FFW/ 105 / 05

TRANSCRIPTS
DAYS
26 – 31

DR. BARTON

Field Fisher Waterhouse LLP 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 **Fax** +44 (0)20 7488 0084
E-mail info@ffw.com **Web** www.ffw.com **CDE** 823

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 16 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-SIX)

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.

(Video link opened)

MR LANGDALE: Just before we start, Dr Barton has resumed her place here. It is clear to her and it is clear to us that we are entitled to take instructions from her about this evidence, or anything arising, but we are not otherwise communicating, just so the Panel knows.

THE CHAIRMAN: Thank you for telling us. That is very kind of you. (To the witness) Can you hear me?

THE WITNESS: Yes.

THE CHAIRMAN: Can you see me?

THE WITNESS: Yes, I can.

THE CHAIRMAN: You should have a piece of paper in front of you with an oath or affirmation on it.

THE WITNESS: I have.

THE CHAIRMAN: Would you please read that to us?

ALTHEA LORD, Affirmed
Examined by MR JENKINS

(Following introductions by the Chairman)

Q Hello, Dr Lord. I am going to stay seated if that is all right. I hope the Panel can see me as well. Can I just ask you what your present position is?
A I am currently working as a full time consultant geriatrician at Hutt Hospital in New Zealand.

Q That is Hutt – H-u-t-t?
A H-u-t-t. It is a small district general hospital which is just outside Wellington.

Q I understand. I think you were a consultant geriatrician in Portsmouth between 1992 and 2006?
A That is correct. Yes. I left at the end of August 2006.

Q We have heard your name many times in relation to patients at the Gosport War Memorial Hospital, and I think you used to see patients there?
A Yes, that is right.

Q Can you tell us what your job involved as a consultant geriatrician when you worked in the Portsmouth area?
A The job was quite mixed, so I had acute patients at Queen Alexandra Hospital, initially at St Mary's Hospital. There were acute wards which at one time were single consultant-led wards, but sometimes shared. I did outpatients alternate weeks at St Mary's

A and Gosport, and then latterly only at Gosport War Memorial Hospital. Also I had rehabilitation beds initially again on Kingsclere Ward at St Mary's Hospital and long stay wards at Gosport. At one point I did St Christopher's Hospital at Fareham as well. As the work in Gosport increased, I ceased doing the rehabilitation at St Mary's Hospital and worked in Gosport War Memorial Hospital. That was a combination of what we call continuing care plus some stroke rehabilitation.

B Q Right.
A And subsequently general rehabilitation. There was also a day hospital, and the day hospital in Gosport was the newest of the four day hospitals in Portsmouth. I initially worked at St Mary's and Gosport War Memorial Hospital, day hospitals, alternate weeks, but latterly it was only at the day hospital at Gosport War Memorial Hospital, which was Dolphin Day Hospital.

C Q I think Dolphin was part of the complex of the Gosport War Memorial Hospital?
A It was.

Q It was on the same site?
A It was the new-build, yes.

Q We have heard that you used to do ward rounds on a Monday at the War Memorial
D Hospital and that on occasion Dr Barton would be there with you?
A Yes. That is correct, yes.

Q Can you tell us about the ward rounds? Which wards were you doing ward rounds on on a Monday?
A At the time, the last lot of ward rounds that I would have done with Dr Barton would have been on Daedalus Ward and Dryad Ward, but prior to that we also had beds on
E Redclyffe Annexe, which was annexe a little bit away from the main hospital complex.

Q We have heard ---
A The ward rounds usually consisted of --- Sorry?

Q No, go ahead.
A The ward rounds were usually on a Monday afternoon when we started stroke
F rehabilitation. It was on a Thursday afternoon as well, and we would have a multidisciplinary case conference, usually for about half an hour, 40 minutes, when the patients were discussed. Then we would do a ward round, when we would go together with the sister of the ward or the senior nurse, to see the patients and make decisions on their management and their prescription. Then usually, if there were relatives to be seen, I would see them at the end of the ward round.

G Q Right. Can I ask you about how long a ward round would take if you were doing one on Daedalus Ward or Dryad Ward?
A Pretty much the whole... We would start at two o'clock, if I remember right, and by the time we had seen relatives it could be five o'clock, sometimes a bit after that, so pretty much the whole afternoon.

Q Did the time for a ward round change over time, over the years?
H

A Yes. Initially the wards were designed to be long stay wards, but as the continuing care ward patients were moved into the community, into the nursing homes, we were taking patients that were probably more slow stream general rehab and slow stream stroke rehab, and at the point when I left in 2006, even fast stream stroke rehabilitation patients in the Gosport and Fareham area were coming to Gosport War Memorial Hospital. So over the years – I was consultant from 1992 – the case mix changed, but it changed gradually.

B Q I want to concentrate ---
A Does that answer your question?

Q It does. I want to concentrate on the period that you knew Dr Barton between 1992 and her resignation in the year 2000.
A Yes.

C Q So you knew her and worked with her for eight years?
A Yes, I did.

Q When you were doing ward rounds with Dr Barton on a Monday, can you tell us how you would deal with each of the patients? How would they be introduced and what would the nature of the discussion be?
A Dr Barton would introduce the patients to me and would say this was a lady, and give
D a brief history, the past history and the reason she was admitted, the reason she was transferred, and then would update me on the patient's condition. If there was anything relevant, then a senior nurse would add their comments to that as well. We would chat with the patients, examine them and then make a decision, a plan, for management, look at their medication and generally we were in agreement with the management plan.

Q Can I ask – did you have time to form a view about Dr Barton and her abilities and
E skills as a doctor?
A Yes, I did. She was a good doctor.

Q What would you say about her level of commitment to patient care?
A She is a committed doctor and a good doctor. She is quite sensible, and she likes working with older people. She is a kind and caring doctor, and she was always ready to go that extra bit for her patients.
F

Q Were there any problems that you had with Dr Barton or disagreements about how patients should be managed?
A No major disagreements. I cannot remember there being any serious contentious issues.

Q I am going to put to you what you said in a statement made for the General Medical
G Council. All right? You said that the ward rounds would normally take up one session. They would usually last between 2 and 5 p.m. Initially you used to finish the ward rounds on time. However, as the years went by the wards became busier and the ward rounds took a lot longer. Yes?
A They did.

Q You say:
H

A "7. ... I would usually finish at around 6pm and complete other work as necessary. The days on which I was working at Gosport War Memorial Hospital were very long days. Sometimes I would not leave until 7 p.m."

Is that right?
A That is correct. Yes, that is correct.

B Q Are you saying there that the wards got busier during the time that Dr Barton was working with you at Gosport?
A The words did get busier in the period between 1992 and 2000. The work that I often returned to after I had finished on the wards would be dictated from the morning day hospital round, so that was done right at the end of the day.

Q I understand. Were the nature of the patients changing, by which I mean ---
C A Yes.

Q --- the sort of conditions that they had?
A The patients were getting more complex and from when I started as a consultant in 1992, quite a lot of patients were offered hospital continuing care for life, and those patients were relatively stable. You got to know them and got to know their families, but over the years there was a move to move the hospital continuing care into the community, into nursing
D homes, and at the same time there was, I suppose, a feeling to keep the beds as a resource you have. Coupled with that Haslar, which was the naval hospital and then became the service hospital, started doing trauma. With that there was an increased throughput of frail older people who lived in Gosport, whose families lived in Gosport, who needed aftercare after their surgery. There were only twenty general rehab beds in Portsmouth at St Mary's, and for some of those relatives it was difficult to travel. So we did take people for general slow stream rehabilitation from the – mostly – fractured hips and other fractures. That is how the
E case mix changed. I am sure this was before Dr Barton left us. We were also doing the slow stream stroke rehabilitation. People with strokes, a week after they had assessment on an acute ward, were moved closer to home for ongoing rehabilitation. So from this continuing care, which are people with probably sometimes complex needs, sometimes really big disabilities that they did not progress, we were then dealing with patients whose needs were changing, a different mix of patients. Looking back at geriatrics over the years, the care of older people, we were beginning to recognise and manage more conditions as I suppose we
F learn more about conditions and more about what can be done. So if I look ... Sorry.

Q That is all right.
A Shall I move on?

Q No. As the nature of the patients were changing, patients with more complex needs, perhaps patients who had undergone surgery recently, was there any change in the resources
G that were available at the War Memorial Hospital?
A No.

Q Were you given more nurses or more doctors?
A As far as I can recall, during the period that Dr Barton with us, I cannot comment on the nursing staff. I do not think we had any more nurses but I cannot remember that for certain. With the change in case mix, at the point that Dr Barton left us, she was still the only
H clinical assistant. Whether her sessional time got reviewed, again I cannot remember.

Q Can I come back to a ward round? When you were seeing patients, would you look at the prescription chart?
A I would.

Q We have seen that for some patients a syringe driver was used?
A Yes.

Q And we have seen that for some patients a syringe driver would be prescribed and not instituted straight away?
A Yes, that is correct.

Q Would you have been aware if that was happening with patients that you were caring for?
A Yes. The "as required" prescribing was in place for the syringe drivers, but also for other medication.

Q And in your view was that appropriate, for a syringe driver to be prescribed in advance of it being required for the patient?
A Yes. The reason the "as required" prescription, including the syringe drivers, are written up is so that if a patient was distressed, then continuous analgesia could be given and that was left, after discussion with the nurses, there was really scope then for the nurses to commence a syringe driver if the need arose. There was no resident medical cover out of hours and it was Dr Barton or her partners who provided that. So the aim of the syringe drivers being on the chart, as I recall, was to ensure that there was something to keep people comfortable if the regular medication and other "as required", the shorter acting medication, was insufficient.

Q As the consultant responsible for patients on the ward, did you have a view as to whether that was a safe way of proceeding?
A The "as required" prescriptions are something that we still do in practice today. With hindsight I think, having looked at the charts and the notes, leaving a syringe driver on the "as required" and having that discussion with the nurses, that they are now at a stage that this is going to be required, it was probably the dose range on the syringe drivers rather than the syringe drivers per say that the dose range probably could have been smaller. But I think to have left the syringe drivers as an option was reasonable practice, and that is something that I would do in my practice today as well.

Q We have seen anticipatory prescribing, a dose range written up for a syringe driver in advance of the patient requiring a syringe driver, where the dose range may be from 20 to 200 mg of diamorphine. Were you aware that that was a dose range that was on occasion written up?
A I had not quite registered that the dose range was that wide and I am not too sure why that was. I knew we were writing up – for me, the fact that it was written up in advance is sometimes necessary, but with hindsight maybe the 20 to 200 was probably too wide a dose range.

Q At the time, does it follow from your answers, you were aware that dose ranges were being written up in advance of a syringe driver being needed at all and you were content with that?

A A Yes.

Q What was your understanding as to how the syringe driver would be started if it was felt necessary to move to a syringe driver? Would the nurses do it themselves?
A The understanding was that the nursing staff would discuss this with Dr Barton or one of her partners and have a discussion about the patient's condition, what the problems were, and then it would be a joint medical and nursing decision to commence the syringe driver.

B

Q From your experience of that process going on, were you aware of any problems?
A The problems probably were when Dr Barton was not on call for a weekend or out of hours. Sometimes getting the cover from her partners was difficult. Some of them did not feel comfortable with palliative care and some of them were very busy. But I am assuming that the nurses would have discussed it with the on call doctor in all instances.

C Q If a decision was made to start a patient on a syringe driver which had earlier been written up by Dr Barton, were you aware of any difficulties with the nurses contacting Dr Barton for there then to be a decision to start the patient?
A I do not recall. If Dr Barton was on call, she was contactable and she also visited the wards fairly frequently: first thing in the morning, sometimes at midday, sometimes after she had finished surgery, as I recall. She was contactable. Sometimes some of the others were busy.

D

Q Can I ask about the nursing staff? You will have known Sister Gill Hamblin on Dryad Ward.
A I did.

Q What was your view of her as a nurse?
A She was an efficient ward sister, she worked hard, she was kind to the patients, she E was exceptional with skin care, I worked well with her and there were certainly no tensions. She was a good nurse. She has left the hospital and I am not too sure if she is working right now.

Q We know she is not well, I am afraid. Can I take you to the other ward, Daedalus Ward? There was a Sister Joynes who was sister there for a number of years. How did you get on with her and what was your view of Sister Joynes?
F A Sister Joynes was on the male ward before she was on Daedalus Ward and she was very much an old-school nursing sister, very professional, very good with patients and relatives, somewhat of a no-nonsense approach, but certainly good care of older people and I got on very well with her.

Q Then the ward manager at Daedalus Ward was Phillip Beed. How was he as a nurse?
A Phillip again was a good nurse. He did well and he has moved – we worked well on G Daedalus – he probably had a different style of management, in that he encouraged the nurses to develop quite a lot of their skills and supported them. He has moved into the community and I believe he is enjoying his role. A good nurse again.

Q Just looking at both of those wards, Dryad Ward and Daedalus Ward, what would you say of the standard of nursing care that was provided for the patients?
H A The nursing care was good, but again, as the wards got busier and we needed more rehab, we probably did not upskill the staff at the same rate. But the nursing care was good.

Q Upskill the staff. What do you mean by that?
A There was a need to move from care of the older person and good nursing to looking at rehabilitation issues. That probably took a bit longer with goal-setting in the multi-disciplinary work. There were therapists visiting the wards even at the time that Dr Barton was there, but the development of the multi-disciplinary rehabilitation took a bit longer.

Q Can I turn back to Dr Barton? If there were occasions when she needed to speak to you and you were not on site at the War Memorial Hospital, what would you say of Dr Barton's willingness to get hold of you?
A I was always contactable by phone and she could get me through the operators at Queen Alexandra Hospital. Most of the ward senior nurses knew what sessions I had in Gosport and when I would be there and if Dr Barton was worried, she would call and discus it, sometimes first thing in the morning, sometimes in the middle of the day.

Q Can I ask about her note keeping? We have seen notes by Dr Barton that are fairly brief, clinical notes.
A Yes. I think looking at the notes, the notes are brief and probably too brief.

Q Tell us, did you ever mention that to Dr Barton during the years that you worked with her?
A No, I did not. I do not recall doing so.

Q Why would that be?
A I am not too sure. It was probably against a background of being busy and at that time there was no formal supervision, where one sat down with a set of notes and went through them and looked at notes as we would do now when supervising other medical staff. Dr Barton was also already in post when I started. She was a competent GP, looking after our beds and we were working well. Looking back over the notes, I now realise that I probably should have been more critical about the notes.

Q You say that looking back. At the time did you feel there was any problem with the notes?
A I knew the notes were brief, but I did not pick up that they were actually lacking in a fair amount of clinical detail.

Q At the time, did you feel as if patients were being in any way let down?
A I do not think the patients were let down because Dr Barton was on the ward every day, certainly at least once or twice a day, sometimes three times a day. So I do not feel the patients were let down, but the records should have been there.

Q You talked about Dr Barton being busy. Is it your understanding that was the reason why the notes were brief?
A It was the busyness and the turnover on the ward and I think we were all busy at the time as well. It is not an excuse, but my understanding is that the wards got busier and, as a result, the note keeping suffered.

Q I am going to turn to certain patients with you now, if I may. I am going to start with a man called Leslie Pittock. Do you have any notes with you?
A Yes. Can I look at them?

Q Please do. It may be that the notes are put into different sections with a letter reflecting the patient. If that is so, this is Patient A, Leslie Pittock, and I am going to ask you to look, please, at a note that we have on page 68. I know you have looked at these notes recently, but I think you cannot recall this gentleman. Is that right?
A No, I cannot recall this gentleman at all.

Q We have looked at this note on a number of occasions in the past and I am just going to invite you to identify as yours an entry for 4 December 1996, where you have written, "Frail 82 year old" and you write down a number of problems that he had.
A That is my handwriting and signed by me at the end of page 68.

Q If you look back one page, you should be able to see Dr Bayly, who was a registrar for Dr Banks, writing to you:

> "Dear Dr Lord
>
> Thank you for seeing Les, who has been treated for many years for resistant depression. On this admission his mobility has initially deteriorated drastically. He then developed a chest infection. Chest now clearing, but he remains bed-bound, expressing the wish to just die. This may be secondary to his depression but we would be grateful for any suggestion as to how to improve his physical health."

That was the context in which you were invited to assess him.
A Yes.

Q Can you tell us what you thought this man's prognosis was from your note?
A From the note, I have said he was in a rest home and at that stage I did not feel that he could return to the rest home, where he would basically need to be independently mobile and manage with a little assistance with his personal care. He was completely dependent and the outlook for him was not good. I recommended additional nutrition supplements, bladder wash-outs and dressings for the ulcers that he had. I cannot recall this patient, but from the notes, the outlook was not very good.

Q If I can ask you to turn to page 188 in the same bundle, which is not very easy to read; there is another copy of the same letter on page 193 which is easier to read, but we do not have the right-hand side of the page. You will have to go to page 188 to see the words I am inviting you to agree. You say that overall, you feel that his prognosis is poor.
A Yes.

Q What does that mean?
A I am trying to give a prognosis and it means that I did not feel that we would be able to get him better to go back to a rest home to the level he was at. I cannot recall the details, but I did not feel that we were going to make sufficient gains in improving his function, given that the had had a depression, his nutrition was poor and his skin had ulcerated, probably from pressure, as well. So the outlook for him generally was not good.

Q In a man whose Barthel score was 0, and given the conditions you have written down in your note and in your letter, would you have anticipated that he would become less dependent as time went on?

A A It would have been very unlikely.

Q Can I turn to another patient, please? I am going to take you, if I may, to a patient we know as Eva Page, Patient C. This is an elderly lady who you saw on Charles Ward I think at the Queen Alexandra Hospital on 25 February.
A Yes.

B Q Just look at your note. You say, "Confused", is it "with some agitation towards afternoon"?
A Probably "and". It could be "with". It is not clear on my copy.

Q It says:

"Says she is frightened – not sure why. Tends to scream at night.
C Not in pain.

Try..."

Is it tablets, or it could be "tds thioridazine"?
A "Try tds thioridazine".

D Q

"Son in Gosport therefore transferred to NHS C/C..."

Is that continuing care?
A Continuing care.

Q "At Gosport", and you have indicated when she could be moved?
E A Yes.

Q We see below an entry by Dr Barton that this patient, Mrs Page, had been transferred to Dryad Ward ---
A Yes.

Q --- continuing care. If you go over the page, do you see two more entries in your
F handwriting in the bottom half of the page?
A Yes.

Q I think you indicated in the first of those entries what the diagnosis was for that patient, cancer of the bronchus. Can you indicate what you have written after the question mark in the line below – is it cerebral?
A "? cerebral metastases".
G

Q Can we go to the start of the note:

"Spitting out thioridazine."

Is that right?
A Yes.
H

Q "Quieter"?
A Yes.

Q And you have written:

"On prn SC diamorphine."

A Subcutaneous diamorphine.

Q Are you able to tell us the date of that note because it looks as though there has been some crossing out?
A That would be 2 March 1998.

Q That is the same day as Dr Barton's note immediately above it, I think?
A Yes, because the son was seen that same day.

Q You have written two entries on the same day, the second one after you have seen the son?
A Yes.

Q I am going to ask you about the "prn subcutaneous diamorphine". I am going to ask you to turn to page 278. Page 278 is obviously part of the prescription sheet for that patient. We see that subcutaneous diamorphine had been written up, but the date of administration is 3 March?
A Yes.

Q If I take you back to your note, are you able to tell us whether your note is correct to say that this lady is on subcutaneous diamorphine as at the 2nd?

A That is an error in my note because at that time she was not on diamorphine. On page 272, she had some intramuscular diamorphine that morning.

Q That is right?
A So in my note there is an error saying that she is quieter on prn subcutaneous diamorphine. I could not find any other prn diamorphine, so I must have referred to the dose that was given at 8 o'clock that morning. It was actually an iron dose and not a subcutaneous dose. That is an error in my note.

Q What we see further down in your note, again on 304, 305 I am sorry, is:

"Fentanyl patch started today."

You have just referred us to page 272, where we see fentanyl written up. We see that the fentanyl patch was administered on 2 March that day in the morning at 8 o'clock and have you signed the prescription for fentanyl?
A I have.

Q Tell us why you would have done that?
A I cannot recall exactly, but I think there was a cost implication with fentanyl. My recollection of this is that the pharmacist wished us to countersign the fentanyl. The reason

A why I signed it – that is my recollection and I cannot think of any other reason why I would have countersigned the prescription, I cannot think of another reason – but I certainly remembered the pharmacist was conscious that fentanyl was quite costly and that was why I countersigned it. That is as far as I can recall the reason for that.

Q If you go back to page 278, we know that a prescription for prn subcutaneous diamorphine was written up at some point. Are you able to tell us whether you had seen what
B we have as page 278 when you wrote your note on 2 March?
A I cannot recall.

Q Do you think you might have seen it?
A I could have seen it.

Q That of course has a range of diamorphine written up of 20 up to 200 mgs. If you had
C seen that, would you have raised a concern about it with Dr Barton or would you have been content with it?
A If I had looked at a 20-200, I could have asked why the dose range was up to the 200, but I cannot recall – now at this stage I cannot recall whether I saw it and whether I did do anything about it.

