, you then prescribe 5 mg

four times daily, plus 10 at night, which would work out, and indeed he did receive something like 30 mg in the 24 hours. All right?
A Yes.

Q The question I would like you to deal with is, why write up an anticipatory prescription for diamorphine at 40 to 80 first of all and then write up another prescription where it has become 80 to 120 and similarly with midazolam: it was originally 20 to 40 and then becomes 40 to 80. Obviously there is a doubling up of the initial dose in the dose range. What is the reason for that?
A Because having seen him on each of those days, in my clinical judgment he was not going to be controlled by the very lowest doses of my usual diamorphine and midazolam prescription.

Q What was it – and I appreciate again this is looking back at a patient who is way back in time in terms of what we are dealing with – what sort of thing would have been apparent to you which would justify starting off that much higher?
A It was the intensity and depth of his pain and stiffness and rigidity and discomfort. Under normal circumstances I would have been very happy to have started on 20 or possibly even 40. That was the original anticipatory prescription I wrote up, but when I reviewed him and looked at this guy again, he was in such discomfort, he was going to need more than that.

Q Can we take it that you would have seen this patient on the 11th as well as having seen him on the 10th?
A Yes.

Q Why not write up the fact of his deterioration, that his position was worse, his medical condition? Why not write that up?
A Because I did not make the time to write that up.

Q It appears in this case that there is no nursing note or notes relating to that particular aspect.
A No.

Q Can I just ask you this quite bluntly? Would you have increased the starting dose of midazolam and diamorphine for no reason at all?
A Absolutely not.

Q I think Professor Ford indicated that this man was in his view dying. What about the concern that this was going to cause respiratory depression or lowering his conscious level?
A I accepted that that was a price that we might have to pay in exchange for giving him adequate pain and symptom relief.

Q None of this is administered on the 11th ; it is anticipatory. On the 13th, two days later, we see:

"Catheter bypassing: Mr Pittock appears distressed."

Over the page, a similar sort of thing in the nursing care page. Then the drug chart on 15 January ---
A They waited for me to come back on the Monday morning.

Q So this is now four days after the anticipatory prescription.
A Yes.

Q The diamorphine is administered at 80, midazolam is administered at 60. 60 is not the lowest dose. Midazolam is now 60 as opposed to 40. It is still within the range.
A And that would have been in discussion with me on the morning of Monday 15 January.

Q We can see the note below that:

"[Seen by] Dr Barton. Has syringe driver at 08.25. Diamorphine ... midazolam ... hyoscine.

Douglas: 19.00: Daughter informed of father's deterioration during the afternoon. Now unresponsive, unable to take fluids and diet. Pulse strong and regular. Comfortable night."

What do you say to somebody who says, "Well, that is an indication. He is now unresponsive, he has deteriorated. The diamorphine and the midazolam are producing significant adverse effects." What would you say to that suggestion?
A I would have said that if I reviewed him the following morning and I felt on my assessment that that was genuinely the problem, I could have reduced either or both of those drugs in the syringe driver.

Q Then let us look at the next morning, the 16th, on page 16, where we can see the same administration of the subcutaneous analgesia.
A Yes.

Q With a prescription for haloperidol, which I will come on to in a moment.
A That would suggest to me that he was not still unresponsive or unconscious, but that he was restless and agitated and needed an additional anti-psychotic adding to his syringe driver.

Q In other words, can we take it you would not have prescribed it if there was no reason for doing so?
A Not at all.

Q 5 mg in 24 hours. That is by way of an addition to the mix, as it were, in the syringe driver. Is that right?
A Yes.

Q We see:

"Condition remains very poor. Some agitation was noticed when being attended to. [Seen by] Dr Barton. Haloperidol ... to be added to driver.
Night: condition remains poorly. All care continued."

A Then we can see the nursing notes as to the problems on page 16. That is on the 15th and 16th. The same amount is being administered. Then on the 17th, the dosage was increased. Why was the dosage increased?
A Because he was becoming inured to the dose of diamorphine and he was beginning to get symptoms of pain and agitation and distress.

B Q If we look at the note relating to this day, shown on page 18, so relating to 17 January, does that reflect what you have just been indicating?
A Yes, "... tense and agitated, chest very bubbly".

Q The significance to you of, "chest very bubbly"?
A It was either that he was developing bronchial pneumonia or that he was getting excessive secretions in the upper respiratory tract or both.