Q If we go back to page 305, staying with your first note you have written:
D

"Agitated and calling out even when staff present."

We have read the next two lines. Is your last line for that entry:

"Ct [continue] fentanyl patches"?

E A That is what it says.

Q "Ct" is continue?
A Continue.

Q Did you write a note having seen Mrs Page's son?
A Yes, I did.
F

Q Can you read it to us?
A

"Concerned about deterioration today. Explained about agitation and that drowsiness was probably due in part to diamorphine. He accepts that his mother is dying and agrees we continue the present plan of management."
G

Then I have signed it.

Q Can I ask you about drowsiness and diamorphine. Clearly, you consider that diamorphine was appropriate as a drug to be given in those circumstances?
A Yes.

H

Q What would you say about continuing to give diamorphine even though a patient may be experiencing drowsiness?
A This lady – and I cannot recall the specifics – from the note we have had difficulty keeping her comfortable. Thioridazine, which is one of the typical phenothiazines, was not working, the other sedation was not working, she was very distressed. The diagnosis of the carcinoma of the bronchus, it was not confirmed but it was accepted that she would be managed as such. The concern was that in someone so agitated as to whether there was a cerebral metastases, as to whether could there have been some spread to her brain. She was not a lady who was ready for more investigation and that had been decided on the acute ward before she moved to Charles Ward. Even though someone is sometimes drowsy, if sedation is required unfortunately there is not the ideal sedative or pain relief that would not have side effects. With using morphine and the other drugs that we would use in palliative care, there is sedation and restricted depression with all of them. That is what I have been trying to explain in that note.

Q There is respiratory depression with all of them. What is your view about whether it was appropriate to agree to permit a degree of respiratory depression when you are treating a patient?
A It is always a balance and it is a balance with what I am trying to achieve. If you are trying to achieve pain control and achieve comfort and get rid of anxiety, sometimes you have to accept some of the side effects. It really depends on what the aim of the treatment plan is.

Q If doctors are there on a sporadic basis to review the patients, was that balance always easy to achieve?
A The close titration was difficult sometimes. During the week there was probably adequate cover and the nursing staff were really quite senior and used to handling syringe drivers. The balance between as to whether we were able to give better monitoring was probably not possible with the staffing levels we had.

Q The Panel here has heard that after Dr Barton resigned she was replaced with a doctor who was there full time, Monday to Friday 9-5, and that at later stages even more medical resources were put on to the wards. Is that right?
A Yes. There is still in place an associate specialist who has a postgraduate qualification from the College of Physicians so has the MRCP, and the people we have had in post since Dr Barton resigned have been of registrar grade or higher. The present post holder is an a non-career grade post. We also have three senior house officers. The out-of-ours cover is, I think, still unresolved, or was unresolved certainly was in 2006 because of rotas, but there is certainly more presence sense, there is also more consultant presence in Gosport.

Q I am going to take you to another patient. For us it is patient Alice Wilkie, pages 99A and 99B. This is a lady who had advanced dementia. We know from the history she had been on Mulberry Ward, which I think at an earlier time might have been described as a psychogeriatric ward. I think different names were being used or different descriptions were being used but that was its purpose. At the time you saw this lady, I think she had a bed at Addenbrooke's, which was a care home.
A Yes, it was.

Q Was that a psychogeriatric care home?

A A Yes, it was. To return there, patients had to be independently mobile. They were in a supervised environment but, physically, they had to be reasonably good; just one of the larger care homes.

Q We have an assessment by you of this lady on 4 August 1998. Is that right?
A Yes.

B Q I do not need to take you through the detail of your note, we see a Barthel score on the third line. We see some investigations that you ordered and were writing the results down from, "NAD", for the chest X-ray and then you see "ACG" means nothing abnormal?
A No abnormalities detected.

Q You have written down a plan:

C "Continue oral Augmentin and subcutaneous fluids"?

A Yes.

Q

"Overall prognosis poor and too dependent to return to Addenbrooke's."

D Is that what you were telling me, that patients needed to be mobile to go to Addenbrooke's?
A Yes.

Q Can you help us with, "Overall prognosis poor", what were you meaning by that?
A That someone who was functionally dependent the Barthel score – there is an error in my note again – the Barthel score should be 1/20. A Barthel score of 20 is someone who is completely independent, able to do stairs and bath or shower on their own. So she scored 1
E out of 20 and was very dependent. In point 3 I have said:

"Overall prognosis poor and too dependent to return to Addenbrooke's."

But in 5, I have said:

"Keep bed at Addenbrooke's."

F

Because sometimes patients did recover unexpectedly, but overall my feeling was that the prognosis was poor.

Q The last line of your note you have written the letters "DNR". We probably know what that means, do not resuscitate.
A Yes.

G

Q Can you tell us why you would have made that decision and written it in that way?
A It is because this lady was very dependent, cognitively very impaired, physically frail – again, this is someone I cannot remember at all, I cannot remember what she looks like – and so cardiopulmonary resuscitation in that event is not likely to be successful. The resuscitation available is only basic CPR in Gosport anyway, so I made the decision that active resuscitation was not in her best interests.

H

Q The next entry we see is an entry by a GP, Dr Peters, that this lady had been transferred from Phillip Ward. He has written for from four to six weeks and refers to the Augmentin for a urinary tract infection. If we turn over the page, we see a further entry by you, I think, on 10 August?
A Yes.

Q Barthel now 2 out of 20?
A Yes.

Q "Eating and drinking better. Confused and slow." Is that what it says?
A Yes, it does.

Q "Give up place at Addenbrooke's". Is it "review..."?
A Yes.

Q "... in a month's time"?
A Yes. That is a review in one month, and if there is no specialist medical or nursing problems, discharge to a nursing home, so as opposed to going to a rest home. If she had remained stable, then we would look to discharge to a nursing home.

Q Can you tell us why you were saying that the place at Addenbrooke's should be given up?
A Because she would have to be mobile to return to Addenbrooke's, but her Barthel would have needed to be about 10 or 12, and in the week that we had her, there was no improvement. She was dependent, and also her cognition was not good. While it would have been nice for her to return to where she came from, at that stage it was not looking optimistic. It is always a balance as to whether you hold on to a rest home place because it would be nice for them to return there, or whether you give up that place because the progress has not been good.

Q The last line of that note is: "Stop fluoxetine." Fluoxetine, I think, is an anti-depressant?
A Yes.

Q Are you able to tell us ---
A It is very difficult...

Q Go ahead.
A I cannot recall the reason for that.

Q Can you tell us, if a patient was towards the end of their life would it sometimes be the case that anti-depressants would be stopped?
A It could be for a number of reasons. With cognitive impairment people can get quite apathetic and quite withdrawn, and it is difficult to know whether sometimes it is an underlying depression, or whether it is part of the cognitive decline. So anti-depressants are started, but sometimes there comes a point where you feel the person is not really improving, but I cannot recall the reason why I made that decision.

Q All right. I am going to move to another patient now. I should say, Dr Lord, that we would normally take a break after about one hour, but I am very conscious that you have had a full working day today and you may wish to continue.
A I would like to continue because I would not like to overrun to next week because next week is even busier than this week.

Q I understand. I will keep going unless I am stopped. I am going to take you to Patient F, please. She is a lady, Ruby Lake. For those who have the bundle open, I am going to take them to page 5515. This is an elderly lady who had leg ulcers in the past and had fallen and fractured her hip. If you have page 515, the bottom half of that page gives her age as 84, and it is a letter written in the medical records inviting you to assess Mrs Lake?
A Yes.

Q From the point of view of her future management. It says:

"[She] was admitted from A&E following a fall which resulted in [fracture] of the left neck of femur."

It details the operation she had undergone on 5 August 1998.

"Post-operative recovery was slow with periods of confusion and pulmonary oedema. She suffered vomiting and diarrhoea. Over the last two days however she has been alert and well and it is now our intention to work on her mobilisation."

You made an entry that we have at page 516, I think?
A Yes.

Q In which you says:

"Thank you. Frail 85 year old with..."

And you go on to deal with the operation she had undergone:

"[Left] cemented hemiarthroplasty of hip"

on 5 August?
A Yes.

Q We have heard before in the hearing but may not have made a note of what LBBB refers to?
A It is left bundle branch block and left ventricular failure. Left bundle branch block is a conduction defect in a heart, usually representing underlying ischaemic heart disease, although there are other causes for it.

Q And left ventricular failure is obviously another reference to her cardiac sufficiency?
A Heart failure, but predominantly of the left ventricle.

Q You have then written, is it "Sick sinus syndrome/AF" meaning atrial fibrillation?
A Yes, it is. It was either a sick sinus syndrome, which could be the heart being sometimes slow, sometimes rapid, and probably there were periods of atrial fibrillation where

A the heart is very irregular. That again could be intermittent or it could be sustained. So there are significant irregularities with heart rhythm and conduction, coupled with some heart failure.

Q You then go on to suggest:

"Dehydrated but improving."

B

Then you refer to ulcers. Point number 7 is hypokalaemia. Just tell us what that is?
A That is a low potassium level. Potassium is one of the essential minerals and it is important for heart function, but also general muscle function. In this context, if potassium is low and someone is on digoxin there is the potential for digoxin toxicity.

Q The next entry is "Normochromic anaemia". Anaemia we probably all recognise.
C What is the "normochromic" aspect?
A It means that the cells have... "Normochromic" as it, the haemoglobin contained in the cells was quite normal, so they were not hypochromic, which means that they have very little haemoglobin in the cells, or microcytic, which means the cells are smaller. It probably should have read "normocytic, normochromic anaemia" – so normal sized cells with normal amounts of haemoglobin but there just was not enough.

D Q You have then put "Vomiting and Diarrhoea ? [Query] Cause." You are questioning why that is occurring?
A Yes. At that stage it was not certain yet.

Q You have suggested potassium supplements?
A Yes.

E Q That she be hydrated orally and that there should be tests done on her stools?
A Yes. "CNS" is "culture and sensitivity".

Q Yes. And you have written:

"It is difficult to know how much she'll improve but I'll take her to an NHS continuing care bed at Gosport War Memorial Hospital next week."

F

A Yes.

Q I do not know if you recall this patient at all?
A Not in any detail, but I have looked at the notes a few times in the last few years.

Q I am reminded, you have written a letter in respect of this patient and it is at pages 26
G and 27. I do not think it adds anything to the note that we have just looked at.
A I am looking for page 26. (After a pause) Yes, I have found it.

Q The first two paragraphs of the letter, you set out the detail of the notes that we have just looked at?
A Yes.

H

Q You talk about stool cultures and, in the third paragraph you refer to the ulcers that she has, and you say:

"... overall she is frail and quite unwell at present."

A Yes.

Q Clearly a number of medical concerns about her?
A Yes.

Q I am going to move on, if I may, to a patient whom I think you may recall, Arthur Cunningham. We have him as Patient G. We have a letter written by you in March 1998 at page 140.
A Yes.

Q I do not think I need take you through it. It speaks for itself. On the second page of that letter, page 142, you talk about the dose of Levadopa for his Parkinson's disease that he was then on?
A Yes.

Q And it appears that you and the patient had a disagreement about what was the proper level?
A Yes.

Q How as he getting more than you thought was appropriate?
A There had been occasions, as I recall, where he would have a house call, usually at a week-end, and would be seen by a GP who did not know him and would say that his Parkinson's disease was quite severe. And so that is how he obtained a supply of doubles of stronger Sinemet than we prescribed. Although we checked medication at the day hospital, he on a few occasions had the stronger strength in his pocket. If it happens ---

Q Sorry?
A The Parkinson's --- Sorry?

Q How as he seeing doctors that he did not know?
A If it is an out of hours house call, it could be someone from the deputising service, they would not necessarily have access to notes when they visited him.

Q I understand. So it was Mr Cunningham's decision to call an out of hours doctor?
A Yes.

Q I understand.
A He was quite disabled. He had a war injury in addition to his Parkinson's.

Q We have another letter from you three months later on page 134.
A Yes.

Q Again, the content of the letter really speaks for itself but you do make a comment at the start of the second paragraph in relation to the amount of weight that he seems to have lost since you last saw him on the 10 March?

A A Yes.

Q Are you able to tell us why that might have been?
A Further on in the letter I said there might have been a degree of depression.

Q Yes.
A Sometimes people with Parkinson's do lose weight quite rapidly for no reasons but
B you do not know that until some time has lapsed. At that point it was not certain. As I recall it, it was quite a striking difference in his appearance and that is why I put it in.

Q Can I just ask you? I am sure the Panel know, but you make reference at the beginning of the third paragraph to a "monkey pole"?
A That is the pole above the bed and ends up with a sling, and then a triangle, that actually helps people move in bed.
C

Q So it is to help him to ---
A It is a form of a bed lever but it is above the bed.

Q If we look over to the second page of that letter on page 136, we see on the third paragraph, you say you have reduced his Levadopa further. You had said at the top of the previous paragraph, you felt he was on too much of that medication?
D A Yes.

Q And you say, towards the end, at the bottom of the page:

"We will need to ascertain as to whether Mr Cunningham is going to remain at Merlin Park..."

E That was the home that he was in?
A Yes. That was the rest home.

Q And I think you saw him again, certainly in September 1998. We have a letter at page 458 of this bundle.
A Yes.

F Q And we have a clinical note for the occasion when you saw him, starting at page 644.
A Yes.

Q Just dealing with the letter, if I may, at page 458, you indicate that he was reviewed in the Dolphin Day Hospital. You refer to a large necrotic sacral ulcer which was extremely offensive?
A Yes.
G

Q You talk about his Parkinson's disease. You say:

"... mentally he was less depressed but continues to be very frail."

A Yes.

H

Q And you say you have taken the liberty of admitting him to Dryad Ward with a view to more aggressive treatment of the sacral ulcer. What were the options for you at that stage given the ulcer that he had and his other conditions?

A The options were that he was returned to the nursing home where was and we asked them to deal with it. The fact that he had developed a pressure sore in a nursing home meant that he needed something that was more specialised and we must have had a bed on Dryad Ward available that day, because we did not admit people from the community direct to Gosport War Memorial Hospital. They usually came through our acute wards. So we must have had a bed vacant and it was either we sent him back to the nursing home he came from and asked them to deal with it, because that was the highest level of care he could have in the community, or we could have sent him to the emergency department at QA, where probably he would have waited a long time on a trolley to be seen and it would not have been an appropriate choice for him. So he was admitted direct to Dryad Ward from the day hospital on the same day.

Q By admitting him from the Dolphin Day Hospital, you are just taking him on to a bed within the same physical site at the War Memorial Hospital, are you not?
A It was in the same building, yes. On the same floor as well.

Q "DDH" in your note is obviously Dolphin Day Hospital. That is where you saw him.
A Dolphin Day Hospital.

Q "Very frail. Tablets found in mouth some hours after they are given." Is that what your note says?
A Yes. That is how it should read. It is badly written, but that is how it should read.

Q Would that be of concern?
A Yes. It meant that he had not swallowed them, had not been able to swallow them for whatever reason. It is important that medication for his Parkinson's and certainly his depression that the tablets are taken. So it indicated his frailty, it could have indicated a reluctance to have medication, it could have indicated a poor swallow, which can happen.

Q You then deal with the ulcer and you have drawn a diagram.
A Yes.

Q Just remind us where the lateral malleolus is?
A That would be the outer aspect of the left ankle.

Q "PD" means Parkinson's disease. "No worse", you said.
A Yes.

Q You then go on to list a number of problems. The fourth one is depression and an element of dementia. Is that right?
A Yes. That is from previous assessments at the time. He spent some time with the psychiatric team as an inpatient and there were concerns that there was significant depression, but a degree of dementia as well.

Q You have written as point 5 "Diabetes mellitus - diet". Does that mean controlled by diet? He was not insulin dependent.

A A Yes. No, he was not.

Q Point 6. Is it "Catheterised for retention"?
A Yes, it is. He had already been catheterised. I think that was some time ago.

Q If we go over the page to page 645, your note continues. You say, "Stop codanthramer + metronidazole + Amlodipine."
B A Yes.

Q What types of medication are they?
A Co-danthramer is a laxative, which is predominantly a softener. The amlodipine is blood pressure and metronidazole is an antibiotic.

Q Are those all in tablet form?
C A I need to look at the chart. Sometimes metronidazole can be used topically as well to the ulcers.

Q Page 757
A Yes. The metronidazole was being given orally. The reason that I do not usually use oral antibiotics unless someone really has a bad infection is that the tissue in the sacral ulcer is often dead and for antibiotics to penetrate that is extremely difficult. So that would have
D been why the metronidazole and amlodipine, because it was not really required for blood pressure control at that stage.

Q We have seen you cross through the amlodipline, the co-danthramer and the metronidazole and you have signed it each time.
A Yes. The magnesium hydroxide on that is also a softener. He had one laxative that was a stool softener.
E

Q Coming back to your note at page 645, the fact that tablets had been found in his mouth some hours after he had been given them, was that in your mind when you decided to stop some of those tablets, or not?
A Partly that, but also partly, were they really indicated? So a combination of reasons.

Q The next entry in your plan is "TCI". Is that "to come in"?
F A To come in, yes.

Q "Dryad today. Aserbine for sacral ulcer." Tell us, how bad was that ulcer?
A That would be probably among the severest of the sacral ulcers, because there is a black scar on top. When that scar lifts, the ulcer would have been several centimetres in depth, because the tissue on top has died, but the tissue underneath that is degrading and that is why the ulcer is so offensive. The Aserbine was to try and lift the lid off it, if you like, and
G then allow the ulcer to heal from the bottom up, in the hope that it would.

Q At the bottom of your note, you have written, "Prognosis poor". What are you referring to there?
A Again, the outlook for him was not good. He had sustained a pressure sore in a nursing home, which really has qualified nurses and a high degree of nursing expertise. He had a long-term condition in the form of Parkinson's disease, which he had had for quite a
H while, and nutritionally he was not good. Mentally he had declined as well and the outlook

for him – at best, he would return to a nursing home, but to heal that ulcer, as I remember it, would have taken several months

Q What you say is that he should be nursed on site, given a high protein diet and "Oramorph prn if pain".
A Yes. So Oramorph if required for pain.

Q Oramorph. Is that a linctus, a syrup?
A That is a morphine elixir, morphine liquid.

Q It is not a tablet?
A No. It will be liquid and it will be short-acting.

Q Again, was it your view that it would be appropriate to go to that level of analgesia, given the condition you saw him in?
A Yes. From what I recall – and it was a long time ago – he was really quite distressed and I feel it was an appropriate decision.

Q We know that this man was subsequently put on a syringe driver with diamorphine and other medication. We have heard that a request was made by his stepson that the syringe driver be stopped at some point. What would your view have been if you had been asked? Is it appropriate to stop a syringe driver once a patient has been started?
A I did not see Mr Cunningham after he was admitted, so I do not know exactly. I do not have a picture of how distressed he was at that stage. In practice, in general, it would be really unusual for us to stop a syringe driver. Sometimes patients decline medication, but that could be for a reason of wanting to settle their affairs because they know they are terminal. Recently I have had occasion when someone has asked for morphine to be delayed until a relative came from overseas, because there were things they wanted to say and settle. It is always a balance, a balance as to whether you feel pain control is the most important thing or whether you feel that it is reasonable to withhold pain control to grant that request by the patient. By and large, once you make a decision to start a syringe driver, you really have worked through the other options and you have had the discussion that this person is at the end of their life and really needs this for symptom control. In my practice I cannot remember that we have actually stopped a syringe driver, but sometimes, as I said recently, we have not started strong medication. That was just a one-off.

Q You have told us that was for someone coming from abroad to see the patient.
A Yes. New Zealand is far away from most places!

Q I am going to take you to one more patient, if I may, and this is the last patient I want to ask you about. It is Patient L, Jean Stevens. The page I want to take you to, please, is 224. Again, I think you have had a chance to look at these notes recently, but you do not recall this patient.
A Not at all.

Q Page 224 is the request, I think of you:

"Please could you give your opinion as to the best path for rehabilitation of this 73 year old [female] who suffered a [right] CVE."

That is neck of femur?
A No, no. It probably was a stroke. It probably means cerebrovascular event.

Q " ... leading to a dense [left] hemiparesis".
A Yes. Hemiparesis meaning the left side of the body was weak. So a stroke affecting the left side of the body, but it was dense, quite a dense weakness.

Q It says:

"She is improving slowly and there is nothing more we can do for her on the acute medical side of things."

Was this an acute ward that you were being invited to see her on?
A Yes. The ward – that is a Haslar record I think – all the patients we saw at Haslar, certainly then, the wards were all acute medical, surgical or acute orthopaedics.

Q I think if we go on to page 228, we have your clinical note. People may want to put a finger in there and also find page 734, which is your letter. In your note you say of this patient:

"Extremely unwell 73 year old with

1. Dense [right] hemiplagia due to [right] parietal infarction."

The parietal region is the side of the brain above the ear, I think.
A It is. Hemiplegia means that there was no movement at all. So I would use the word hemiplegia when there was complete paralysis and not just partial paralysis.

Q "Ant MI". Is that an anterior myocardial infarction?
A It should be anterior myocardial infarct and left ventricular failure.

Q Atrial fibrillation we recognise. What would you say about the level of cardiac problem that this lady had?
A If I recall correctly, I think she was actually admitted with a myocardial infarct and then went on to develop a stroke.

Q You have written "Aspiration pneumonia". Aspiration means inhalation of stomach contents, leading to pneumonia?
A Yes. A poor swallow, probably associated mostly with the stroke and then inhalation of whatever the stomach contents into the lungs and pneumonia following that.

Q How serious a condition can that be in a patient of this sort of age and in this sort of condition?
A I do not recall the patient, but certainly from my letter I was not keen to take her because I thought she was probably not going to survive even the short journey from Haslar to Gosport.

Q You say at point 5 in your note "Previous sigmoid colectomy". That is surgery on part of the bowel?
A Yes. On the lower part of the large bowel.

Q You say in your note, "She is very chesty?"
A Yes. Chesty, flushed and tachyapnoeic. Tachyapnoeic meaning she is breathing rapidly.

Q Then:

"I don't feel she is well enough to transfer to GWMH at this stage, and overall I feel is unlikely to survive."

Can you tell us, why do you think you were being asked to look at this lady at all?
A With a view to taking her over. This was 1999, so we were probably doing some after stroke rehabilitation at that stage. Again, with Haslar being busy with their emergency department, there was always pressure to move patients on to a facility that was slower stream. So I think we were being asked – it was unlikely this lady would have rehabilitated very quickly, but sometimes with strokes people do need a period of observation. I cannot recall the exact detail behind this.

Q She was coming from an acute medical ward and the request of you said, "We've done everything that we can."
A Yes, but sometimes that is not a good reason to move a patient. Sometimes people do need a bit longer. Transferring patients is not always in their best interest even though the distance is quite short. We have certainly had instances of patients who have been very poorly on arriving in Gosport. My opinion at that time was that she really was not well enough for the transfer.

Q That is certainly what you say in your letter at page 734.
A I have not been able to find 734, although I have read it. I have read the letter, I have not marked it.

Q Can I tell you what it says?
A Yes.

Q You detailed the concerns that you had from your note as to the medical problems. You go on to say that:

"At present Mrs Stevens is extremely unwell."

You list the hemiplegia, the left ventricular failure and also an aspiration pneumonia. You say:

"The speech and language therapist did not think her swallow was safe at all and at present she is on intravenous fluids. Overall I think Mrs Stevens is too unwell for transfer to Gosport War Memorial Hospital, but am willing to consider this if she is stable next week."

A Yes.

Q Overall her prognosis is poor, you have said?
A Yes.

Q Does it follow that you did not think she was stable at the time you saw her?
A Yes. From what I have written down, she certainly was not even stable enough to transfer, and the fact that I have commented that I certainly knew that she would not survive meant that the outlook for her was not good.

Q You say:

"I do not think it is appropriate for nasogastric or PEG feeding in her condition."

PEG, or PEG feeding, is that a line into the stomach?
A That is a line. The nasogastric means it is a fine tube down the nose into the stomach and PEG feeding would be direct feeding into the stomach through the abdominal wall. PEG tubes are better tolerated but they are more permanent and, given that the outlook for her was poor, at that stage I felt it was not appropriate to proceed to that.

Q We know that this lady was subsequently transferred to the War Memorial Hospital. Can I leave her and come back to the question of transfers. What you have said is that the process of transfer, even though it may be a small distance, may cause severe problems with patients?
A Yes. Some of the problems were that they were just too frail and moving them causes them to be quite distressed. I cannot remember whether this was during the time when Dr Barton was working with us and subsequently a few people with feeds in progress actually inhaled the feed while they were transferred, so we had to draft a policy that feeds will be discontinued on the morning of transfer. Sometimes blood pressure was low and they were just quite distressed.

Q Can I take you back to one of the patients we have looked at, Patient C. We were looking at Patient C at pages 304 and 305. I am going to ask you to look at a note at page 272. Looking at the entries on page 305, you made two on 2 March 1998?
A Yes.

Q Are you able to tell us whether that would have been a Monday when you did a ward round?
A Probably. I did not check this, some of the others I checked, but it was probably a Monday.

Q We will check it. If it was a Monday and you were doing a ward round, you told us you would have started the ward round at about 2 o'clock?
A Yes.

Q I am told it has been checked and it is a Monday. If we go back to page 272, we see that Mrs Page was given an intramuscular injection of diamorphine at 3 o'clock that afternoon. That is signed by Dr Barton on the prescription and given, I think, by a nurse with the initials SH, who we think would be Shirley Hallmann.
A Yes.

Q Would you have been aware of that if that was a ward round and you were going round the patients?

A A Yes, I would have.

Q Is it a proper inference that you would have thought that appropriate treatment at that stage?
A Yes, it is because ---

Q Thank you. Do not let me stop you. If you want to say something else, please do.
B A No.

MR JENKINS: Thank you, those are all the questions I wanted to ask.

THE CHAIRMAN: Thank you. We will take a short break at this point. It is important not only that we keep you as fresh as possible and I appreciate it has been a long day for you already, but the same applies also to all of us in this room. We are going to take a break for
C 15 minutes. Please feel free to get whatever refreshment you can and we will return in 15 minutes when Mr Kark will have some questions for you.

THE WITNESS: Thank you.

(The Panel adjourned for a short time)

D THE CHAIRMAN: Welcome back everybody and welcome back, Doctor. Have you been able to get some refreshment?

THE WITNESS: Yes, I have. I have had a drink and some chocolate.

THE CHAIRMAN: Thank you, we are fit to continue. Mr Kark, please.

E Cross-examined by MR KARK

MR KARK: Dr Lord, I am standing up. I am probably in silhouette because I have a window behind me, but can you just about see me?

THE WITNESS: Not now, but you were quite clear.

F MR KARK: As long as you can hear me, it may not matter too much.

THE WITNESS: I can hear you well.

MR KARK: Let me start by asking you about your work with Dr Barton. You told us you worked with her from 1992 until 2000 when she resigned?
A Yes.
G
Q You worked with her from for an eight-year period?
A Yes.

Q You built up a friendship with Dr Barton, is that right, as well as a professional relationship?
A Yes, I did.
H

Q Indeed, there came a time at the CHI inquiry when Dr Barton was giving evidence, that you acted as her friend, you were her supporter. Is that right?
A No, I do not recall that occasion, but I did go with her to an independent review somewhere. Yes, I did.

Q Let me make it quite clear I am not criticising you for one moment for doing that. You covered both of these wards at various times,but your actual clinical input on each was on alternate weeks. Was that right?
A Yes, at some stage we were covering for maternity leave and is when I think the alternate weeks came in. We had locums in the department and that did not work out very well, and I think it was over the cover for maternity leave that it went to alternate weeks, as far as I can recall.

Q It follows that you did not see the day-to-day running of the wards, nor even, in fact, the week to week running of each ward?
A No.

Q By the --
A The ward rounds ---

Q Sorry, there is this delay, I did not mean to interrupt you, did you want to add anything?
A No.

Q By the time you came to have any interaction with Dr Barton, she had in fact been a clinical assistant longer than you had been a consultant?
A Yes, that was so whenever I started.

Q When you were interviewed by the police, you also told them that Dr Barton and the nursing staff had, as you put it, a fair grasp of the situation and you could not think of an instance when you had been required to go down to the hospital on a day which was not one of your regular days?
A I had done so intermittently, but I cannot remember the exact details.

Q So far as Sister Hamblin was concerned, we have heard quite a bit about her. She was a very experienced and, can I suggest, a fairly formidable Sister in charge?
A Not sure about formidable. I did not find her formidable.

Q You did not. Did you on any occasion that you can remember challenge her administration of opiates to a patient?
A I do not recall.

Q Of the patients you have been asked about, and I am going to run through them – that is Lesley Pittock, our Patient A; Eva Page, Patient C; Alice Wilkie, Patient D; Arthur Cunningham, Patient G; and Jean Stevens, Patient L – you saw of those patients only Eva Page and Alice Wilkie once they had been transferred to the Gosport War Memorial Hospital. Is that right?
A Yes, that is right.

Q Is it fair to say, and again this is no criticism of you whatever, that it is very difficult for you to add anything to your notes because of the length of time that has passed?
A Yes, with most of them I cannot recall anything at all. Just with Mr Cunningham I can recall the overview of his care because I had seen him on a few occasions, but there is a lot of detail I cannot really put together.

Q Absolutely, and Mr Cunningham you were dealing with prior to his transfer?
A Yes, I certainly saw him at home, I think once in outpatients, then on a few occasions in the day hospital so we had contact over a period of time.

Q I want to try to understand your evidence about what you knew of the prescriptions. You have accepted that the dose ranges that you now know were prescribed, in other words the 20 to 200 mgs were too wide. Do you agree with that?
A Yes.

Q When you started, back in 1992, were those prescriptions already being written?
A I cannot recall.

Q At no stage did you challenge those inappropriate prescriptions, did you?
A No, I did not.

Q You told the police that you did not register that it was possibly an inappropriate use of morphine. Would that be right, that you did not register at the time that it was an inappropriate use of morphine?
A As regards the dose range, yes.

Q The reason why you now appreciate that those prescriptions were too wide is because you recognise that they could lead to harmful consequences?
A Yes.

Q Do you agree that they left too much to the discretion of nurses?
A Yes. We would expect the nurses to start at the lowest end and then have a discussion with the doctor on call, or the doctor who was covering, or Dr Barton about the dose increases, but there is no documentation of that.

Q Not only that, but we know, for instance at weekends when Dr Barton was off duty, one of the purposes of a variable dose was to allow the nurses to have a discretion to increase? You nodded, but we have to get your answer.
A Yes.

Q When you gave evidence to this Panel in relation to what the nurses could and could not do your first answer, which I noted down – the advanced prescription, the anticipatory prescribing – left scope for nurses to start a syringe driver as necessity arose. And then later you said that you were assuming that the nurses would discuss the initiation of the syringe driver. Can I just ask you, please, about that. To your knowledge, was the position that there were occasions when nurses activated syringe drivers on their own authority, obviously with an anticipatory prescription supporting it?
A Yes. With the prescription there, the nurses could start it, but by and large they would discuss it with the doctor on call.

A Q Where does that information come from?
A Was the ----

Q Sorry. I did not mean to interrupt you.
A That is from what I --- Yes.

Q Where does that information ---
B A That is what I --- That is what I recall. I would not be able to prove that.

Q So your understanding was that by and large the nurses would discuss the initiation of the syringe driver - yes?
A Yes, because that would indicate there was a change in the patient's condition ---

Q Exactly.
C A --- that required a syringe driver.

Q And the syringe driver was the start for many patients, was it not, of a palliative care end of life route? Sorry, you are nodding but could you give your answer?
A Yes, it would.

Q You have told the Panel, quite rightly, that a variable dose is something which you
D still do and you said, I think, that a PRN prescription is something that you still use. Yes?
A Yes, I do.

Q Do you agree that where a PRN prescription is going to be written up that the prescription has to have a close range, a confinement, as to how much can be given?
A Yes.

E Q And would you agree that there has to be, or ought to be, a clear notation as to the circumstances in which such a prescription could be given? Did you hear the question? Can you hear me?
A Yes, I can. You asked me as to whether there should be an indication ---

Q A clear note.
A --- about the circumstances?
F
Q Yes.
A Under which there should be an "as required" prescription?

Q Yes.
A Yes. Our charts with hindsight did not really have room for that as to the exact indication.
G
Q The danger of writing out a wide variable dose, without a clear note to the nurses as to how and when it can be used, is that a patient could be over-sedated. Do you agree?
A Yes, I do.

Q So far as note-keeping is concerned, you have agreed, I think, that Dr Barton's note-keeping was not satisfactory. It was too short?
H A Yes.

A

Q You saw that, but you never picked her up on it?
A No, I did not.

Q Did you see the wide variation in dose ranges?
A I probably did, but it the significance of it did not register.

B Q So you noticed the lack of noticed, and you noticed the wide prescriptions, and you did nothing about either of those two problems. Is that right?
A Yes.

Q All right.
A Yes. Yes, that is right.

C Q So far as the notes are concerned, would you agree with this. In assessing where Dr Barton was only visiting the ward for, say, an hour a day – so an hour out of twenty-four – it was very important to have first of all a proper assessment of the patient's condition? Yes? You are nodding again, I am sorry.
A Yes, yes.

Q And one which was noted?
D A Yes.

Q A clear plan of treatment and one that was noted?
A Yes.

Q And clear prescribing and careful instructions in relation to the prescribing?
A Yes.

E

Q I am going to turn, briefly I hope, to each of the patients whom you have spoken about. So far as Mr Leslie Pittock is concerned – and I am going to try and avoid going through the notes, but we can certainly look it up if we need to. I think you referred to page 68. You said, "I cannot remember this gentleman at all." Yes?
A No. What I said is correct.

F Q Yes. We are going to have to look at his notes. I am sorry. Can we go to page 68? On the 4 January, I think it should be, we can see your note.
A Yes.

Q And you make a suggestion as to his future care?
A Yes.

G Q

"High protein drinks
Bladder wash-out ..."

Is that twice a week?
A It is twice a week, yes.

H Q And then is it a form of dressing for his buttock ulcers?

A A Yes. It is an iodine dressing.

Q And you say:

"I'd be happy to take him over to a long stay bed at GWMH."

Yes?

B A Yes. That is long stay, yes.

Q As a consultant you would not transfer a patient to the Gosport War Memorial Hospital unless you thought that the patient was stable enough for that transfer to take place. Is that fair?

A Yes.

C Q And when you wrote this note "High protein drinks and bladder wash-out twice a week" and then a note about his dressing, did you expect that somebody would pick up on those suggestions and hopefully act upon them?

A Yes. That was giving some direction to the care prior to transfer.

Q And the purpose of high protein drinks for this patient would have been what?

A Improve nutrition, with the hope of improving the ulcers and help healing. Nutrition

D is also important for a sense of well-being. All of this for someone who was quite dependent. The serum albumin was low; the protein level in the blood was low, so nutrition is an important part of well-being and healing.

Q And in order for him to heal, you would have expected those instructions to be followed ---

A Yes.

E

Q --- or at least to be taken into account?

A Yes.

Q You did not review this patient at the GWMH – is that right?

A I could not find any other entries. No. That was ---

F Q All right.

A --- the only time I saw him.

Q Let me turn, then, please again very briefly to Patient C, Eva Page. You were asked about drugs being used in a palliative care setting, and you spoke about having to weigh up the dangerous side effects of respiratory depression against balancing that up with a need to palliate the patient's pain. Is that right?

G A Yes.

Q And this was the patient, of course, or one of the patients – I am sorry – who was given a fentanyl patch. Yes? And there is no criticism of that.

A Yes.

Q You knew about that. You apparently countersigned the prescription because there is

H some funding issue. Is fentanyl something you still use in your practice today?

A A Yes, very much so.

Q Now in those days, fortunately or perhaps unfortunately, the lowest dose of fentanyl patch was 25 mcg, was it not?
A Yes, it was.

Q That has now changed because there has been a recognition of the dangers that such a
B high dose can bring about. Yes? You can now get, I think, a 12.5 mcg?
A I think it is 12.5, yes.

Q And so when using a relatively large dosage such as that would you agree that considerable care has to be taken if you start adding any drugs to it?
A Yes. The way the fentanyl works is that it takes about 24 hours to build into the system. Then it remains relatively constant for approximately the next three days and then
C the patch needs to be changed.

Q In a patient who prior to the commencement of a fentanyl patch was opiate naïve, you would have to be extremely cautious about adding any further opiates to the drugs in that patient's system. Is that fair?
A Yes.

D Q I am sorry, you are fading a little bit. Can you speak up?
A Yes. Certainly, you sometimes need to use opiates in the first 24 hours, but after that you have to be really careful about opiates thereafter.

Q In the first 24 hours the reason you might need to use opiates is if the patient is in pain and you need a bolus dose. Is that right?
A Yes.
E
Q Right.
A Yes, yes.

Q And you would not give a patient a bolus dose via a 24-hour syringe driver, would you?
A No.
F
Q You do not know, or did not know at the time, that a syringe driver was started while the fentanyl patch was still in place?
A I cannot remember that.

Q If you had known that, can we take it that that is something that you would have countenanced against?
G A Yes, it would have been, and in my notes I had not been specific about taking the fentanyl patch off when the syringe driver was started.

Q But that is something you would expect Dr Barton to know in any event?
A And the senior nursing staff.

Q Can I turn, please, to Patient D, Alice Wilkie.
H A Yes.

Q You may not need her notes, but by all means if it makes you more comfortable, please do turn them up. I think you referred to page 99a and b.
A Yes, I have them.

Q You saw this patient four days after her transfer to GWMH. Is that right?
A Yes.

Q You cannot remember her ---
A Yes, I do.

Q You cannot remember her at all?
A No.

Q And so far as stopping the fluoxetine is concerned, you told us that there may be a number of reasons for stopping it. It is not necessarily a recognition that the patient is at the end of their life?
A I cannot recall the reason I discontinued it.

Q I am going to ask you about a patient that you have not been asked about by Mr Jenkins, but about whom you were interviewed. That is Gladys Richards. Do you remember being interviewed about a lady called Gladys Richards by the police?
A I do.

Q You do?
A I do.

Q Because it was in relation to that case that I think the first police investigation was started and you were interviewed in relation to it. Yes?
A I was.

Q I should have checked. Do you have Patient E's notes with you or not?
A I do not have the notes, but I do have my statement. Excuse me a minute. (The witness went to check) I am sorry, I do have the notes.

Q You do have the notes? All right. Because you have not been asked about this, I think it would be unfair to ask you questions without you looking at something. Could I suggest you go to page 63, which I hope is a prescription. I am just going to get a note of mine as well, if you will forgive me. (After a pause) You can see that this patient was given midazolam on I think 18 August and at the same time as that this patient was on a syringe driver with diamorphine in it. Do you have a recollection of this being put to you Dr Lord?
A I cannot recall any detail about that, but I have read these statements very briefly and I certainly was questioned about the prescribing.

Q Do you recall saying:

> "I think it is highly very unusual for someone to require that amount of, someone who is up and walking wouldn't, wouldn't require this degree of sedation and the fact that some of this dose was administered and they have kept, the administration went on for a few days means that we have now gone into the palliative care situation."

That is just to remind you of what you said to the police. Do you agree that for an elderly, frail patient, as I suggest this lady was, to give her – I am just going to check – 40 mg of diamorphine together with 20 mg of midazolam would be a very large amount of opiates?
A It is a large amount of opiate, but it is very difficult to comment, because I did not see this lady at all.

Q I understand. I am going to move on Patient F. I am not going to ask you to turn up the file. Ruby Lake. You saw her on 13 August – that was five days prior to transfer – and you did not see her once she was at the GWMH. Is that right?
A That is right.

Q I think you said, "I don't remember this patient in any detail" and you simply went through your assessment with Mr Jenkins. You cannot really add to your notes.
A That is correct.

Q Can I then turn to Arthur Cunningham, Patient G? You yourself admitted this patient to GWMH. Is that right?
A I did.

Q The reason for doing so was because you felt that his care needs could not be met.
A That is correct, yes.

Q The purpose of admitting him was for aggressive treatment of his sacral ulcer because he needed specialised nursing care. Correct?
A Correct.

Q Can we take it that with your knowledge of the nursing care on Dryad Ward, you felt that he could get that sort of treatment there?
A Yes. Dryad Ward, the nursing and nursing staff on Dryad Ward were very good with pressure sores and skin conditions. Also Arthur Cunningham had come from a nursing home with a pressure sore and we could have sent him back there, but I felt, as I said before, we probably did have a bed available as well. So it was to give him a chance to see if the pressure sore could be improved.

Q We have looked at your note on 21 September at page 644 of the patient notes. You have commented that tablets had been found in his mouth and that has already been dealt with. If we go over to page 645, you end up by saying that his prognosis was poor, but you set out a plan for him:

"[To come into] Dryad today
Aserbine for sacral ulcer."

Then is it "nurse on site" or "nurse on side"?
A Side. So that he was turned on his side to keep pressure off the pressure sore.

Q Again we see "High protein diet"?
A Yes.

Q And "Oramorph prn if pain". Yes?

A A Yes.

Q Would you have examined the patient before you made this note?
A Yes, I would have. I would have examined him.

Q We can take it that certainly at that stage you did not think that the patient was then and there destined for a syringe driver with intravenous diamorphine that day.
B A Not from that day's examination.

Q I have been corrected, quite properly. I said intravenous. You did not think that this patient was at the time of that assessment destined for a syringe driver with subcutaneous diamorphine being put into him?
A Not from my assessment in the day hospital that day. That probably would have been the morning.
C

Q The note that you have made is "Oramorph prn if pain". You at that time did not prescribe him Oramorph, did you?
A I cannot remember. I need to look at the chart. I think I might have written up – I did write Oramorph on page 754.

Q Can we just have a look at that? Is that your prescription on page 754?
D A Yes. The Oramorph is my prescription.

Q Can we just look at what it is? This we know obviously is oral morphine. Can you just help us with the dose?
A It is 2.5 to 10 mg and the special direction is four-hourly. The route is oral and the date was 21 September 1998.

E Q That is an as required prescription?
A Yes.