C Q What about the opiates themselves, the diamorphine, causing him to be tense and agitated? What would you say to that?
A I would disagree because, initially, the opiates had made him unresponsive and they were not now going to be making him tense and agitated. His underlying condition and his approaching death was making him tense and agitated, as was his developing bronchial pneumonia.

D Q And he, "Remains distressed on turning", as we have seen.
A Yes.

Q On that same day, on the 17th, when you had seen him in the morning, here we have an indication of you seeing him again, it seems. Is that right?
A Yes, I came back in the afternoon.

E Q I suppose it is impossible for you to remember whether you came back for him or whether you came back, in any event, for some other reason.
A 2.30, I probably came back for him.

Q Which would be in response, would it ---
A To the concern of the nursing staff.

F Q You reviewed and altered the medication. That is what brought about the increase? No, that cannot be right because the increase occurs at eight o'clock in the morning. Let us just look at the previous page and get the times right. I am sorry. I was trying to move on a bit too fast. On the 17th, on page 17, in the morning 120 diamorphine is administered, the dosage having been increased. Then it is administered again, same dose, at 1535 after you come back to see him in the afternoon. Right?
G A The only change at 1535 is the midazolam has increased and the haloperidol has increased.

Q The reason for increasing the midazolam and the reason for increasing the haloperidol?
A Terminal restlessness, agitation. Not obviously felt to be, at that point, pain as much as restlessness and agitation.

H Q Why not just leave it like it was? Let me put that to you.

A A Because they called me back and they felt he was uncomfortable and was suffering and I responded to that.

Q Why not leave it because of the risk of it having an adverse effect? I would like you to deal with that, if that is being suggested.
A At that point I was not concerned about any potential adverse effect. I wanted Mr Pittock comfortable and free of all these wretched symptoms that he
B was suffering.

Q Yes. What is the significance then of him remaining tense and agitated, having been on 80 mg for two days? What is that telling us?
A It tells us he was not having enough diamorphine.

Q Why increase the haloperidol as well? I think Professor Ford was raising a
C criticism of it was all right to raise one of them but not all of them. What do you say to that?
A We did not have time to play around with altering one at a time. We had to make Mr Pittock more comfortable. It seemed entirely sensible to make a reasonable increase in the dosage of both.

Q Then on the 18th, the following day, further deterioration, bottom left-hand
D corner of page 18:

> "[Subcutaneous] analgesia continues. Difficulty controlling symptoms. Try nozinan."

First of all, "Difficulty controlling symptoms", what does that signify?
A He remained restless and agitated and uncomfortable. I would not say so much in pain but terminally distressed.
E

Q Why did you say, "Try nozinan", and, indeed, nozinan was administered. Why add in an extra drug?
A I knew it was a different sort of sedative. I knew it acted in a different way and I was concerned to try and see if I could make him more comfortable that way.

Q Would you like to deal with this: why not take away the haloperidol
F altogether and replace it with nozinan?
A I should, in retrospect, have. I think they stopped the haloperidol the following day anyway, but I think I should have stopped the haloperidol and tried the nozinan on its own.

Q We know what Dr Briggs did and I know you are not in disagreement with that.
G A No, not at all.

Q That was your rationale for trying nozinan?
A Yes.

Q Because it had a slightly different ---
A Different sedative effect from the midazolam and the haloperidol.
H

Q Over the page, page 19:

A

> "Poorly condition continues to deteriorate ... Syringe driver recharged with diamorphine 120mg, midazolam 80mg, hyoscine 1200ug, haloperidol 20mg and nozinan 50mg."

Over the page, on page 20, we can see what the drug charts show. I am not going to go over that because we know what the position was. Then on the 19th, the
B following day, the drug charts show diamorphine is now 120, as it had been, hyoscine same, midazolam the same, haloperidol and nozinan the same. Over the page, on page 21, still on that same day, the 19th:

> "Marked deterioration in already poorly condition. All nursing care continued. Breathing very intermittent. Colour poor."

C Another sign that he is in the process of dying?
A Yes.

Q I think that is something that had been apparent before this date, that this man was coming to the end of his life. On the 20th the position remains the same, save for the call to Dr Briggs, and if we can just take on board what happened there. We have heard evidence from him. He had been unsettled on the
D haloperidol, a verbal order to increase nozinan, that is what Dr Briggs said on the telephone. You were obviously not available. Right?
A Yes.