Q When you write out a prescription such as this, as required but four-hourly, are you expecting it to be given four-hourly, or are you saying it should not be given more frequently than four-hourly?
A It is not more frequently than four-hourly.
F

Q Although this patient's prognosis you have described as "poor", he was not at the time that you examined him for palliative end of life care, was he?
A The treatment that we were going to give him was not going to be curative. So it depends on how you define palliative care. Palliative care for some people really is over a long period of time, the care you give people to help them cope with death and keep them symptom-free. His treatment was palliative and he was towards the end of his life, having
G moved from rest home to nursing home, but from my notes, we thought we would have a go at trying to get the sacral ulcer better.

Q Because if you could get the sacral ulcer better, which you hoped to do with treatment on Dryad Ward, his quality of life would be considerably better, would it not?
A He would have been less uncomfortable, but probably would have still, if he survived and the ulcer had healed, he would probably still have had to go to a nursing home and he
H disliked being in residential care of any kind, from what I recall.

Q I understand that. He was not going to be able to go to his own home and look after himself, but if the sacral ulcer had been curable, as it were, or treatable, then there was the prospect that he would be able to return to a nursing home.
A Possibly.

Q You have been asked about the reaction to his stepson. He had requested that the syringe driver be stopped. First of all, you took no part in the decisions post transfer, did you?
A No.

Q You said that it would have been very unusual to stop a syringe driver once one had been started.
A Yes.

Q This patient was described by his stepson when he went to see him. He had been able to have a proper conversation with him some days earlier and he was described by his stepson as being "unconscious and unrousable". What the stepson wanted was to find out the patient's wishes. Would it be unreasonable in those circumstances not necessarily to stop, but to reduce the level of sedation?
A It is possible to reduce the level or possibly even stop the syringe driver if it was appropriate, but I did not really see him at the time and I did not see him when he got really distressed when the syringe driver was started.

Q Dr Lord, all of that so far as you and are concerned is perhaps speculation. What I am asking you is if a relative comes to you and says, "My stepfather is unconscious and unrousable and I want to find out if that is the state that he wishes to be in when he dies", it would be perfectly reasonable, would it not, to reduce the level of sedation so that he could at least speak?
A Yes, it would be reasonable to reduce it and monitor how he is.

Q And allow that sort of conversation to take place.
A That would be appropriate.

Q Finally, I am going to turn to Mrs Stevens, Patient L. You do not need to turn up any notes, but please feel free to do so if you wish. When you saw this patient, which was I think on 6 May 1999, you have described her as being "extremely unwell" and at that stage you did not want to transfer to the GWMH. Yes?
A That is correct.

Q I do not think you dealt with this patient thereafter, did you?
A No. I had no contact with her after that.

Q In fact, she was transferred 14 days later, after that date about which you have been asked, and you do not know what the state of her health was on transfer, do you?
A Not at all. I did not have any contact with her after that initial assessment.

MR KARK: Thank you very much, Dr Lord.

Re-examined by MR JENKINS

Q Can I come back to Sister Hamblin, Dr Lord? You were asked questions about her and you told us that she was very experienced. It was suggested she was formidable and you did not agree with that. If it were suggested that she was a sister with whom one would be reluctant to disagree, what would you say?
A I am sure we had our disagreements, but I do not recall there being any animosity or bad feeling or any particular issues.

Q What would you say about the level of co-operation amongst nursing staff on Dryad Ward so far as you were able to see?
A The atmosphere was always very good, very cordial. They seemed to work well. I did not have any problems.

Q You have told us that Sister Hamblin was particularly good with nursing people with skin problems or bed sores.
A She was. We had quite a lot of bad ulcers and really extensive pressure sores which took a long time, but healed very well and in some instances healed completely. I certainly recall someone on Redclyffe Annex that probably took the best part of a year, but healed completely.

Q Can I come to syringe drivers and the anticipatory prescribing that we have seen? What you told us is that you would expect the nurses to start at the lowest end, the bottom of the prescribed range. Yes?
A Yes.

Q Is that what happened in practice from your experience?
A They usually did start at the lowest end. However, having gone through some of the records, I find that they have probably gone for a little above the lowest end of the range that had been prescribed.

Q What you agreed when you were asked questions by Mr Kark was that it is important to have a proper assessment of the patient and for that to be noted in the records.
A Yes.

Q From your understanding of the position, were patients being properly assessed?
A I feel that patients were being properly assessed, but the documentation did not support that.

Q As far as the actual administration of medication was concerned, and particularly using the syringe drivers, what was your view as to whether that was being dealt with appropriately by nursing staff or not?
A Is that with hindsight or at the time?

Q At the time.
A At the time, they were being dealt with appropriately.

Q If you had felt that your patients were not being treated appropriately, would you have said something?

A I would have. I would have said something to the nursing staff and, if nothing was resolved, we would have gone to the nursing managers.

Q Did you ever need to speak to the nursing staff or Dr Barton to express concerns that you might have had about patient care?
A I did not have any occasion to do that.

B Q You were asked about Patient A, Mr Pittock. I am sorry I am going to ask you to draw up the records again. We have look at your note for 4 January 1996. This gentleman had bed sores and you raised the suggestion that he should be given a high protein diet?
A Yes.

Q If we turn, please, to page 226 towards the back of those records, do we have a nursing care plan?
C A Yes.

Q Would you expect nurses to draw up care plans of this type in respect of patients and the problems that were to be dealt with?
A Yes, I would.

Q Is that a nursing priority or a medical priority?
D A It is a nursing priority and at the time the nursing documentation and the medical documentation was separate. They were not integrated notes and this was part of the nursing documentation and would be the responsibility of the nursing staff.

Q Looking at page 226, what comment would you make about the awareness of the nursing staff that Mr Pittock's diet was not good and that he needed to be encouraged?
A It has been documented that the diet and fluid intake was poor and the desired
E outcome would be to make sure it was adequate. The nurse who documented this has written down:

"Soft pureed diet. Encourage fluids and to have clear drinks after food."

Q Was it apparent that the nursing staff were responding to concerns about Mr Pittock's diet or concerns about it?
F A The patient would also have, as I recall it, menu cards, in that the high protein options would be chosen for them or they would be assisted with that. I am getting a bit jumbled where I am in time, because at present we document the food supplements on the drug chart, but I think that is for New Zealand. We did not do that in the UK.

Q If we look at the pages preceding the one I have asked you to look at, we see a whole series of nursing care plans. Let us look at page 220 as an example.
G A Yes.

Q The problem identified is the superficial broken areas of skin on Mr Pittock's scrotum and a plan is drawn up to deal with that.
A Yes.

Q If you go on two pages to 222, a similar plan with regard to a sore on his sacral area
H and the left hip?

A A Yes.

Q Are these examples of plans that one would expect nursing staff to draw up if there were problems with a patient?
A Yes, we would.

Q You were asked about Patient E, Gladys Richards. I do not ask you to draw up any
B notes. You were asked a comment on a particular dose that was administered and you said, "It is very difficult to comment because I did not see this lady at all". In commenting on a specific dose of medication, particularly analgesia and whether it was appropriate for a patient to be given that, would you need to see the patient?
A I would need to see the patient. I would also need to have a discussion with the people who saw them on a day-to-day basis in order to discuss how they had been the previous day, the previous night, what had been tried, what their intake was like, could they
C swallow tablets. It was a joint decision. But to comment as to whether it was appropriate for a particular patient without having seen someone, it is very difficult to comment.

Q Can I deal with Patient G, Mr Cunningham. Again, I think there are care plans and we have some at page 873-876. I do not think I need to ask you to read them, but is it apparent from 873, as an example, that the nursing staff drew up a care plan to deal with the sacral sore present on admission?
D A Yes.

Q On the following page, we have the actions that have been recorded by nursing staff to follow that care plan?
A Yes.

Q Similarly with 875?
E A Yes.

Q Also 876?
A Yes.

Q You were asked if this gentleman could be transferred to a nursing home and you said it was possible he could have gone to a nursing home if he had survived and the ulcer had
F healed, that was what you said. From your assessment of this gentleman, was there a possibility that he would not survive because of his condition?
A When someone is as frail as he was, anyone with a pressure sore, particularly with a pressure sore where the classification would be the most severe – it would be what we call a grade 4 pressure sore which is, of the grades, the top grade of pressure sore – the chance of surviving it, of it healing, was remote. The length of time it would take would be quite extensive, it would be some months. It would require someone not lying on the pressure
G sore, being able to lie on his side. From what I recall of his back injury, the reason he developed the pressure sore in the first place was probably because he was unable to lie on his side, with a combination of his, probably mostly, his back injury but also the Parkinson's he suffered from. Does that answer your question?

Q I think it does, but you told us this was the worst grade of pressure sore you can get?
A Yes.
H

Q You were asked about the stepson and it was suggested that the stepson's account was that Mr Cunningham was unrousable. If the records kept by nurses, and indeed the doctor, indicated that the patient was in pain, he was in pain when being attended to by the night staff and the day staff also noted that he was in pain – they thought especially in the knees – if the doctor's note commented that on what he was then receiving, the subcutaneous analgesia was controlling the pain just, would you have thought it appropriate to reduce the dose that the patient was receiving?

A Everyone has to – you have to judge this on an individual basis and, using it hypothetically, it is possible to consider it. Whether it would have been appropriate with Mr Cunningham, in Mr Cunningham's case, I really cannot comment because I did not see him on the ward at that time.

MR JENKINS: I understand that entirely. Thank you very much, Dr Lord, that is all I ask you.

(Microphone adjusted for Panel questions)

THE CHAIRMAN: We have reached the point when it is open to members of the Panel to ask questions of you. I am going to look now to see if any of them do have questions. First I am going to introduce you to Mrs Pamela Mansell, a lay member of the Panel.

Questioned by THE PANEL

MRS MANSELL: You probably feel you have answered these questions, but for me some of your answers have made me want to ask other questions. If I look at Mr Cunningham, to Patient G.

A Your voice is coming and going. (Microphone adjusted)

Q Can you hear me now?

A Yes, I can.

Q Mr Cunningham. I read your initial assessment or I read your assessment for admission to Dryad Ward and, although you are saying at that point that the diagnosis for him was actually poor, simultaneously you were saying that the nursing home had to keep the bed open for the next three weeks. If you thought that there was absolutely no way that this pressure sore was going to be improved for several months, why would you be putting in to keep the nursing home open for the next three weeks? That seems a conflicting statement.

A Yes. The difficulty with giving up rest home or nursing home places is that they would be really hard to come by. Theoretically, even with a pressure sore, he could return to the nursing home and some people with pressure sores did return. It was just keeping that option open because that was the place that was, as far as we know, home for them. It was probably just being practical, I suppose, being pragmatic, to say that if it came to the point that it might have gone a bit better, we could have discussed ... Some of the nursing homes actually like to take people back as well, whether the pressure sore is getting better or not. The decision to keep the place open, I was just being mindful that if we were looking for a discharge from the ward for whatever reason, we had somewhere for him to go. It probably was not tied up with the prognosis for him. I was just being careful with having a destination for him to go.

Q As a lay person, when I read your plan here, it came through, for me it came through, that this was indicating possible treatment but also with a continuing care context. Are you saying that was different to that?
A Yes. The intention was always to treat him and, however poorly someone is and whatever palliation you use in the form of pain control, I was of the opinion that we had to have an attempt to heal the pressure sore. So, while we are saying the outlook is not good, let us give him some treatment because sometimes what we predict is not what happens, sometimes people look very poorly, but given time and we have all had that, people do get better. I could see why it probably sounds very ambiguous that I was saying that, "He was not good, let us do this", but then his outcome is not good so – I am probably not explaining this very well. It is probably recognising that he was towards the end of his life but was there something we could do because if this got better, maybe we could improve the other problems, so it was to give him that chance.

Q Let me take you to another point because what you actually talk about is the high protein diet. If I actually have a look at Dr Barton's assessment, which is at page 647 which I think is on the same day as you made your assessment – is it the same day as you made your assessment?
A Can you give me a minute, I have not turned it up. (Short pause)

Q We have no mention in that about the high protein diet. We do have the phraseology that we have come to understand is linked to palliative care end of life care. That is about make comfortable, give...

> "...Give adequate analgesia and I am having happy for the nursing staff to confirm death".

When we look at the nursing notes which Mr Jenkins took you to, we saw a lot of emphasis on the pressure sores and trying to improve those, but I do not think there was the same emphasis on the high protein diet and actually seeing this man as getting him prepared as continuing care to try and improve his condition other than improvement of the sore. Am I interpreting it incorrectly or is that how you might see this? I suppose the question is, would you see how Dr Barton has written up this person and the care plan for this person as being consistent with your own? I am questioning that there are differences, but what would be the consistency?
A My interpretation would be that Dr Barton and the nursing staff took into account what I had written. They would have included the actions there because they did use the English they might have used anyway, the nursing staff could have made that decision anyway, but I ---

Q Might this assessment here indicate that on the ward they are actually seeing this patient in a poorer condition than you have actually seen him.
A That was the same day.

Q That is right. So I am just questioning whether it looks to you like a worse prognosis than you have actually given? This looks much more like the end of life assessment.
A The nursing staff certainly ----

Q No. I am looking particularly at Dr Barton's initial assessment.

A A With that assessment, I would have anticipated that she took into account what I had said anyway, and then putting this down in addition. That would be my reading of that.

Q So you did not actually get to review this person on the ward, did you?
A No, I did not.

Q So this person probably dies more quickly than you had expected him to die?
B A Yes. That is correct.

Q So what review did you actually do to satisfy yourself that the treatment and the plan was appropriate for him? How he was being cared for on the ward.
A I did not do any review after he had passed away.

Q It did not actually raise any concerns for you?
C A No, it did not.

Q But I understood that you wanted to be satisfied that the care, et cetera, on the ward was of a very high standard, and the treatment that they were giving, an analgesic control by the medical staff, was up to standard?
A Yes.

D Q So in what way could you have satisfied yourself?
A I certainly heard that he had passed away but I did not look at the notes, Dr Barton's notes or the nursing staff's.

Q When you were being asked by Mr Jenkins about the quality of the care was that based sometimes on assumptions?
A Yes, it would have been what I observed on the wards.
E

Q Rather than any detailed assessment of how patients were being treated?
A We did not do any critical review or audits in those years, I do not think. I do not recall.

MRS MANSELL: Thank you very much, Dr Lord.

F THE CHAIRMAN: Thank you, Mrs Mansell. Mr William Payne is a lay member of the Panel.

MR PAYNE: Good day to you. Good day. Can you hear me well? Can you hear me?
A I can hear you well. Yes, I can, thank you.

Q I would like to ask you a question with regard to the amount of time Dr Barton spent
G at the hospital. You said that you worked with her for eight years. Was it eight years that you worked with her?
A Yes. Yes.

Q We were told that Dr Barton had a contract for around 14-20 hours. Would you say that she over-fulfilled that contract? Would she be there longer than 14 hours per week?
H A More than two hours a day, and she often did pop in at the weekend. There certainly could have been occasions when she did more than 14.

Q I am trying to ---
A But I ---

Q Go on. Carry on, please.
A I would not have been on the ward every time she visited the ward, but from what I knew of the time she did visit, and I am not aware of the details of her contract either, she probably could have done more than 14 hours on some weeks.

Q But she certainly attended every day through the week, Monday to Friday, every day?
A Yes. Yes. Except when she was on leave.

Q The reason I am asking those questions is with regard to the anticipatory prescribing. If she is going to be there every day, is there a necessity to prescribe in such a way that she did, using a syringe driver – that type of prescribing for pain control?
A My understanding was that although she was there during the week-days, she was not always there at the week-ends, and there would be some nights when her partners – the partners in her practice – would be on call. So my understanding was, it was to cover those times that some of the anticipatory prescribing did occur.

Q But some of these patients were prescribed on days like Monday and Tuesday, anticipatory prescriptions. The week-end is a long way away. That is what I am saying.
A Yes.

Q And she is going to be there every day, and ward rounds with yourself, that is all afternoon. I am just wondering why there was a necessity to use that type of prescribing?
A She would not have been on call out of hours every day. During the week, there would have been some days when her partners would be on call as well.

Q Yes, she mentioned that. That is another question that I have. You said – I think you said anyway – that her partners were reluctant to prescribe a syringe driver. Did you say that?
A Some of them were not comfortable with palliative care or prescribing opiates at all.

Q Do you know why that was?
A No.

Q Can you just give me a second, please? (After a pause) If a nurse on the ward when the doctor was not there felt that she needed to get a different dosage of any type of drug, could a doctor have been contacted and given verbal permission for that drug to be administered?
A The usual procedure with a verbal order would be that you repeat it to two nurses.

Q Right?
A So sometimes we give a verbal order, but you would repeat it to one nurse, and then you repeat it to a second nurse. That was protection of the nursing staff.

MR PAYNE: I think you answered my question. Thank you very much indeed.

THE CHAIRMAN: Thank you, Mr Payne. Dr Smith, do you have any questions?

DR SMITH: Yes, please.

THE CHAIRMAN: Dr Smith is a medical member of the Panel.

DR SMITH: Hello, Dr Lord. I am going to confine my questions to Mr Cunningham as well. I think you still have the file in front of you in case we need to use it?
A Yes, I do.

Q First this, just in general terms about sacral sores. Of course, you said this was is horrendous and probably the worst one you had seen, but help me with this. Does the fact that a sacral sore is very large and looks horrendous – does that mean that it will be painful? Is there a correlation between the size and depth of a sore and its pain?
A Not consistently. Everyone is different, and sometimes the sores are painful when they start off. Sometimes it is painful when the scars lift off and they are healing. Sometimes it is painful when they are inflamed. Sometimes pressure sores are not painful at all, so it is very variable.

Q Thank you for that. In your note in the day hospital you said that he should have Oramorph if in pain, but you have not made a note that he was in pain. Do you agree with that?
A No.

Q You have not?
A Yes, yes, I do.

Q You agree with that?
A I have not.

Q Then to Mr Jenkins you said that he was really quite distressed and I am wondering if that was an assumption or recollection?
A It is a vague recollection. Mr Cunningham, the last few times we had seen him, was always quite distressed. He was distressed with being in residential care. It is a vague recollection. It is not a very clear picture

Q And so you associate the word "distress" with different things?
A Yes.

Q It might not be pain. It might ---
A It might not be.

Q --- be unhappiness about his lot, as it were. Okay.
A Yes.

Q On Dryad Ward there is a team and you are at the top of that team, and Dr Barton is working for you. Is that correct? Is it right to say "for you"?
A I do not know. Probably.

Q In medical hierarchical terms would that be right?
A I would carry the consultant responsibility for the patients. So, yes.

Q Under your direction?
A Employed by... Under my direction. Yes.

Q And obviously with you.
A Yes, certainly.

Q And then there is a team of nurses, day nurses and night nurses, and they have a hierarchy. You have described, I think, quite graphically at one point how starting a syringe driver with diamorphine and midazolam at that time in your experience, in your knowledge, signals the start of an end of life pathway. Was I right to make that ---
A Thank you;

Q You went on to say that it is not stopped, the driver is not stopped. It carries on, and the ---
A Not usually.

Q Not usually? And my assumption to that would be, until the patient died. Would that be correct?
A Yes.

Q So am I right in this, then? That a decision to start such a syringe driver is in fact a decision to enter an end of life pathway?
A Yes.

Q Who makes that decision, that this patient – your patient – is now entering an end of life pathway?
A It should be a joint decision with the patient, with the staff looking after him and wherever possible with the relatives as well.

Q You never saw him again once he left the day ward? The day unit.
A I did not.

Q So you were not involved in a decision to put him on a syringe driver, a decision that may be parallel to an end of life pathway. Is that correct?
A No, I was not.

Q You were not involved in your patient's change in status?
A No. I do not recall the involvement.

Q Does that concern you?
A Dr Barton and the nurses were competent, and the nursing decision that night, if I recall it right, was that night the syringe driver was to be commenced. Sometimes they do need to make the decision. I cannot remember if I was contacted about it while Mr Cunningham was alive. I really do not recall.

Q You have drawn attention to the fact that a line of treatment was started after what I suggest was an acute event. It would be reasonable to call it an acute event. You brought that subject up. Is that your understanding? Something happened in the night?

A A Yes. He was clearly very distressed at night and we did not know that there had been distress at night as actively before.

Q He was distressed. By all means refer to the notes, but do you recollect what that distress consisted of?
A No. I did not see him at all, and this is from the nursing notes.

B Q My understanding was that there was an episode of acute aggressing that he threw things around and made some threats to the nurses. Does that ring a bell to you?
A Yes, yes. It does.

Q We have heard from our expert witness that such episodes of aggression or acute confusion do occur in elderly patients. They are almost to be expected from time to time when they are in distress. Is that something you would agree with too?
C A Yes. Yes, I would.

Q So we have a man who, in your mind, because you write it down had prospects. Would you agree with that? He had prospects for some recovery?
A There was a chance. At that stage I was willing to give him that chance.

Q And you were quite ---
D A That is what I felt at the time.

Q You were quite precise in laying out a plan for his prospects?
A Yes.

Q And you sent him to a ward where you were confident that they had a particular skill in treating bed sore. You were quite happy with that?
E A Yes.