Q Nobody is criticising what he did. He says quit the haloperidol, as we can see on page 22, and Mr Pittock, "appears comfortable". It is stated on the nursing care plan, if we can just look at the box for the nursing care plan on that date, on
E page 22, the second box down. When one looks at what is, in fact, page 227, the nursing care plan says:

> "Now unable to cope with dietary/fluid intake. Please give regular mouth care."

First of all, does that signify that he had been taking some kind of oral dietary substance or fluid at least?
F A It does.

Q Why is this man on a syringe driver when he can apparently still take some form of oral intake?
A Because there would be no way that orally you could control his restlessness and agitation and general psychotic symptoms, even if you could control his pain.

G Q Then 21 January, the situation continues. There is a note relating to Dr Briggs who has come in to see him:

> "Much more settled. Quiet breathing. Rate 6/min. Not distressed. Continue."

Dr Briggs has given his evidence about that. "Breathing quietly and slowly",
H appears on page 23. Then also on page 23, 22 January, these drugs continue,

"Poorly but very peaceful". Again, you would have been reviewing this man each day that you came in?
A I would have seen him again on the morning of the 22nd, the Monday, yes.

Q Assuming it is a day you were there.
A Yes.

Q So you would be reviewing him each day?
A Yes.

Q Did it seem to you that there was anything wrong with the treatment that he was receiving or that it ought to be changed or altered in any way?
A I could see nothing wrong with what he was being given and I made no attempt to change any of it.

Q 23 January, on page 24, the situation continues. We can see what the nursing notes record. The following day, in the early hours of the morning, Mr Pittock died. Cause of death bronchopneumonia. You have heard the criticisms that have been made by Professor Ford. Does that alter your view as to what you thought was appropriate at the time?
A Not at all.

MR LANGDALE: I am just pausing to see if there is anything else in relation to the contents of your statement that I need to ask you by way of supplementing what you have already said in your evidence. (Pause) That is all I need to ask you about Patient A.

I will move on to Patient B. I was imagining that a sensible time to adjourn would perhaps be something in the region of four thirty, but I can start on Patient B.

THE CHAIRMAN: It is a matter for you. If you are happy to make a start.

MR LANGDALE: I think it is preferable if we can keep going. We can at least make some progress.

THE CHAIRMAN: Use your discretion.

MR LANGDALE: Thank you.

THE WITNESS: Can we just also check the chronology again? Does this one have a subsequent or is just the original one?

MR LANGDALE: Mr Jenkins will just take a look and see what needs to be done.

MR JENKINS: The chronology is in a separate folder.

THE CHAIRMAN: Mr Kark, do you have spares?

MR KARK: There is a chronology file, so instead of looking at the chronology at the beginning of each patient folder, if Dr Barton could turn to the chronology file that has the up-to-date version of them.

MR LANGDALE: I had not realised this. So for the witnesses there is a separate file containing each one of the chronologies?

MR KARK: Yes.

MR LANGDALE: Thank you. I am sorry, Dr Barton. That is my fault. I did not realise that is what you were faced with.

Patient B, Elsie Lavender, the lady whose GP was Dr X. We can see on page 1 of the chronology she is one of a number amongst these twelve who had to go to hospital because of a fall. This is the lady who fell down a flight of stairs at her home address and we have seen the position more than once as to what had developed. We can look at page 2. She is complaining of pain. She is prescribed, on the bottom of page 2, co-proxamol and dihydrocodeine which is administered until transfer to Gosport War Memorial Hospital.

Over the page, page 3, we have seen this more than once, the complaints about pain continuing. Analgesia given but never ever gets on top of it, shoulders and arms and so on, and we can move to Dr Tandy's review of her on 16 February, on page 5, of the chronology, pain, long standing stress incontinence, atrial fibrillation, weakness in hands:

> "Most likely problem is brain stem stroke leading to fall. Might want to consider asprin. I'll get her over to Daedalus Ward for rehab as soon as possible."

This is the case where Dr Tandy had assumed that the x-ray of her neck was normal. Her note also actually says:

> "I'm not sure ... we'll get her home but we'll try."

Over the page, on page 6, 20 February, physiotherapist, still complaints about pain, the 21st, same situation continues and then on the 22nd she arrives at Daedalus Ward under Dr Lord, reviewed by you, and you recorded:

> "Fell at home top to bottom of stairs. Lacerations on head. Leg ulcers. Severe incontinence. Needs a catheter. Insulin dependent. Regular series BS."

A Blood sugars.

Q Thank you. "Transfers with 2". What does that mean?
A It needs two people to get her standing or back onto the bed again.

Q Thank you.

> "Help to feed and dress. Barthel 2. Assess general mobility ? suitable for rest home if home found for cat."

This is a lady who had ...
A A feral cat.

Q ... a somewhat singular-minded cat. She seemed to be the only person who could really cope with the cat. In terms of comorbidities, we are thinking of insulin dependence?
A For 40 years.

Q Atrial fibrillation; she had also got a problem in terms of her sight. When you assessed her, what was your view in general?
A I felt exactly as Dr Tandy had felt, that she deserved the opportunity to try some general rehabilitation but I was not very hopeful, as you say, in view of those comorbidities and the amount of pain she had, even at that time.

Q Why not (to deal with matters raised with Professor Ford) say to yourself, "this pain seems to have gone on an awful long time. I had better find out what is causing the pain"?
A I, like Dr Tandy, assumed that there had been normal x-rays taken at Haslar Hospital before her transfer and I would have been thinking in my mind was I going to find any cause for this pain that was treatable, and the answer was there was not.

Q What about the particular history of this lady, who was then 84, I think, I may have got the age wrong, having fallen down the stairs in the way that she had, a significant fall, perhaps. What was your view about the likelihood of pain remaining?
A If she had crushed a cervical vertebra or a thoracic vertebrae she would still have considerable and significant pain even at this time after the original injury, but other than adequate analgesia there would have been nothing I could have done for her. There was nothing that was remediable or treatable.

Q Would you explain that, please? Supposing she had had that sort of injury.
A There would be no operation or procedure that could be done to make it more comfortable for her. Somebody suggested immobilising the neck in a collar. I think she would have found that even more uncomfortable. She was a small, tubby lady and those proper neck collars are seriously uncomfortable to wear. So there was not anything we could do for her, other than give her adequate pain relief.

Q What about sending her back?
A What could they do at the acute hospital? Nothing further.

Q Explain that.
A They had an MRI, they could have put her through and determined if there was cord compression or not, but, again, there would be no treatment for that either. The treatment is expectant pain relief and gentle mobilisation when it becomes possible, if it becomes possible.

Q What would you have had to do if you were thinking to yourself, "Well, it may be there is some kind of fracture problem or crushed vertebra problem"? What would you ---?
A Nothing different from what I did for her anyway.

Q What about a lady of this age having had a fall like that on the 5th, so over a fortnight before, still being in pain as result of bruising and so on, or internal bruising – whatever it might be – from the fall? Would that be ---?
A Totally appropriate.

Q And the problems with grip in both hands, what in your view was the significance of that?
A She could have had a neuropathy associated with her 40 years of insulin dependent diabetes. She could have had a specific nerve problem, perhaps, in the carpal tunnel in the wrist. I did not think that the difficulty with grip was necessarily anything to do with the acute injury. It might have been pre-existing.

Q And what were the prospects when you put "Assess general mobility. ? [Query] suitable for rest home if home found for cat." What were the prospects if she had in fact got a crushed vertebra? That was the thing.
A She might slowly, slowly improve sufficiently to go to residential care, given enough time.

Q Yes. Then the analgesia that is given was dihydrocodeine in respect of this lady, as we can see at the top of page 8, when she comes in – all right?
A Yes.

Q May I ask you this: she has this pain. Why not put her straight on to Oramorph?
A Because, having come across on what I felt was a decent step two analgesic, I thought it was better to assess how she responded to that before starting on an opiate.

Q Then if we look down the page, page 8, we see what the position was on 23 February and then the 24th. On the 24th, when you reviewed her – you reviewed her on the 23rd and you reviewed her on the 24th. I had better just ask you, please, about the 23rd. The clinical notes by you say,

"*Catheterised last night. 500 ml residue. Blood + protein. Trimethoprim.*"

Would you just explain that?
A She had a urinary tract infection which probably contributed to the urinary retention she went into, and that was treated with an antibacterial.

Q So you are trying to cope with that problem there?
A Yes.