Q And he has an acute episode, and then he goes on an end of life pathway, a terminal pathway. Can you help me, because I would quite like to hear how you would reconcile what happened to the man with prospects. He was your patient. How do you reconcile what happened?
A The way I would need to reconcile that would be to have a more detailed conversation
F with the nursing staff who were on duty overnight and what is not clear from the notes is that there was agitation. What is not written is as to whether there was any pain, any other distress.

Q No. We do not know.
A From the notes.

G Q We do not know because there is nothing written to say that. That is true.
A Yes. Without knowing that detail, I cannot really comment on that.

Q Finally, you have tackled the same question that was put in a slightly different way, but I would still like to ask it again. What is it that makes you feel that the syringe driver might not have had its dose reduced, if not stopped, to see how Mr Cunningham might have been, if not to allow his stepson's request, to see if Mr Cunningham could tell us what his
H wishes were?

A I am sorry. I lost the beginning of your question.

Q I am sorry. That was too long a question, I think.
A Yes.

Q In this train of thought ---
A It is about reducing ---

B

Q Yes. In this train of thought, in the context of an acute event, how do you say, why do you say, that the dose might not have been reduced or the driver not stopped to reassess Mr Cunningham? Let us put it that way.

A When I replied I think to Mr Kark, I said it is something that could possibly have been considered and we do occasionally consider that.

C

Q Let me crystallise it this way. If you had been asked, because his stepson had requested it and the nurses brought that request to you, what might you have said?
A We would have discussed it. It might have meant reviewing the patient to see what happened or suggesting a lower dose. There could have been any number of options. An alternative option, if we felt there really had been pain and distress, would have been to talk to his family and explain and see if they still wished to have it reduced. It is very difficult
D because it is all hypothetical. I know the request was made, but I do not really – from the notes, I cannot make out whether there was any definite pain which would have been significant for me to make that decision. Sometimes you might have needed to have reduced it, say, for a couple of hours and then seen if that really caused any distress. It is possible to consider it.

Q It is an option?
E A It is an option, but without knowing a lot more detail of how Mr Cunningham was that night or the next day, it is difficult to comment.

DR SMITH: Thank you.

THE CHAIRMAN: Dr Lord, we have now reached the stage when I will ask the barristers concerned whether they have any questions for you which arise out of questions that were
F asked by members of the Panel. Mr Kark?

MR KARK: I have no questions.

THE CHAIRMAN: Mr Jenkins?

<u>Further re-examined by MR JENKINS</u>

G

Q I have three questions and they are all about Mr Cunningham. You told us you certainly heard that Mr Cunningham had passed away.
A I did.

Q What was your reaction when you heard that?

H

A I cannot recall an exact reaction. Some sadness, because I had known him for some years and, when you have known people for some years, there is always a little bit of sadness. But I cannot recall whether there was any other reaction.

Q You were asked about pain and I would like to ask you to look at two pages in the records: pages 865 and 866. This is an assessment sheet, it is completed by nursing staff and we see on the second page of it that it is dated 22 September 1998, in other words, the day after Mr Cunningham's admission to the ward, and it is completed by a nurse we heard from called Freda Shaw. If you go back to the first page, we see that when she has completed the document, she has ticked at the bottom two boxes, one to indicate that yes, he was in pain, or that there was pain, and yes, it was being controlled. Yes?
A Yes.

Q I think if we go back to the prescription sheets for this patient, page 754, we know that Freda Shaw has signed the document and dated it the 22nd. We do not know when she has filled in the other bits of it and filled in when Mr Cunningham was in pain and when it was controlled, but we know that as a result of your prescription of Oramorph, Mr Cunningham was administered Oramorph on a couple of occasions on 21 September.
A Yes.

Q Can I ask you about the dose range? Why did you choose a wide range: 2.5 to 10? It is a factor of four, is it not?
A 10 is not that large a dose if someone is really distressed and in pain. That was the dose range. 2.5 was sometimes enough for patients, but often not. It could be enough. It was just so that there was scope for the nursing staff to increase the dose if they felt it was appropriate.

Q I think if we go on to page 758, we can see the date when the syringe driver was started.
A Yes.

Q It was at night, 11.10 at night on the 21st, the day after he was admitted.
A Yes.

Q Again, I am not going to take you through the nursing records or the other medical records, but if the records suggest that Mr Cunningham was uncomfortable when he was being administered to, both at night and in the daytime, over the succeeding days, the 23rd and 24th – and again, Dr Barton's entry is that the analgesia seemed to be controlling his pain just on the 24th – would you think it proper care for the patient to reduce the pain relief that he was then on?
A As I said before, it is possible to consider it, but you really need to judge everyone on an individual basis. It is really impossible to generalise on that.

MR JENKINS: I am grateful. Thank you. That is all I ask.

THE CHAIRMAN: Doctor, that really does bring you to the end of your testimony. Thank you very much indeed for joining us by video link today. It is enormously helpful to Panels when we are able to receive live evidence, even if it comes by way of video link. We recognise that we have put you out quite considerably to accommodate us with the difference in time and we really are very grateful to you. Thank you very much.

THE WITNESS: May I just ask a question?

THE CHAIRMAN: You may ask. I do not guarantee to be able to answer it.

THE WITNESS: Do I have to come back tomorrow or am I done now?

THE CHAIRMAN: Your testimony is at an end. You are free to go.

THE WITNESS: May I make a comment?

THE CHAIRMAN: You may.

THE WITNESS: It is looking through these notes, it is something that I have got used to hearing in New Zealand – and I am not trying to say that anything is better – but I really feel that we need – and certainly when I left Portsmouth, we did not have what are called integrated notes, where every specialist, every different discipline writes in them. Having looked through these notes recently and when I have looked through the current notes that I am using, it is very valuable to even have a therapist or a social worker enter, "Patient not seen. Extremely unwell with temperature". That gives you a better reflection of the patient and I really feel that notes should be integrated. That is just a suggestion.

THE CHAIRMAN: Thank you very much for that suggestion, doctor. You are free to go. Thank you very much indeed.

(The witness withdrew)

THE CHAIRMAN: I think we will adjourn now for luncheon and return at 1.55.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Dr Barton, although we have had a witness interposed, I do not think we need to swear you again. You are on oath and you remain on oath. Mr Langdale?

JANE ANN BARTON, Recalled
Examined by MR LANGDALE, Continued

Q Dr Barton, when we adjourned your evidence yesterday, we were dealing with Patient B, Elsie Lavender, and I was asking you questions in relation to the chronology. Do you have that in front of you?
A Yes.

Q In relation to the chronology for Patient B, we had reached page 11 at the point when we stopped. At the top of page 11 – this is relating to the date 26 February 1996 – we had reached the point where we were about to look at the drugs that you prescribed on that date. First of all, there is the MST, which you have already covered. 10 mg was administered at 0600, then discontinued and then 20 mg twice a day commenced at 2200. So she is now, as it were, on 40 mg a day of MST. Then the prescription by you relating to diamorphine, 80 to 160, midazolam 40 to 80, hyoscine 400 to 600 mcg. None of those were administered on that

day. I need you to deal with this question. There is this lady with the continuing pain, as we already discussed yesterday, the analgesia being prescribed at that time and indeed administered was MST. Why write up an anticipatory prescription in her case? Are the reasons the same as in other instances you have mentioned?

A I anticipated that should her condition continue to deteriorate, there would come a time when she would be no longer able to take oral analgesia or her condition would merit other than just pain relief and I would want to administer it subcutaneously. She was now not opiate naïve, so I would not be starting at 20 mg of diamorphine; I would go in at a higher dose.

Q Why 80 as opposed to 20?

A Why 80 rather than 40? Because I anticipated that I might well need a higher dose of diamorphine when the time came to use it. Because of the nature and severity of her pain, which was not typical of cancer pain or pain that we have seen in some of these other cases following recent surgery or anything like that; it was a very atypical sort of pain.

Q If you were, as it were, doing the half calculation on 40 mg of oral morphine, MST, divide that by two, you get 20.

A Assuming her condition was stable and she did not require an increase.

Q You allowed for an increase to allow for the fact that if subcutaneous analgesia has to be started, it is going to be pain not being controlled by MST.

A Yes.

Q What I want you to deal with is, why not put the lowest dose in the range as 60? Why choose 80? I wonder if you could help with that.

A Because I anticipated, with the nature of the pain that she was suffering, that she was going to need a higher dose of diamorphine. Standing there at the bedside, looking at this lady, I felt with my clinical experience and that of my nurses that it was going to be necessary.

Q If subcutaneous became ---

A If we came to subcutaneous analgesia.

Q And midazolam. Why 40 to 80?

A Similarly, a slightly higher dose for the same reason: to control her symptoms. There was a lot of restlessness and agitation with the pain already when she was being seen to even on the 25th, 26th, 27th.

Q I am not going to trouble you with hyoscine. I will just ask you to deal with a point that was raised by a member of the Panel with Dr Lord. If it is the case that this is not, as it were, a long weekend or anything of that kind, you are going to be coming into the hospital normally speaking the following morning. Why write up an anticipatory prescription at that stage?

A You need a range, a small range, to cover the time at which the syringe driver is going to be changed and the assessment of the patient is going to be made. Depending on when it went up, it might have been 24 hours later before I came into the hospital or some time after I left the hospital. So I needed that amount of flexibility in the system to cover that 24 hours.

Q If we can go back to something we have already touched upon in your evidence, but I would like you to deal with it specifically in this context. If you did not write up an anticipatory prescription and, say, two days later she, in the view of the nursing staff, required subcutaneous analgesia and you are not there and you are not due in in the next hour or so, what would be the practical disadvantage of your not having already written up the prescription?
A This patient would have to wait in pain. An hour might be acceptable to members of the public, but it could be anything up to 24 hours and I was not prepared to allow my patients to suffer pain and distress for that length of time while they waited for me to come and sign the prescription.

Q How might it happen that there might be a delay of 24 hours from the time that the patient was sustaining pain at a level requiring subcutaneous analgesia?
A Just after nine o'clock, I had left the hospital on a morning. I was doing other things, I was not due back until the following morning. It could be very nearly 24 hours before they got me back on the ward again.

Q Supposing it happened on a Friday evening. What is the problem about getting out an on call doctor?
A Because the experience and safety of the on call doctors could vary enormously. You could get one of your partners or a local GP who understood the situation and was familiar with prescribing syringe drivers and happy to do so. You could get someone else who was not.

Q The consequence in such a case is that the patient would wait over the weekend in effect.
A Yes.

Q Moving on, on that same page of the chronology we can see the administration of the MST on the 27th, that is the following day, at 40. There are other matters relating to the nursing care and you can see:

> "Analgesia administered. Fairly effective. Able to help when dressing this [morning]."

We bear in mind that on 29 February – I think this is something we added to this in handwriting – you were contacted with regard to blood sugar levels and you prescribed Actrapid.

Q What was the purpose of that?
A This was to bring a very raised blood sugar down which would have had the advantage of making you feel more comfortable and reducing the risk of her going into a diabetic coma.

Q On 1 March, still the problem with pain. In fact she refused medication that evening and then she was persuaded to take the MST, it seems. The following day.

> "Slight pain, took medication well."

A Two days later, which I think is 4 March, which I think is a Monday:

> "Patient claiming of pain and having extra analgesia PRN. MST dose increased to 30mg twice a day."

So she is now on 60mg?
A Yes.

B

Q Although you may not be able to specifically recall this patient, that would be a Monday morning visit by you?
A Yes.

Q As you are able to write the prescription to indicate the increase, would you have examined her on that day?
C A I would. I would have noted the marked deterioration in her overall condition. She was now definitely going downhill.

Q The physio sees her that day and recommended three turns of the head to the right, five neck retractions every two hours. She needed reminding. The analgesia had been increased as we have seen. Over the page on page 13, in relation to the drug charts, they show what it was you had prescribed by way of the increase. On the 5th, which is the
D Tuesday, the following day, you reviewed her and wrote:

> "Has deteriorated over the last few days. In some pain therefore start subcutaneous analgesia. Let family know."

What is not recorded on the chronology, and I think we may have hand written in, you also wrote:

E

> "Not eating or drinking."

In relation to the administration of subcutaneous analgesia, your prescription was 80-160 diamorphine; 40-80 midazolam. Did you have in your mind a risk that those doses of diamorphine and midazolam might over sedate or produce respiratory depression in this lady?
A I did.

F

Q How do you approach the exercise, what is the judgment you make about it?
A The judgment is that I wanted to give her adequate pain relief and relief of her symptoms of what were now becoming terminal restlessness, so I was minded to give her adequate analgesia and sedation to control those and I was accepting that she might well be over sedated.

G Q Why not, in those circumstances, if I can ask you this, lower the dose to, hopefully, achieve pain control and agitation control without over sedation or respiratory depression?
A And run the risk of putting her through another 24 hours of discomfort like the weekend and then the Monday she had already had. She needed an adequate level of pain relief and relief of restlessness.

Q That was your judgment?
H A That was my judgment.

Q "Let family know", what does that signify?
A That signifies that the discussion we had with Mr Lavender at the end of the previous week, to the effect that we were going to need to use subcutaneous analgesia, had now arrived and the syringe driver was going to be put up and that she was dying.

Q We can see the entry below that, which is from the significant events notations:

"Patient's pain uncontrolled."

So she had had a very poor night obviously:

"Syringe driver commenced at 09.30. Son contacted by telephone, situation explained."

There is a similar note which we need not bother with on the nursing care plan. Over the page, page 14, we can see what the prescription was. Here it was diamorphine 100mg, so it had gone up, midazolam 40mg and hyoscine we need not trouble with. Professor Ford raised this issue in relation to this situation, suggesting that it should have been checked why she was deteriorating, "It would be difficult to tell if it was affected by the opiates", in other words the MST. What do you say to that, as to what the practicalities were of you checking with regard to the deterioration or any other steps you might have taken?
A We did check for the obvious things like dipping her urine and a full examination of the lady to see if there was any obvious cause for this sudden deterioration such as an infection. The likeliest reason, logically, for her deterioration was an extension of whatever was happening following her possible brain stem stroke or following her crush fracture of the vertebrae or whatever it is postulated was happening. Whatever was going on, it was getting worse and none of those would have been treatable in any way, shape or form.

Q The following day she is reviewed by you and it rather looks as if it might have been a morning visit?
A The syringe driver was then renewed.

Q Further deterioration and it says, "SC analgesia commenced", but it had been on the 5th:

"Comfortable and peaceful. Happy for nursing staff to confirm death."

On that day, you also indicated, it would seem that you indicated, that medication other than through the syringe driver should be discontinued. Over the page:

"Pain well controlled. Syringe driver renewed at 9.45."

That day there was a further administration of the same subcutaneous analgesia for the reason you have already indicated. It was working, "pain well controlled". Was this lady in a coma by this stage, are you able to say, or what was her general state?
A I am not able to say anything other than she was peaceful and comfortable.

Q Would that be an expression you might use which would cover a patient being, in effect, unconscious or in a coma or unrousable; different people have used different expressions?
A Or closely approaching death. I do not think there is any way of distinguishing between those different terminologies describing the same event.

Q I expect you have already answered this, from what you have told us, but why not, if she was very much, I am going to use the expression, "out of it" reduce the diamorphine and the midazolam to keep her, if possible, more alert. What would be the point of doing that?
A More alert to feel more pain.

Q That is what you consider?
A That is exactly what I would have felt.

Q She died at 9.28 on Wednesday 6th. That is all I need to ask about Patient B. Patient C, the lady with the suspected carcinoma. We have been through the history already in some detail. Admitted to QAH following a collapse. A general deterioration and if we look at page 2 of the chronology, there is a record at page 299 in the notes. I am not going to turn it up but we did look at it earlier. On page 299 there are entries at the hospital for 12 and 13 February, which is why I am referring to it at the top of the page of the chronology, for palliative care and the son agreeing that she was not for invasive treatment. We move on through the month of February, still at the Queen Alexandra under Dr Lord. She was transferred to Charles Ward and we have heard about that. Over the page at page 4 of the chronology, she was reviewed by Dr Lord on 25 February. We have dealt with that evidence very recently, and on 27 February she is transferred to Dryad. Diagnosis in the transfer form is set out and in the bottom of the left-hand column on page 4 we can see the notes you made in relation to reviewing this patient on 27 February.

> "Transferred to Dryad continuing care. Diagnosis of Ca bronchus made on CXR on admission 6 February. Generally unwell, off legs, not eating. Catheterised. Needs help with eating and drinking. Bhartel O.
> Plan: Get to know. Family seen and well aware of prognosis. Opiates commenced. Happy for nursing staff to confirm death."

There is no dispute that she was plainly very ill when she came into Gosport. Professor Ford makes no criticism of your notes there and many people in those circumstances, he indicated, would use opiates even if she was not showing pain. Professor Ford indicated that in his view there was a view that opiates could be prescribed for the relief of anxiety and agitation in cancer patients, in effect, is what it appeared to be. As far as you are concerned and in terms of the symptoms exhibited by a patient, would there be any difference in your mind at that time in the 1990s as to what was appropriate to a patient who was suffering from cancer but was exhibiting exactly the same symptoms as a patient who was medically unstable, unwell but not with cancer. Would you be saying to yourself, "I can legitimately use opiates because this patient has a carcinoma of some kind, but I cannot in another patient who is exhibiting exactly the same symptoms"?
A I always felt at that time that it seemed very unfair that if you had a diagnosis of cancer, then it was legitimate to give you opiates to relieve anxiety, distress, fear of dying, aguish, all of these things, but because your illness was equally terminal but caused by heart failure or a severe stroke or something else medical, you were denied opiates, they were not appropriate to use simply because you did not have cancer. I never understood that concept.

Q Then we can move on over the page to page 5 of the chronology where the significant events section of the nursing notes, care notes, sets out the situation. I am not going to read all that out. Past medical history is given on the nursing care plan, a spell summary. The drug charts. You prescribed Oramorph, there is no criticism of that, 2.5-5 ml (5-10 mg); thioridazine and the other things that you prescribed are digoxin, frusemide and so on. The next entry on the chronology, page 6 in our record, shows the next day 28 February:

> "Very distressed, calling for help and saying she is afraid. Thioridazine given with no relief. Patient remains distressed. Oramorph 2.5mg given with no relief. Doctor notified. S/B doctor for regular thioridazine and regular heminevrin [at night]."

It looks as though it was a Dr Lang, it does not perhaps matter very much, but not you. What would be the rationale for the doctor taking the action that he did at that stage, regular thioridazine and heminevrin?

A Because as an out-of-hours on-call doctor he was presented with a patient whom he did not know who was presenting with symptoms of distress and agitation and difficulty getting off to sleep. He very properly prescribed a major tranquiliser and a sedative for the night time.

Q Nursing care plan for the 28th:

> "Can make her wishes known quite well. Does as she is asked. Pain: Yes on movement. Pegasus mattress. Urinary catheter...
> Encourage fluid intake."

And so on. The drug charts for that day showing 5 mgs of Oramorph, thioridazine, heminevrin, as we have already seen in relation to the picture. On page 7 of the chronology, the 1 March, we can see what the drug charts show. Two doses of thioridazine and the heminevrin continues:

> "Slept well but calling+."

Presumably calling a lot.

> "Shouting from approximately 05.30. Spat out all medication."

That is over the weekend because the next date shown on chronology, 2 March, is in fact a Monday so you come in on the Monday, see her and record in the notes:

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

It looks as though you knew Dr Lord would be coming in to do a ward round that afternoon. Can we take it, if you look over at page 8, that when Dr Lord reviewed her, it looks as though it was a Monday afternoon ward round, you would have spoken to her specifically about this patient?

A Yes.

Q You would have indicated what your thinking was?

A A Yes.

Q And deal with the question with regard to the necessity or requirement for opiates. If we look on page 9 of the chronology, we can see that on the morning of that Monday, Monday the 2nd, you had prescribed in terms of diamorphine 5 mgs which was administered at 8 o'clock in the morning and also at 3 o'clock in the afternoon. Is that right?
A That is correct.

B

Q On the 2nd?
A That is correct.

Q And whose decision was it to start the fentanyl ?
A Mine.

C Q Because we can see your prescription and the patch administered at eight o'clock in the morning. Would you explain, please, what it was you were doing and why, because we have a fentanyl patch being placed on the patient at eight, so it is starting to provide diamorphine, and diamorphine being given as a single injection of 5 mg at eight o'clock and then again at three o'clock in the afternoon. Professor Ford does not criticise the administration of the diamorphine, and thinks the decision to use fentanyl is reasonable. Would you explain what is in your mind in terms of that process?
D A I knew that the fentanyl would take up to 24 hours to build up to its maximum effect in a patient, so that I knew that I would need to give a small loading dose of diamorphine to provide her with immediate relief from her symptoms which would last for approximately four hours, and I could then give a second one at about three o'clock in the afternoon to aid her with this process as the level of fentanyl built up in the body and she began to get relief from her symptoms.

E Q Can I use this instance to deal with another point. I appreciate this is fentanyl.
A Yes.

Q Why not, when you thought it right for subcutaneous analgesia to be provided, diamorphine – let us take it by itself – why did you not in those cases provide a single injection by way of a loading process in those instances because of the time that it would take for the subcutaneous diamorphine to start taking effect?
F A There did not seem to be the same degree of time lag before you got an effect from the subcutaneous analgesia in the syringe driver as we saw with the fentanyl. The fentanyl was definitely much slower to kick in. This subcutaneous syringe driver seemed to start to work more quickly. I know from Professor Ford's evidence he felt that it took 17 hours or more. Clinically it appeared to be effective much more quickly. I very rarely had to use a loading dose of diamorphine at the start of the infusion.