Q Sister Joines' note:

"The pathology phoned – Platelets 36 ? too small sample. To be repeated Monday. Dr Barton informed ...".

Again, what is going on there in terms of what is being done for her?
A I did not know what the significance was of that platelet count, but I was happy to repeat the blood sample after the weekend and do it again.

Q With a view to checking what when you are ---

A A Whether that was an artefact, or whether that was a genuinely low platelet sample.

Q Then reviewed by you on the 24th:

"*Pain not controlled properly by D.F. 118. Seen by Dr Barton – for MST 10 mg BD* [twice a day]. *Nocte* [Night]: *Comfortable night.*"

B A First comfortable night.

Q I am sorry, Doctor, I did not quite hear you. Sorry?
A First comfortable night.

Q Yes. Then perhaps you can just indicate what your rationale was for prescribing and having administered MST because over the page, on page 9, we can you prescribed it, C obviously in the morning, and it is administered, it appears... Presumably it was administered first of all at 18.00 on the 24th, and then 6 o'clock the following morning?
A Yes.

Q But why prescribe MST? I am sorry if the answer is obvious, but do explain.
A Rather than Oramorph?

D Q Yes.
A She was able to take tablets at this point, therefore she would be able to take the capsules. I felt a steady low dose of slow release morphine might be as effective – more effective – than her D.F. 118 that she had been having.

Q Professor Ford seemed to be saying, you do not usually convert to MST from D.F. 118 because it is very slowly absorbed. You might not get the right dose, and it was E recommended to start on Oramorph. What do you say to that?
A That was his opinion.

Q Then, the following day, MST again, 20 mg in all.

"*Appears to be in more pain. Screaming 'my back' when moved but uncomplaining when not. Son would like to see Dr Barton.*"

F

Over the page, please, to the 26th.

"Reviewed by Dr Barton."

So you are seeing her again.

G "*Not so well over the w/e. Family seen and well aware of prognosis and treatment plan. Bottom very sore. Needs Pegasus mattress. Institute sc* [subcutaneous] *analgesia if necessary.*"

And the note below:

"*Seen by Dr Barton. MST → 20mg BD* [twice a day]. *She will see Mrs Lavender @ 14.00* ...

H

14.30: Son and wife seen by Dr Barton – prognosis discussed. Son is happy for us to just make Mrs Lavender comfortable and pain-free. Syringe driver explained."

Obviously what is being recorded both by you and the nursing staff is contact with relatives?
A Something has happened over that weekend.

Q Yes?
A 24th, 25th February she has definitely deteriorated. She is now moving from palliative care, gentle rehabilitation, to end of life. So when I examined her and assessed her on the Monday morning, I needed to see the family to explain that to them.

Q The Panel heard evidence from Mr Alan Lavender – and I am not going to go through it all. He indicated that he had had several conversations with you and it appears that all he could remember was you saying to him, "You can get rid of the cat," and "You know your mother has come here to die." Is that the tenor and nature of your discussions with him?
A I hope it was not. I have no recollection of putting the facts to him as baldly as that. I knew the cat well and I would not have said, "Get rid of the cat." But I would have explained to him that something had happened to his mother over that weekend. She was not nearly as well and she was probably dying.

Q Did he indicate, as the note records, that he was happy for "us" – in other words the hospital nursing and medical staff to just make Mrs Lavender comfortable and pain free?
A He wanted her comfortable and pain free.

MR LANGDALE: Sir, I think to go on to the end, because there is a bit more, may take a little more time that is not justified at the end of the day. If I may, I will stop there.

THE CHAIRMAN: Absolutely. Thank you very much indeed, Mr Langdale. We shall break now, ladies and gentlemen, returning tomorrow morning at 9.30, please.

MR LANGDALE: In relation to tomorrow morning, we have – cross fingers – the video link with Dr Lord.

THE CHAIRMAN: You are quite right. We are starting at nine for that purpose, yes. So nine o'clock start, please.

MR LANGDALE: We understand four hours, if everything works. Then at the end of that, no doubt after an adjournment for lunch, Dr Barton can continue her evidence tomorrow afternoon, hopefully. That may be as far as we will get, assuming everything works with Dr Lord, until Friday afternoon, when we will be stopping early.

THE CHAIRMAN: Thank you very much.

(The Panel adjourned until Wednesday 16 July 2009 at 9.00 a.m.)