G Q Can I just ask this. It may be an unnecessary question, but if you had thought it necessary ---
A I would have done it.

Q --- to provide diamorphine by way of a loading dose by way of injection ---
A Yes.

H Q --- I presume you would have done so?

A A Yes.

Q So that is really based on your clinical experience as to what appeared to be the effect on the patients you were treating.
A Yes.

Q So Dr Lord comes in on the Monday afternoon, and it is clear from her evidence, and
B nobody is suggesting to the contrary, she did not in any way disagree with what it was you had instituted by way of analgesia?
A Yes.

Q Her note continues, having recorded what she had diagnosed and so on:

"Continue fentanyl patches.
C Later: Son seen. Concerned about deterioration today. Explained about agitation and that drowsiness probably due in part to diamorphine. Accepts his mother is dying. Agrees to continue present of ..."

I think it is "management" rather than "medication". Dr Lord has confirmed what it meant and so on. In relation to the drowsiness where Dr Lord, it appears, was saying to the son, "The drowsiness is probably due in part to diamorphine." Is that something you would have
D appreciated at the time yourself?
A I think I would have been well aware that having given 5 mg diamorphine intramuscularly that she might well be drowsy for a couple of hours after that.

Q And the son, it seems, looks as if it probably was some time in the afternoon---
A He visited ---

E Q ---- because there was a second administration of diamorphine at three o'clock that afternoon.
A Yes.

Q Although nobody can give precise times, does that appear to fit the chronology on this day?
A Dr Lord would have asked to see him at the end of her ward round, which would have
F been approximately between four and five, as we heard from her.

Q Then in relation to the significant events documentation, the picture is set out again. We need not go through it all because it is covered by what has taken place before. I would like us to move on to page 9, where we can see the prescription and, indeed, the administration of the drugs we have just been talking about. As Professor Ford indicated, she was inevitably dying at this stage and in relation to end of life care, you can take some risk or
G risks that you might not otherwise take with regard to the effects. That was his view – the adverse effects of these drugs. On that same day you had written up an anticipatory prescription on 2 March for diamorphine, midazolam and hyoscine. Why did you need to do that, bearing in mind this patient on the morning of the 2nd was receiving fentanyl and during the day was to receive two intravenous injections of diamorphine? Why write up an anticipatory prescription? First of all, why an anticipatory prescription at all before we come on to doses?
H

A A There were two reasons for writing up the subcutaneous infusion. One was to cover the situation if her pain relief was not adequate on the fentanyl patch.

Q So if the fentanyl was not doing the job, it was to cover that.
A 24 hours, when I came in the next morning, I would be able to make an assessment of whether the fentanyl was doing the business. The other reason was, she was no longer now able to take her thioridazine. She might well need an anxiolytic and a terminal restless drug
B in the form of midazolam, and the only way that I could administer that drug would be subcutaneously. There was no other way of doing it. At that point, therefore, I would have to make the decision to change over from the fentanyl patch to the subcutaneous infusion.

Q Perhaps I can ask you about that just by way of procedure. If that was to happen, if you were there when it happened; in other words, the patient being taken off the fentanyl and subcutaneous analgesia starting, would it be the case that you would see to it that the fentanyl
C patch was removed?
A Immediately.

Q In terms of your understanding of the way the nursing staff operated, assume you were not there and the decision was taken to commence subcutaneous analgesia, what did you understand would normally happen with the nurses?
A The patch would be removed and a notation to that effect made against the
D prescription on the drug chart. You would not want to have the fentanyl patch still applied and be running the subcutaneous infusion.

Q It appears in this case, and I think maybe in another, that although the fentanyl patch may have been removed, nobody recorded it?
A Yes.

E Q They neither recorded that it was still there, nor that it had been removed?
A Yes.

Q In this case that is the position save for the fact, I suppose, that on the 3 March, at the bottom of the drug charts do not show fentanyl being administered in any way?
A It would not show that it was still being administered, except that it had been written up for three days, but it does not show that it was actually physically removed from the
F patient – but that would have been the procedure.

Q Thank you.
A Bearing mind there was still some fentanyl in the body, as the fentanyl level gently reduced, then the syringe driver level would be gradually building up.

Q Then can we move on to that, because I wanted to ask you about your perception as to
G what would be going on with the analgesia, when a patient has been on fentanyl and they have been on a fentanyl patch for, let us saying, 24 hours?
A Yes.

Q And the switch is then made from fentanyl to subcutaneous analgesia in the form of diamorphine and midazolam, in this particular case they started at 10.50 in the morning on the 3rd. What was your understanding as to what was going on with the fentanyl, which is
H

A still there in the patient, patch removed, subcutaneous analgesia starts to be administered. What is the picture there?
A Fentanyl, in my understanding, in those days would have been out of the system by another 24 hours, so that the level was gradually reducing in the body through the 3rd. At the same time, the 20 mg of diamorphine was gradually increase in level in the body so there would be a cross-over moment when the analgesia would be equal.

B Q Can we look at that, stick by step. You take the fentanyl patch off?
A But there is still some.

Q The fentanyl has reached its peak, and your understanding was that whatever fentanyl was still there in the body would have gone after 24 hours?
A Yes.

C Q Therefore the actual amount of analgesia that the patient is receiving would be declining throughout what would have been the second day of the fentanyl patch administration?
A Yes.

Q At any particular rate? At a steady rate or what are we going get?
A I assumed at a steady rate, other factors being equal.

D Q Then the subcutaneous analgesia is administered with the fentanyl patch off, and obviously it builds up in the way that it normally does and so there would, as you say, be a cross-over point?
A Yes.

Q Was there a risk in your mind, because the diamorphine that is being administered is
E at 20 mg and the midazolam is at 20? Was there any risk in your mind that with the administration of those drugs and the fentanyl still being there, a risk of over-sedation or, indeed, respiratory depression because of the declining effects of fentanyl?
A There would always been a risk. I was prepared to accept that risk in order to give her adequate analgesia and to add in the midazolam. I thought that that risk was acceptable in this particular patient.

F Q On the 3rd, in the normal course of events you would have visited the hospital, because that is a Tuesday, 3 March?
A Yes.

Q No record by you of anything to do with this patient. Would you explain why, because on that day ---
A I would institute a marked changed in her medication.

G Q Why no note?
A Because I should have, and I was time constrained and I did not. I saw to the patient rather than making a note in her notes.

Q But it follows from what you have just said that obviously you were there that morning?
H A I saw her.

A

Q You would have seen her, and it would have been your decision ---
A Yes.

Q --- to say, "Start the subcutaneous analgesia."
A Yes.

B Q So it is not a case of the nursing staff taking a view and having to contact you. So, as you say, you should have recorded the reasons for that, or something to do in your view which you did not, but that was our rationale -=--
A Yes.

Q --- on the day?
A Yes.

C

Q Then over the page, onto the last page of the chronology, significant events. The documentation shows the note by Sister Hamblin.

> "Rapid deterioration in condition this morning. Neck and left side of body rigid – right side flaccid. Syringe driver recommenced at 10.50."

D In relation to that, just to get the picture in term of the timing, it looks as though Sister Hamblin, when she came on duty that morning, recorded the fact on information presumably, and either she saw herself, or somebody indicated, "... deterioration in condition." What is the significance to you of the neck and left side of the body being rigid, and so on?
A I imagine she had had some sort of cerebral event, possibly had bled into a cerebral metastasis, or had had a stroke.

E Q Assuming that is information that was available to you that morning when you did the visit, your regular visit, would that have had any bearing on your decision that the subcutaneous analgesia should be administered, or did it play no part?
A It played no part.

Q I am not going to ask you anything more about that. This lady died at 9.30 that evening. Patient D, please, Alice Wilkie. This lady was in her early eighties at the time we F are considering. She goes into Queen Alexandra in July 1998 with an unresolved urinary tract infection. She was a demented lady, as we can see and, over the page, page 2, from the records, she in fact suffered from dementia. On 1 August the clinical notes records at the hospital advanced dementia. Over the page, at page 3:

> "[She] needs plenty of encouragement with food and fluids."

G Haloperidol and Augmentin prescribed and administered. Can we move on to page 4? This is 4 August 1998. Reviewed by Dr Lord. We have heard the evidence from Dr Lord about this this morning and we have seen what she had to say about the situation, as she described it in her evidence. She was very dependent, cognitively impaired, very frail and therefore active resuscitation would not be in her best interest. We will move on to page 5, when she is transferred to Daedalus Ward. The doctor who clerked her in – not you; we have heard evidence about that. We can see that the referral letter, half way down that page, point out

H

A UTI, pyrexia, dehydration, dementia and so on. For four to six weeks observation "Then decide on placement." For antibiotics, Waterlow 16, Barthel 2.

"Mentally she is dependent and needs feeding."

The fluid intake at QAH had been supplemented with s/cut fluids. She slept very well.

B "For Dryad Ward Gosport today."

The notes go on at the hospital. Then over the page, on to page 6, she having been clerked in by that other doctor, notes from the nursing staff at Gosport, Nurse Joice:

"Transferred from ... QAH for 4-6 weeks assessment and observation + then decide on placement. Medical history ...".

C

Then at the bottom of page 6 on the left, Nurse Joice is recorded:

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

In relation to patients with advanced dementia, or indeed perhaps earlier dementia, can it be
D quite difficult to tell what pain they have?
A Very difficult for them to tell us, or even for them to understand themselves what they are suffering, but they are undoubtedly suffering.

Q So you may get a patient who is screaming out or shouting out or calling out as a result of something other than pain. It may be that it is pain?
A They are giving you lots of non-verbal clues, but they do not understand them and you
E have difficulty in understanding them.

Q Would you say there is any advantage in terms of either nursing experience or experience of a doctor acting as clinical assistant in seeing patients over years with these sorts of conditions? Is there any advantage or assistance that you are given just by that experience, in terms of trying to make a judgment as to whether the signs which might indicate pain or in fact pain, or is it still very much open to question, however many years' experience you
F have?
A I think if you have had a lot of experience in dealing with demented patients, you perhaps are more alert to these non-verbal signs and to the clues they are trying to give you. You have to be careful obviously not to miss something obvious like a urinary tract infection. If you have ruled out all those sorts of physical causes, you are then left with the problem, is this mental anguish? Is this physical pain? From the point of view of treatment, does it matter? Are you not going to try and help the patient whatever you think the cause of the pain
G is?

Q Then on page 7 of the chronology, "Visited on Daedalus Ward". This is the CPN notes. "Daughter was also there." The person recording the notes says she will contact the ward in three to four weeks' time. Then she was reviewed by Dr Lord on 10 August. Again, we have heard from her about that:

H "If no specialist or nursing problems D to a [Nursing] Home."

In effect, Dr Lord said that was if she remained stable. She stopped the fluoxetine, the antidepressant, but she is unable to recall now why she stopped it. There may be more than one reason which might have applied. Then the CPN notes for 12 August, two days after Dr Lord has seen the patient:

"... physically unchanged. Very needy, not expected to return to Addenbrooke."

We have here a phase, starting on 6 August, which is shown on the fifth page of the chronology, where she had been clerked into Daedalus Ward – I cannot offhand tell you what day of the week that was – Dr Lord sees her on 10 August – that might well be a Monday, if it was a Monday ward round by Dr Lord. Then we get an entry for 12 August and we get an entry for 17 August, but nothing by you. When we look at page 8, we can see that although it is undated, it looks as though you have written up an anticipatory prescription on perhaps 17 August, or it might I suppose be the 18th. Why is there no record by you of anything for what is a period of over a week, 11 days, it would seem, before we see you writing out a prescription? How do we view the picture there?

A If a doctor who cannot be named clerked the patient in that day, it suggests to me that I may have been not there for a few days. When I came back, we were faced with a situation on the ward that we had mayhem occurring.

Q Would you explain what you mean by that? We are now in August 1998. What was the problem?

A We had a patient on the ward whose family were causing us considerable problems, both with the nursing and the medical staff.

Q That patient being?

A Gladys Richards. It became increasingly difficult to settle to any sort of clinical routine which would involve the making even of scanty notes in the patient's medical records.

Q I wonder if you could just help us with this? Would it be the case, or might it be the case, that for a period of say a week you might be visiting the ward in your normal way in the morning and not making any record about a patient who had been reviewed by Dr Lord at one point?

A Yes. And who we thought at that point was relatively dependent but stable.

Q Can we take it that so far as one can judge it, on 10 August, when she was reviewed by Dr Lord, you were not present? The afternoon of a Monday perhaps.

A It is perfectly possible that I was not present on a ward round.

Q So it may be that you were not on the ward at all during those days; it may be that you were. Is that how we look at it?

A Yes.

Q Then on 17 August, in terms of the records there are, on page 8 of the chronology, it says "Deterioration recorded". This says "Contact record".

"Condition generally deteriorated over the weekend.
Beed:"

That is Phillip Beed –

> "Daughter seen – aware that mum's condition is worsening, agrees active treatment not appropriate ..."

That is, the daughter –

> " ... and to use of syringe driver if Mrs Wilkie is in pain."

The daughter is a lady called Marilyn Jackson from whom the Panel heard evidence pretty near the beginning of this hearing. Judging by Phillip Beed's note, is that consistent with the syringe driver having been written up on the 17th?
A It is.

Q So although it is undated, it is difficult to see how he could have referred to the use of a syringe driver unless he knew that that was something which might arise.
A Yes.

Q Therefore you had prescribed it. If that is the 17th that you had written out the prescription, the anticipatory prescription, the same question, because it is a different patient. I am going to ask you why did you write up an anticipatory prescription on the 17th, as opposed to writing it up any earlier? What was it about the 17th which made you think that that situation might arise?
A I would have been alerted by Phillip and by Phillip's report on what the daughter had said that Mrs Wilkie's condition was now deteriorating. She was not as well as she had been, she was not eating and drinking as she had been. She might well soon reach the point where she was unable to take oral medication and we needed to focus more on some terminal care for her.

Q I would like you to deal with this. Had this patient been on any form of opiates prior to 17 August?
A None at all.

Q Why then prescribe, albeit anticipatorily, these strong opiates on the ladder, the highest level? Why not prescribe something like a middle range opiate?
A A middle range opiate is not going to address the problem of terminal restlessness, agitation, distress. Co-codamol or co-proxamol would not have been appropriate, even if she had been able or willing to take them.

Q Would you say this was the position or not? If this lady had not exhibited any pain, her condition has deteriorated generally over the weekend, but she does not exhibit any pain, would there be any necessity for first of all subcutaneous analgesia?
A There would not be any necessity for subcutaneous opiate analgesia. There would have been a possibility, had she become very restless and agitated at the end, that they might have wanted to use some midazolam in a subcutaneous form.

Q Can we pause there just so we can take stock? If no pain had been exhibited or observed in this lady, but terminal restlessness/agitation had exhibited itself, it would have

A been appropriate, or might have been appropriate, to administer subcutaneously just midazolam?
A It might have been.

Q Do we think of it in this way? If there is no pain exhibited, do not administer diamorphine.
A Think very carefully on clinical examination whether an opiate is necessary.

B

Q If you wrote her up for that prescription on that day, albeit anticipatorily, it seems to follow that you must have been there and seen her that day on the 17th.
A Yes.

Q Would you have spoken to Phillip Beed about this patient in the ordinary course of events?
C A Yes.

Q Why not prescribe Oramorph in terms of pain initially for this lady?
A Again, because she was reaching the terminal stage. Oramorph would only help with pain and distress, but not terminal restlessness, agitation and pain. It would not be appropriate by itself orally.

D Q Three days later, 20 August, diamorphine is administered from 1350 and midazolam at the same time.
A Yes.

Q What has been happening over that three-day period: the rest of the 17th, 18th and 19th?
A She has been quietly deteriorating, quietly dying.

E Q Would you help us as to why there appears to be no note made either by you or the nursing staff as to what was going on over that period?
A Because, to my eternal regret, our concentration was all focused on the other situation and I did not make a record. I would have seen her when I went round the ward, but I did not make a record of what was going on. She was quiet, she was not causing any trouble, she was reasonably comfortable, although she was going downhill, she did not get any analgesia or anxiolytic until literally at the end of her life.

F

Q When you would have been on the ward doing your normal morning visit, would you have noted the fact, when you discussed the patient with the nurse or just said, "Is everything all right" or whatever it was, would you have noted one way or the other whether there were nursing records of what was happening to the patient on those days?
A No. As Dr Lord pointed out this morning, the nursing records were in a separate part, so they were not immediately available. I relied on verbal reports from the handover night
G staff to day staff in the morning, not the written records.

Q You have made reference for the second time to the problems that were existing at that stage. I would like you to indicate in a little bit more detail what they were. What were the problems in relation to Gladys Richards? Not the patient herself, but was this something to do with relatives?
A Yes.

H

Q What was the difficulty?
A Sitting just inside the patient's single room with a notebook each, recording who was going past, what was going on, what the nursing staff were doing, stopping and questioning nursing staff who were on other duties on the ward, totally disrupting the routine of the ward. Phillip Beed found it very disruptive and I think he lost his normal rhythm of running the ward daily. The normal handover to me was not as good and as full and as appropriate as it could have been on those days.

Q Was that something that the nursing staff spoke to you about?
A There was nothing we could do about it.

Q Forgive me. Was that something the nursing staff spoke to you about?
A They spoke to me and I was aware of it happening when I went in each morning.

Q I will come on to you in a moment. The nursing staff spoke to you about it.
A Yes.

Q You yourself witnessed it.
A Yes.

Q On those occasions that you visited on your morning visits – and we are concerned with Daedalus Ward – I will come on to the patient in a moment when we look at the history with regard to Gladys Richards – in general terms did you speak to the relatives or did you not speak to them or what? What is the general picture if you saw them?
A I would say good morning to them, but I did not feel that it was appropriate that they should disrupt my business round and my attending to and caring for the other patients on the ward.

Q Did you ever say anything to them about the effect that this appeared to be having?
A No.

Q Why not?
A I am a coward. I felt really that it was a nursing management problem. I felt that the management should have come on to the ward and helped Phillip Beed deal with the problem. I felt that I, as the visiting clinical assistant, was purely responsible for the medical care of the patients in the ward, not what was going on.

Q We will come on to the history with regard to that particular patient soon. Dealing with the situation with regard to Alice Wilkie and Marilyn Jackson, she told the hearing that on 20 August, when she was visiting at some point in the early afternoon or round about lunchtime, she indicated – and this is before she is ever on any opiates – she could see that her mother was deteriorating, was less mobile and so on, and she had called in at the hospital and spoken to Phillip Beed before this, who had said she was not well at all and she said, "I could see she was going to die in there." She confirmed that she did not want her mother to suffer. She says that she was never told anything about the kind of drugs that were being administered, but I am not going to trouble about that difference in evidence, because the Panel heard from Phillip Beed about what had been said about that. She does say (the daughter, Marilyn Jackson) that on the 20th her mother indicated to her that she was in pain. That indication was such that she went out of the room to summon a nurse and it appears the person she got hold of or the person who arrived was Phillip Beed and he said – this is her

account of it – something along the lines of, "We'll give her something." It appears that shortly after that, or some point after that, the diamorphine and the midazolam was administered, if Marilyn Jackson's account is right. What you had prescribed in relation to diamorphine three days before was 20 to 200 and midazolam 20 to 80. If it is right that it is Phillip Beed administering the diamorphine, he has not kept to the minimum dose. Are you able to say anything about that?

A I imagine that he would have contacted me before he put that syringe driver up at 13.50 that afternoon and said, "I have the situation, I wish to start at 30mg of diamorphine and 20mg of midazolam", and I would have agreed.

Q Why agree to 30mg when all that happened, if this is right, is that the patient has indicated she is in pain, why not say to Philip Beed, if we he had got in touch with you, "Start at 20mg". What would make anyone decide not to go to that dose?

A Because he felt 30mg would be more appropriate.

Q If that is what occurred, that he contacted you and said that was his view, would you have agreed with it or disagreed with it?

A I would have been happy to agree with that. His was the most recent clinical judgment at 13.50 that day, although I had seen her first thing in the morning and written up 20mg.

Q This is a patient in relation to whom you had already had formed the view that she might well reach that stage in any event?

A We had decided that.

Q On page 9 we can see what happens the following day in terms of the records. There is the entry made by you in the clinical notes:

> "Marked deterioration over last few days. Subcutaneous analgesia commenced yesterday. Family aware and happy."

No details are given as to what the marked deterioration was, but how would you describe it, particularly with regard to the last couple of days before this entry?

A Her whole demeanour would have changed. She would have become more withdrawn, quieter, not taking food or fluids, not wanting to move. The whole general picture of when I saw her that morning as compared with previous mornings on the ward, so it was just an overall general picture.

Q She had been deteriorating since the 17th, it would seem. Did it occur to you that the deterioration you observed on the 21st, or the state she was in on 21 August, might have something to do with the diamorphine and midazolam?

A Not at all, because the deterioration was already well underway and was proceeding, or I was hoping that the subcutaneous infusion would make the deterioration more comfortable for her.

Q We can see a note by Nurse Joice at 12.55 on the 21st:

> "Condition deteriorating during the morning. Daughters and granddaughters visited and stayed. Patient comfortable and pain free."

A We can that she remained on that dosage of diamorphine and midazolam during the day and she died at half past six that afternoon or early evening?
A Yes.

Q In relation to Marilyn Jackson, there is one thing I need to ask about. She indicated that your name was never mentioned and she had never met you, but at another point in her evidence she said you had walked onto the ward, ignored her and her two daughters, and had B said, "It will not be long now", and walked back out. Is that something, a picture, that you recognise or not?
A It was not an appropriate or caring thing to say to a patient in front of relatives, and I would be mortified if anybody had thought I had said that to a patient in front of relatives. It was not my custom to go into a room and make comments like that.

Q Do you remember whether you had any contact with her or the daughters?
C A I cannot.

MR LANGDALE: That is all I was going to ask about that particular patient. Perhaps this would be a sensible time to break. May I mention one thing? There is a matter where Mr Kark and I do not agree about a witness who is going to be called, or may not be called if my learned friend is right. It is a witness who will have to be called, her availability being only Monday, it would have to be on Monday. It is not a long witness, but it does mean that D the Panel and your Legal Assessor will have to hear some argument about whether this witness is going to be called or not.

It is difficult to know how long these things take. I do not think it will take an enormous amount of time, the issue is quite a narrow one. It may be sensible for the Panel to consider, once we have had the break, whether it would be better to hear the legal argument at about quarter to four and then the Panel will be able to decide whether they need to take any great E length of time, having considered whatever advice is needed. It will give you some leeway if it turned out to be a knotty problem, which I do not think it will, so that if you needed further time you can consider it tomorrow morning.

THE CHAIRMAN: Why do we not take the break now, and on our return we can hear the issue and we can take it from there.

F MR LANGDALE: With respect, that seems entirely sensible.

THE CHAIRMAN: We will rise now and return at half past three.

(The Panel adjourned for a short time)

THE CHAIRMAN: Mr Jenkins?

G

MR JENKINS: I am dealing with this point which concerns a nurse trainer called Betty Woodland. She is a witness that we hope to call on Monday. She has worked as the Royal College nursing representative and has given support to a number of the nurses who have given evidence before you and also at the inquest that took place in March and April this year.

H THE CHAIRMAN: Was that the lady that was sitting at the back throughout a large number?

MR JENKINS: That is absolutely right. She was sitting at the back as a supporter of nurses who have been called to give evidence. We were entirely content for that to happen. Although we had a statement from Betty Woodland, we were not anticipating calling her as a witness. She has given us further information after the witness Shirley Hallmann gave evidence, evidence about various matters but including the proposition that she, Shirley Hallmann, discussed her concerns about the use of diamorphine with Betty Woodland. Betty Woodland has something to say on that issue as to what was said to her, if anything, by Shirley Hallmann about that.

We would like to call Betty Woodland to deal with that issue essentially, although she is able as a witness to give evidence about various other matters. She can talk about any concerns in 1991 because she was there at the time and the importance of them and how they were dealt with. She can deal with Dr Barton as a doctor about her skills and her character.

Had it just been those issues, we would not have sought to call her but, because matters have been raised by Shirley Hallmann which are significant and may be important for the Panel, we would like to call Betty Woodland on this issue. She does not deal with any of the twelve clinical cases with which the Panel are concerned, so her hearing evidence from other nurses is not going to affect any evidence she might give to you. In any event, she was present for, I think, nearly all the evidence at the inquest which covered a number of the patients and most of the patients that you are considering.

Sir, you will know as a lawyer that anyone who is going to give evidence at an inquest is entitled to sit in at all stages, so Betty Woodland was perfectly entitled to sit in and listen to every word of evidence whether or not she was to be a witness there or here. I would hope that the fact that she has heard some evidence and has sat in during some of this hearing would mean that her evidence is not affected in any way. She is relevant, we would say, certainly on the question of Shirley Hallmann, any concerns that Shirley Hallmann had and whether she, Shirley Hallmann, raised concerns to others and whether Shirley Hallmann raised concerns about the use of syringe drivers and diamorphine at a time when she was making that complaint. I think you had the document, you recall Shirley Hallmann being cross-examined about it, she made a written complaint to Sister Hamblin, and to a lesser extent Dr Barton, about the way which she was treated as a nurse.

In broad terms we would like to call her. She has heard some evidence and it would not be usual for a witness to be called who has heard some evidence in a hearing. I hope that would make no difference at all. It should not affect the nature of the evidence that she is going to give. She was here for some of the day that Shirley Hallmann gave evidence, but our understanding is that she was not here when Shirley Hallmann was asked about her letter of complaint. Even if she was, I do not think it would affect her evidence one way or another. We have clearly gone back to Betty Woodland to out what her recollection is of discussions she had with Shirley Hallmann.

The rules that govern that evidence at this hearing are obviously the 1988 rules. I think we have looked at them already in this hearing. It is rule 50 with which deals with evidence and you will know that the Panel can receive oral, documentary or other evidence of any fact or matter which appears to them relevant to the inquiry into the case before them.

There a proviso, a caveat, to that, and it is that:

A

> "Where any fact or matter is tendered as evidence which would not be admissible as such if the proceedings were criminal proceedings in England, the Committee shall not receive it unless, after consultation with the legal assessor, they are satisfied that their duty of making due inquiry into the case before them makes its reception desirable."

B I do not address you whether it is or would be admissible in the UK, the real test is whether its admission is desirable and we suggest it is. It is an important matter which goes to the extent of the credibility of Shirley Hallmann. She is the nurse and the only one who has suggested that she had concerns about the use of syringe drivers and diamorphine during the time with which you are concerned.

C We know the history of 1991 and you have heard a number of witnesses saying whether those concerns were still live in the mid-1990s and thereafter. Shirley Hallmann is the only one who talks about the period with which you are concerned and this is evidence which she undermines. Therefore, we say it is important and for that reason it is desirable that you should hear what Betty Woodland has to say it. That is the application and the basis upon which it is made.

D THE CHAIRMAN: Thank you, Mr Jenkins. Before we hear from Mr Kark, I wonder if we should allow the doctor to return to her customary seat on the defence bench. It seems unfair to keep her isolated. (Witness left witness stand)

E MR KARK: Before I respond, I want to be clear about the ambit of the evidence that is being sought by the witness because my learned friend has raised essentially three areas: the first is general evidence about Dr Barton's skill and character, which is plainly material that the defence would have been be aware this witness could speak about when she was sitting in the public gallery; secondly, what she, Betty Woodland knew of the issues in 1991 when, as we know, they were raised; and, thirdly, the Hallmann grievance, as perhaps I could call it, in 2000. Is it being proposed that she should be called to give evidence about all three of those issues, two of them or just one of them?

F MR JENKINS: If she is to be called, I will deal with all the issues that she has raised. I think it would be fair to her, but the decision to call her is based upon one of those. I should add, I know Betty Woodland can say a little more about Shirley Hallmann and other concerns that have been expressed either by her or about her.

G MR KARK: I do not follow the logic of "it would be fair to her". What you are concerned with is whether you ought to receive this evidence in the case of Dr Barton. First, about Betty Woodland. As I understand it, she has been representing the nurses, not only the nurses who have been called to give evidence before you, but the very large number of nurses who have previously been interviewed by the various parties, the police at various inquiries and the GMC. We know that she sat during the coroner's inquest and you are all aware that she was sitting at the back of the room – I think she was the lady who sat with Mr Barton – throughout the evidence of the nurses, perhaps missing out Shirley Hallmann in the afternoon, I am not sure. I accept that from my learned friends if they say so. The application that is being made is in fact under rule 50(5) which reads:

H

A

> "Without leave of the Committee no person shall be called as a witness by either party in proceedings before the Professional Conduct Committee unless he has been excluded from the proceedings until he is called to give evidence."

The rule is automatically engaged. Whether we object to the evidence or not, it is an issue you have to consider.

B

The first matter I would respectfully suggest that you ought to consider is how important is the evidence that the defence are seeking to lead. Within that, you will have to consider what is the ambit of the evidence because you would be entitled to admit part of the evidence and not other parts. If you feel part of the evidence is important for you to hear but the other parts are less than important or potentially contaminated, you would be entitled to say, "We will hear A and B but not C", or however you want to put it. You need to look at the danger of contamination which affects its weight, and you need to look, in my submission, at the

C

specific issue which has given rise to the reason why the defence say they now want to call Betty Woodland when they did not before. That, as I understand it, is essentially simply in relation to the 2000 grievance that Nurse Hallmann had.

You may take the view, although it is a matter for you, that when trying to see the woods through the trees in this case, that is a relatively minor issue, if not a very minor issue. It is a complaint made in 2000. You have D1 in your bundles. Nurse Hallmann spoke about that.

D

So far as Betty Woodland is concerned, what she actually said about it when she was cross-examined by Mr Langdale on Day 13/at page 81, was:

> "...this was a very general letter that Betty Woodland, my Union representative, helped me to write because I went to her with my concerns and she advised me to make a grievance, which I did, and she sat down with me and helped me to compose this letter."

E

She said:

> "This was a very informal letter to put the grievance in."

She said on page 82 of Day 13:

F

> "...two people knew about what was going one. One was Barbara Robinson, the hospital manager, and when I went down and saw Betty Woodland about this complaint, she said to me that it was already in hand and that a complaint was ongoing but I obviously was not privy to it and I had no knowledge of what it was. When she helped me write this, she did not advise me to put it in about the syringe drivers, but I had expressed to her my concern about them."

G

That is it. You will have to consider whether, in all the circumstances, it is necessary for you to hear further evidence about that, weighing up the fact that the witness has had the advantage of listening to all the nurses in the case. I am not going to spend any more time on it. It is right that it should be flagged up for your attention. It is entirely a matter for you whether this evidence is so important that you should give leave to call it in spite of the breach of the rules.

H

THE CHAIRMAN: Thank you. We will hear from the Legal Assessor.

THE LEGAL ASSESSOR: I advise as follows. Although, of course, the Panel technically has look at rule 50(5) first of all, it might be helpful for the Panel to look at that last when it has come to some conclusions about the desirability of hearing the evidence.

I already advised as to rule 50(5) on Day 1 of the hearing on page 4 but then, as the Panel will recall, we were looking at it from a different angle. The Panel was looking at if from the question of whether somebody who was a witness should be allowed to sit in. Now the Panel is looking at whether somebody who has sat in should be permitted to be a witness.

I gave some advice, but it is not totally applicable to the present situation because of the changed facts. I would advise the Panel that a sensible test for them to apply and consider would be whether they are satisfied that their duty of making due inquiry into the case makes the reception of the witness desirable. The Panel can properly bear in mind that the witness has already heard some evidence in any event and the issues of cross-examination might be dealt with properly in cross-examination. I would suggest that the Panel applies that test later on.

So far as the other matter is concerned, as I understand the position, there are, perhaps, four areas as to which the defence are seeking to call Betty Woodland: first, as to general character and the skills of Dr Barton. Secondly, as to what she knew of the 1991 issue, if I may call it that.

Thirdly, a conversation dealing with Betty Woodland, and that appears, I think, in transcript Day 13, pages 65 and 81. I would invite the Panel to look at those in due course.

Fourthly, as I understand it, Mr Jenkins had also wished to call Betty Woodland to deal with some other peripheral issues concerning Nurse Hallmann. I am not quite certain what they are, whether they would amount in some way to a challenge to her credibility, or a challenge to her skills as a nurse – I know not. However, if one looks at page 85 of the transcript on Day 13, as I understand it, the third area in which Mr Jenkins would wish to call Betty Woodland is this. I will just find page 81, in fact.

MR JENKINS: The pagination often differs between the hard copy and the computer version.

THE LEGAL ASSESSOR: I think I am at page 82. I hope I am. The passage I have is this. Mrs Hallmann was asked:

> "Q … What I am asking you to clarify is, why not put in one extra sentence, 'I am also being harassed...', or whatever the right word was … if that was really part of your complaint?"

I hope the Panel has found that reference. The reply was:

> "A It was and two people knew about what was going one. One was Barbara Robinson, the hospital manager, and when I went down and saw Betty Woodland about this complaint, she said to me that it was already in hand and that a complaint was ongoing but I obviously was not privy to it and I had no knowledge of what it

A

> was. When she helped me write this, she did not advise me to put it in about the syringe drivers, but I had expressed to her my concern about them."

If one concentrates on that last sentence, one could perhaps say it is ambiguous as to what was said by Betty Woodland about the syringe drivers, but it is unambiguous that Nurse Hallmann is saying that she had expressed to Betty Woodland her concern about the syringe drivers. She is quite clear about that.

B

As I understand it, that area of the evidence which I have just read out is one important matter – perhaps the main matter – upon which Mr Jenkins would like to call Betty Woodland to give evidence. Mr Jenkins has described it as an issue of Mrs Hallmann's credibility or credit but that, of course, is a matter for the Panel to consider.

There is some guidance in *Archbold* which says at paragraph 8-146:

C

> "Generally evidence is not admissible to contradict answers given on cross-examination as to credit – i.e. the answer cannot be impeached by the other party calling witnesses to contradict a witness on collateral matters: ... One test was formulated by Pollock C.B. ... 'If the answer of a witness is a matter which you would be allowed on your own part to prove in evidence – if it had such a connection with the issues, that you would be allowed to give it in evidence – then it is a matter on which you may contradict him.' The question whether evidence is relevant to an issue in the case or truly collateral being one for the judge, the Court of Appeal will only interfere where his decision was plainly wrong."

D

So generally, evidence is not admissible to contradict answers given on cross-examination as to credit.

E

The position here, of course, is this: the Panel may think that if Nurse Hallmann is to be asked about that specific conversation with Betty Woodland I have referred to, yes, in a sense it does go to Nurse Hallmann's credit, but it is also as to a specific issue in the case, namely the use of syringe drivers at that time, and the view that people had as to the use of those syringe drivers.

F

My advice to the Panel is this. The Panel has to consider whether the evidence called by Mr Jenkins, or proposed to be called by Mr Jenkins, from Betty Woodland is collateral, whether it is relevant to an important issue in the case or whether it is clearly irrelevant and going purely as to a matter of credit.

Clearly the evidence about character and skill is something which, I think it is conceded, is something which could be called in any event, subject to the issue of Betty Woodland having already sat in in the case. Certainly the 1991 issues have been raised in the case at some length by both parties.

G

So far as the conversation with Betty Woodland is concerned about the syringe drivers, and expressing concern as to them, as I said it is a matter for the Panel, but the Panel may think that that does go to an issue in the case. Perhaps I may illustrate the situation. If the defence were wishing to call evidence about the behaviour of a GMC witness in completely different circumstances, if they wanted to allege that she behaved in a disreputable way socially, or something like that, the Panel I am sure would have no difficulties in concluding that that was

H

A a purely collateral matter. But here the issues raised are issues which the Panel may think, at least potentially, go to the heart of the case.

As far as the other matter, the last matter referred to by Mr Jenkins, is concerned the Panel may not be clear as to what that in fact involves, other issues surrounding Nurse Hallmann. The Panel might take the view that if the defence were seeking to call Betty Woodland to give evidence about Nurse Hallmann's behaviour on other occasions or her general
B reputation, or something like that, the Panel might well take the view that it is a collateral matter that purely goes to the credit of Nurse Hallmann and does not deal with the real issues in the case.

May I try to bring matters together? What I advise is that the Panel consider whether these four areas which have been raised by Mr Jenkins are collateral areas, or whether they are areas which properly go to real issues in the case. If the Panel is of the view that they do,
C then that will assist the Panel in coming to a conclusion under Rule 50(5). If, of course, the Panel decide that the evidence which Mr Jenkins seeks to call is collateral and does not really relate to any issues in the case, then the Panel may come to another conclusion under Rule 50(5).

That is the advice that I give to the Panel. I do not know, Mr Chairman, you might like the parties to comment if they would like to do so.

D

THE CHAIRMAN: Yes, it is my invariable practice to ask if there are comments on the advice.

MR JENKINS: Sir, I have no comments on the advice but can I help on the facts. As to the fourth issue, I have been vague, and deliberately so. Can I be a little less so. Betty Woodland was asked to adjudicate on a complaint made by Shirley Hallmann about another
E member of staff in a different setting at Jubilee House. Betty Woodland did investigate the complaint and ----

MR KARK: I am sure my learned friend is not about to reveal ---

MR JENKINS: I am not going to let the cat out of the bag, but I am going to point to the bag. Betty Woodland was asked to adjudicate and consider whether there was a sound basis.

F

THE CHAIRMAN: We have seen the bag. It is in sight. Thank you.

MR JENKINS: I am going to leave it there.

THE CHAIRMAN: Thank you.

G MR JENKINS: That, I hope, is a little more detail on the fourth matter.

THE CHAIRMAN: Yes. I think what I would like to do is to ask strangers to withdraw and I want to have a preliminary discussion with members of the Panel. It may be that we will ask you to come back swiftly, or it may be that we will not do so. Either way, you will hear something from us within a few minutes, but there is a preliminary issue in there I need to discuss.

H

STRANGERS, ON DIRECTION FROM THE CHAIR, WITHDREW, AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Welcome back, everyone. Mr Kark and Mr Jenkins, the Panel have disposed of the preliminary issue that I was concerned about, and need say no more about that. It goes no further.

We have considered how we are going to proceed. We are going to be taking some time in terms of some of the transcripts that are going to be required. As a consequence, we will not be in a position to give you a determination, which will be written, until tomorrow morning. I would hope that it will not be long into the day, but I would say not before ten o'clock. If we are ready at ten, that will be great; if not, it will be as soon thereafter as we possibly can.

We will formally go back into camera and tomorrow morning the Panel will deliver its determination. Thank you.

STRANGERS, ON DIRECTION FROM THE CHAIR, WITHDREW, AND THE PANEL CONTINUED TO DELIBERATE IN CAMERA

(Parties were released until Friday 17 July 2009 at 10.00 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 17 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-SEVEN)

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 am sorry if I should have given you a later start time than I did yesterday. I also find it very hard to gauge how long a Panel is really going to take, but we are there now.

DECISION

THE CHAIRMAN: Mr Jenkins, the Panel has considered your application to adduce evidence on behalf of Dr Barton which relates principally to the credibility of an earlier witness called by the GMC, Mrs Shirley Hallmann. You stated that "She is the nurse and the only one who has suggested that she had concerns about the use of syringe drivers and diamorphine during the time with which you are concerned."

You seek to bring contradictory evidence before the Panel in the form of testimony from Ms Betty Woodland, the nurse representative, who has been present in the public gallery for a large number of days of this hearing. In addition, you also propose to adduce evidence from Ms Woodland as to the general character and skills of Dr Barton, what Ms Woodland knew of the 1991 debate over the use of opiates, and finally evidence concerning unrelated dealings Ms Woodland had with Nurse Hallmann and which you say would go to Nurse Hallmann's credibility.

The Panel has in mind Rule 50(5) of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 which states:

> "Without leave of the Committee no person (other than a party to the proceedings) shall be called as a witness by either party in proceedings before the Professional Conduct Committee unless he has been excluded from the proceedings until he is called to give evidence".

The Panel has had regard to the evidence of Nurse Hallmann in relation to her claimed concern over the use of opiates, in particular the use of syringe drivers. The Panel has also had regard to exhibit D3, 'Notes of the meeting between Dr Jane Barton and Rosemary Salmond, Investigating Officer, on Friday 7 April' and to Dr Barton's own evidence in chief.

The Panel notes that this additional evidence is corroborative of Nurse Hallmann's testimony as to her concern over the use of opiates at the time in question.

Accordingly, it appears to the Panel that this is a settled issue. In the circumstances, the Panel does not find that it would be helped by hearing from Ms Woodland as to what issues had or had not been discussed by her and Nurse Hallmann when preparing the harassment complaint and the Panel does not find that the reception of such evidence is desirable in the face of Rule 50(5).

So far as the other matters of evidence which you wished to adduce are concerned, the Panel has considered whether those are collateral to the real issues of the case or whether they have an importance which would make it desirable to admit them at this stage regardless of Rule 50(5).

So far as testimony to the general skills and character of Dr Barton are concerned, the Panel has already received considerable evidence and may well hear more from other witnesses who have not been present during the proceedings. The significance of this evidence is not such as to make it desirable for the Panel to receive it regardless of Rule 50(5).

Similarly, the Panel has received a great deal of evidence, both oral and written, as to the circumstances of the 1991 debate. The recollection of Ms Woodland is not something which the Panel feel would be likely to add to its understanding of the matter. It follows that the Panel does not take the view that such evidence is of sufficient significance to make its reception desirable in the face of Rule 50(5).

Finally, you alluded to testimony connected with an unrelated collateral matter which it is said would reflect on the credibility of Nurse Hallmann. The Panel sees no value in receiving this testimony since Nurse Hallmann's evidence on the subject of opiate concerns is already corroborated by other evidence.

In all the circumstances, this application is denied.

MR LANGDALE: Sir, we will continue with the evidence of Dr Barton.

JANE ANN BARTON, Recalled
Examined by MR LANGDALE, Continued

MR LANGDALE: Dr Barton, we had reached the stage where I was going to ask you questions about Patient E, Gladys Richards, so can we turn to that now, please? In respect of this patient you made a statement, which the Panel have, and this you told us was the first statement that you made with regard to any of these patients in relation to the police inquiries?
A It was.

Q Once again I am going to use the chronology as the platform for my asking you questions about these matters. Patient E, Gladys Richards, looking at the chronology on page 1, we start there with 4 February 1998, assessed by Dr Banks – "severe dementia" and so on. And, as we know, that entry of hers indicated:

> "End stage illness; not surprising considerable periods of sleep. Obviously needs some help to relieve the distress she experiences when awake."

Perhaps I can ask you this: in terms of drowsiness or being sleepy, is that something which you experienced or encountered in cases where patients were demented?
A It was often part of the picture that patients presented but when they were awake they might well be quite distressed and agitated; so they would show both aspects of the picture.

Q Then on page 2, the fall which occasioned her going into the Royal Hospital Haslar and we do not need to go over the detail of that again. And we can pick up on page 4, on 3 August, whilst she was still there, she was reviewed by Dr Reid:

> "Should be given opportunity to try to re-mobilise. Will arrange transfer to GWMH."

And Dr Reid told the Panel in his evidence that he felt her prospects for re-mobilising were not good.

On to page 5, this is an instance where the referral letter seemed to be – when she arrived at GWMH and transferred to Daedalus Ward – rather over-optimistic.
A Yes.

Q Claiming:

> "Now fully weight bearing, walking with the aid of two nurses and a Zimmer frame."

And so on. When she got to the hospital in Gosport, to go into Daedalus Ward, obviously, as we can see, you reviewed her:

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

And we know if we look over the page that on that day – that is the day of admission, 11 August – you prescribed Oramorph, which was administered that day at quarter past two in the afternoon, and I think that everybody is agreed that the 11.45 is actually 11.45 p.m. And

A you also anticipatorily prescribed diamorphine, hyoscine, midazolam. Some haloperidol was prescribed and administered that day and also Lactulose was prescribed and administered that day. There is a lady that you have recorded as being not obviously in pain and "transfers with hoist". First of all this, in terms of the mechanical side, "transfers with hoist" would signify what?
A Quite dependent; unable to shift herself to the side of the bed even with the help of two, so needed a mechanical aid to put a sling under her body to move her across to get her
B on to a bedpan or off the bed and into a chair.

Q So that is something that would have been apparent to the nursing staff before you examined her; is that right? Is that how we picture it?
A Yes.

Q We do not know precisely how long after she arrived that you actually saw her, but
C that would appear to be consistent with that picture?
A Certainly.

Q Dealing with this particular case why did you put in this case "happy for nursing staff to confirm death"?
A That was a routine entry I made into the notes of patients who might at some time in the future die on the ward. It meant that should a patient die out of hours the nursing staff
D who had not got a certificate for confirming death did not have to bring in an out of hours duty doctor to confirm death, so that the body could be moved off the ward and down to the mortuary. Leaving the body on the ward was distressing for other patients and for the staff and it was a kindness for someone to be able to confirm the death and the body to be moved down to the mortuary.

Q Professor Ford I think in relation to that said that he did not think that the nursing staff
E note was inappropriate in those terms.
A It did not signify that at that time I felt that she was close to death; it was a fairly routine entry in the notes.

Q What Professor Ford said in his evidence was to this effect. He said he would have expected to see a plan with regard to mobility.
A Yes, I could have written "gentle mobilisation". Really the point was that we needed
F to get to know this lady to see whether over the few days she was going to get back to the level of mobility that Haslar had claimed for her or whether we were seeing a more honest picture when we looked at the lady in the bed on Daedalus Ward. So it was not really quite time yet for a proper plan.

Q You prescribed Oramorph to a patient who you described as not obviously in pain and we know that the Oramorph was administered 10 milligrams possibly not that long after you
G had seen on her admission, if this was a lunchtime admission, as it were, and a further 10 milligrams later on that evening. I would like you to deal with this: why prescribe Oramorph and it is administered soon after with a patient who is not obviously in pain?
A The snapshot view that I gained of that patient when I examined her on the bed that afternoon was that she was not obviously in pain; but I knew perfectly well that she had just had a transfer from another hospital, she had not long had fairly major surgery and she was very frail anyway. She was going to be very uncomfortable for the first few days and I was
H minded to make available to the nurses a small dose of oral opiate in order to make her

A comfortable during that time – not to be administered regularly but at their discretion if they felt she needed it.

Q You indicate a small dose. The dose range was 5 to 10 milligrams.
A Yes.

Q In a case like this, when 10 milligrams are administered by the nursing staff at quarter
B past two in the afternoon and indeed in the evening that would be within their discretion, as it were?
A Totally.

Q What sort of judgment would you be expecting the nursing staff to make as to how much of the Oramorph you prescribed should be administered? In other words, what is going to make them start at 10 as opposed to 5?
C A The level of discomfort that they encountered when seeing to her, putting her on the commode, getting her back into bed, looking at her bottom, all of the general nursing duties that they would have had to do when she first arrived on the ward.

Q And the Oramorph would last for about four hours, I think you said.
A Four to six hours.

D Q Something like that, so four hours after the administration at quarter past two takes us to quarter past six in the evening, and maybe a little bit later; and what would you expect to have happened in terms of the administration later on that evening? That she would have been monitored?
A She would have been very carefully monitored; she would have been given her supper, she would have been made ready for bed. Presumably at that time she was sufficiently comfortable that they did not feel they needed to give another dose of opiate but
E it was there available to them if they felt clinically it was needed.

Q I would like to ask you about the anticipatory part of the prescription, the diamorphine and midazolam in particular. Why write out that prescription on that day with this patient?
A Because I felt that this lady – her outlook on the background of her very severe dementia and this fool and the major surgery, that her general outlook was poor. She was quite possibly going to need end of life care sooner rather than later.
F

Q Here we have the dose range of 20 to 200 and midazolam 20 to 80; did that fall within the usual bracket that you envisaged for cases of this kind?
A It did.

Q We have already dealt with the question of the dose range generally speaking and I am not going to go over that again. In general terms if it was the case that the post-
G operative analgesia was inadequate or had been inadequate, was that something which would occasion you any surprise or not? If at the hospital the post-operative analgesia had been inadequate?
A I regret that often post-operative analgesia appeared inadequate.

Q And with a lady of this age and this sort of condition, having had an operation of such a type, would you expect pain post-operatively, as it were, to continue for a period of time?
H A I would.

A Q What sort of period of time?
A I would certainly expect her to have still been in pain when she was transferred across to me.

Q At the top of that page, with regard to the prescription we have just been looking at, we can see the assessment by nursing staff:

B "No apparent understanding of her circumstances due to impaired mental condition. Barthel 3. Waterlow score 27."

Waterlow score of 27 is?
A High. Her skin was at risk of breaking down.

Q Moving on to the following day, the 12th, which was a Wednesday:

C "Reviewed by the nursing team.
Requires assistance to settle and sleep at night."

What does that mean, "Requires assistance to settle and sleep", is that talking about analgesia or what?
A She had had analgesia. They were hoping that that would help her sleep. She was
D probably not very comfortable on the bed and she was probably very anxious being in a strange ward with nursing staff who she was not familiar with, so it was a combination with unfamiliar circumstances and probably pain as well.

Q "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."

E Would that be an indication that the Oramorph had been appropriate or not?
A Yet, 15 minutes later it looks as if they administered the Oramorph, so they must have initially at 23.30 ---

Q It depends when that note was made. It is apparently made on the 12th, but quite on the basis of what information by the author of the note we are not sure. You can see that Oramorph was administered at 6.15 in the morning and on that day you also prescribed 5mg
F four times daily and 10mg at night PRN?
A Yes.

Q That would be a total of 30mg, but as we all know the Oramorph which was administered at 6.15 in the morning was the last administration at that time?
A Yes.

G Q Again, that would be the nursing staff deciding that in fact she did not need any further Oramorph after that administration?
A Yes.

Q It would further confirm that she had seen that patient that morning apparently on your usual morning visit?
A Yes.

H

A Q On Thursday, the following day, Thursday 13th, she had the accident where she had fallen off a chair or something of that kind and was found on the floor at half past one in the afternoon. There is a note by Philip Beed:

> "Found on floor at 13.30. No injury apparent on checking. Hoisted into safer hair. Pain right hip."

B It appears, Dr Barton, that you were not available because Dr Briggs was contacted and he advised an X-ray and analgesia?
A Yes. From my recollection he did not advise – he was not contacted until out of working hours. I would not have been around at 1.30 in the afternoon on the Thursday afternoon, I would have been doing an antenatal clinic. After that I would have gone home, but I think Dr Brigg was contacted early evening by which time our little X-ray department was closed and the X-ray was going to have to wait until the following morning.

C Q Perhaps we can pick up what is said about the drug charts on page 8 relating still to the Thursday. The nursing staff gave her 10mg of Oramorph, haloperidol was also administered and it records that you also prescribed:

> "0.5ml/1mg 'if noisy' (in the regular prescription section, crossed out with 'PRN' written in)."

D Would that mean you would have been present at some stage on that day, or is it open to question?
A I would have been present at some time that day, but it would have been in the morning not later on in the day.

Q So that prescription in relation to her haloperidol ---
E A Was before the accident.

Q --- was in the morning?
A Yes.

Q You did not play any part in what happened in terms of her treatment after the fall it seems. The nursing staff and Dr Brigg were involved, and the following day, the following
F morning, when you came in in the normal way, obviously you saw the patient as we can see from the chronology?
A Yes.

Q You noted down:

> "Sedation/pain relief a problem. Screaming not controlled by haloperidol but very
G sensitive to Oramorph. Fell out of chair. Right hip shortened. X-ray. Is this lady well enough for another surgical procedure?
>
> Later note:
>
> Appears to have dislocated right hip. Referred for relocation."

H

There is no criticism by Professor Ford in relation to this. Clearly, she is in a lot of pain, he said, at this stage and analgesia was justified, but why was it you put "very sensitive to Oramorph" because this lady had been on Oramorph, on your prescription, on the day that she arrived, Tuesday 11th, on Wednesday morning, not on Thursday before the fall and on Oramorph after the fall. What was it that caused you to say, "very sensitive to Oramorph"?
A I was aware of two things. There was a mention in the Haslar notes to a sensitivity to morphine, if not Oramorph, and it was one of the things that was mentioned by her daughters. They felt she was sensitive to Oramorph, so I made a note of that in the clinical notes.

Q This would come after you had initially prescribed Oramorph, this information?
A Yes.

Q There is no criticism made of your consideration of the question, "Is this lady well enough for another surgical procedure?" Then your later note relating to, "Appears to have dislocated right hip", in what circumstances would that have happened, a further note made in the same morning or later on in the day or what?
A Certainly later on that morning. I would have come back to contact the hospital having looked at the X-ray and written a referral letter and gone back to Haslar.

Q The X-ray would have been taken where?
A At the Gosport War Memorial, the first thing that morning, I think it was a Thursday morning.

Q It was a Friday, this particular day?
A Friday morning.

Q When would you have seen the X-ray?
A That morning.

Q Why was it that you would have seen the X-ray and it had been taken that quickly, if I can put it in that way?
A Because one of the nurses would have gone down and said, "Please, we need this X-ray doing urgently, we have a patient with a possible dislocation", and they would have very kindly done it for us straight away, the radiographer would have done it straight away.

Q How would it come about that you would know that the X-ray had been taken and be in a position to look at it, would somebody contact you?
A They would probably have contacted me at the surgery and say it has been done, but I would have been sufficiently concerned about this lady that I would have come back anyway.

Q We can see the X-ray report at the bottom of that particular page. Over the page, still on the same day, Friday 14th, we see that that you saw a daughter of this lady, "Informed of situation", so you your updating the relative about what was happening about transfer and so on.

"Letter from Philip Beed to Haslar A&E."

He points out what the position is and records the fact that Oramorph was given that morning:

A "Happy to take her back following reduction of dislocation."

We can see what the drug chart shows with regard to the administration of Oramorph and there is no criticism made of that. "Readmitted to Haslar for relocation". It gives the details of what was done.

B "Given splint to discourage further dislocation. Can however mobilise, fully weight bearing."

What is your view as to that, bearing in mind you saw her on the Monday when she was transferred back?
A My understanding of that note was that the surgeons at Haslar felt that it would not compromise the procedure they had done to the hip if she was fully weight bearing on it. I was not of the understanding that she was fully weight bearing, but if we were able to do it
C she could, it would not harm the prosthesis.

Q Over the page, page 10, would you bear in mind the reference to what drugs she was given at Haslar. There were the 2mg of midazolam in connection with the sedation required for the procedure and so on. We have heard evidence about that, and at Haslar they wrote up Oramorph, but it was not given. Co-codamol was actually given there. "Transferred back on Monday 17th". It appears that this would be a lunch time transfer in terms of your arrival and
D review?
A Yes.

Q Reviewed by you. Apparently, it would seem that you did have the information from Haslar to take on board what had happened. Is that right?
A Yes.

E Q "Closed reduction under IV sedation. Remained unresponsive for some hours".

You would only know that from the hospital?
A Yes, I understood that she was unconscious for most of the day following a single dose of midazolam intravenously which led me to think that perhaps she had not responded well to the anaesthetic.

F Q If you realised that she had remained unresponsive for some hours, and knew that there had been an administration of 2mg of midazolam intravenously, did you not say to yourself, "I do not think prescribing midazolam is going to be a good idea for this lady"?
A I did not think the two forms of administration of the drug were comparable.

Q Would you explain that a bit more please?
A An intravenous bolus of midazolam in order to induce anaesthesia and pain relief to
G have a procedure done, is a completely different matter from a slow subcutaneous infusion through a syringe driver for terminal restlessness, agitation, anguish and anxiety.

Q "Only give Oramorph if in severe pain". No criticism is made of that, but I am wondering why you said it. What caused you to say, "Only give Oramorph if in severe pain"?
A This was because of the perception of the daughters that they did not want her given
H overly amounts of analgesia or sedation.

Q At this time it is apparent you were seeing, I think there were two daughters present at the hospital, maybe not both of them together at the same time every time, but you were seeing them every time you paid a visit to the hospital?
A Yes.

Q In general terms, we will come on to some later events, what was your manner towards them and their manner towards you in general?
A Polite.

Q Polite on both sides?
A Yes.

Q Did they at any time ever criticise you when they saw you?
A No.

Q Did they ever question, either of them actually question, what you were doing when they spoke to you?
A I think they were very concerned about what drug management their mother should be given.

Q Did you explain it to them when you spoke to them?
A Yes.

Q What was their reaction?
A They seemed content.

Q That is just dealing with you and you obviously cannot speak as to what was said between them and any of the nursing staff unless you were present. If we move on to page 11, we can see what the nursing staff had recorded for this same Monday, Monday 17th, the day that she is back at Gosport. Nurse Joice:

> "Patient very distressed, appears to be in pain. No canvas under patient."

This is the problem with the transfer by the particular ambulance crew it would seem. Nurse Couchman's evidence was that she had just had come back from a holiday break that day and she has recorded:

> "In pain and distress – agreed with daughter to give her Oramorph 2.5mg. Daughter reports surgeon to say she should not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an X-ray."

Is that what happened to the best of your recollection?
A Yes.

Q Because of this unfortunate transfer back carried out in the way it was, there was this further problem and this further cause of pain?
A Yes.

Q Hip X-ray and the situation was reported that it was in fact relocated and therefore there was not a dislocation. Is that right?

A A No further dislocation.

Q As far as the drugs that were administered, Oramorph 5mg administered three times during the day and 10mg administered at 20.30; haloperidol. May I ask you this: there is no criticism of the administration of those drugs by Professor Ford but why, when one had seen the remarks about sensitivity to Oramorph and so on, did you carry on giving Oramorph?
A Because it was the most appropriate and effective analgesia in this unfortunate lady
B who had undergone another surgical procedure and was in a lot of pain.

Q There is no criticism of the administration of that drug. I am going to move on to page 12, the 18th which was a Tuesday. You saw her again that morning.
A Yes.

Q "Still in great pain. Nursing a problem. I suggest subcutaneous
C diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable."

What was the significance of your writing in that particular review, "I suggest subcutaneous diamorphine" and so on?
A It was because at that point it was going through my mind that the lady was deteriorating. Pain relief was still proving to be an enormous problem and together with the
D pain relief, there was obviously a lot of restlessness and agitation. I needed to be able to control that with the use of midazolam and diamorphine, so I needed to be thinking about using a subcutaneous infusion and get the daughters on side, get the daughters' permission to do that for their mother.

Q If we look at the note that follows:

E "Philip Beed: 7 am: Reviewed by Dr Barton. For pain control on syringe driver. Beed: Later: Treatment discussed with both daughters. They agree to use of syringe driver to control pain and allow nursing care to be given. 20.00: Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs."

We can move on to look at the prescriptions that were written that day: Oramorph 10mg
F administered twice – that was an administration rather than a prescription – in the early hours; you then prescribe in relation to diamorphine 40-200 and 40 was administered at 11.45 in the morning after, obviously, your morning visit; midazolam was administered 20mg at 11.45, the same time; haloperidol, we can see what is there, also administered at 11.45.

There does not appear to be any record in the nursing notes or in your review about agitation. I will come back to the question. Why prescribe and have administered midazolam when
G only pain is recorded, I would like you to deal with that?
A It goes back to that entry on page 11, "Couchman: In pain and distress", and she remained in pain and distress.

Q The figure of 40 for the diamorphine as opposed to 20, why 40 as the minimum dose in this case?

H

A I calculated the number of doses of Oramorph she had had in the preceding 24 hours and the conversion for that should have been approximately 20mg, but her pain was not controlled so I was minded to increase it, hence 40mg.

Q So, in effect, if the figure with regard to the Oramorph was a total of 45 in the previous 24 hours - all right?
A Yes.

B

Q If you have done the half calculation, taking it down to 22.5, and the increase from the direct conversion of half the Oramorphine would have been, therefore, from 22.5, to be precise, up to 40?
A Yes.

Q Did that in any way seem to you to be an excessive starting dose?
C A It seemed a very appropriate starting dose for her symptoms.

Q If it had been appropriate to prescribe 20 as the starting dose, would there have been any difficulty or problem with your doing that if that was your view?
A Not at all.

Q Did you consider as to whether the administration of those two particular drugs – I am
D leaving out anything else for the purposes of these issues – did you consider that there was a risk with the administration of diamorphine and midazolam that there would be adverse effects which would outweigh the benefit to the patient of relieving her pain and her agitation?
A I considered that there were potential hazards and side effects to it but my overriding priority was to make her as pain free as possible.

E Q Then 19 August, the following day, diamorphine was administered at the same dosage and also midazolam, haloperidol also and hyoscine was added. Hyoscine we have covered more than once as to what the purpose of that was and
I do not think anybody is suggesting that was an improper medication to provide at that stage. In relation to this lady, having come back on the 17th, the Monday, Tuesday the 18th, we are now on Wednesday the 19th. At what point had she reached a terminal care stage, in your view?
F A Overnight on the Tuesday when she started to become bubbly and was probably developing bronchopneumonia.

Q One appreciates that these are not absolutely hard and fast lines, the line between palliative care and end of life care, but that would be a significant development, in your view?
A A significant downturn in her condition.

G Q Why not have some further examination of her hip, either on the 17th, the Monday, when she is brought back, or the 18th, the Tuesday, or the 19th, the Wednesday? Why not carry out some sort of examination of the hip and have some discussion with the orthopaedic team?
A She was not well enough to return to the acute orthopaedic ward. We knew she had a large haematoma, or bruise, around where the dislocation had been put back. I knew that nothing surgically could have been done for this condition and that it would just have to be
H allowed to heal in its own time, if her condition permitted and she remained well enough.

Q We can see that it is recorded in relation to the contact record that in the morning of the 19th, the Wednesday, she was comfortable, daughter was seen, she was unhappy with various aspects of care. Is that something that was ever brought to your attention, that either of the daughters was unhappy with aspects of her care?
A Yes.

Q What did you do when that was brought to your attention, if anything?
A There was very little that I could do. We had explained to the family what was going to be our course of action and what was going to be the likely outcome. There was nothing further - I did not feel that a transfer back to an acute unit at that point was in Mrs Richards' interests. She probably would not have even survived the journey back, so we had to continue on our route of palliative care, becoming terminal care.

Q I think the evidence of one of the daughters who gave evidence to the Panel, Lesley O'Brien, was that you at some stage told her that in your opinion it was not appropriate for a 92 year old to be transferred back to Haslar for a further procedure. Is that something that you remember saying or is it something that you think you may well have said or what?
A I think it is something I might well have said. It would accord with how I felt about her condition.

Q Did either of the daughters ever complain to you about any aspects of her care?
A No.

Q On page 14 of the chronology, the syringe driver administration of the subcutaneous analgesia and the haloperidol and the hyoscine continue. Right?
A Yes.

Q There is no note by you on 20 August, but would it be the case that you would have seen her on that day?
A Yes.

Q The 20th?
A Yes.

Q On an ordinary morning visit?
A Yes.

Q Would you have reviewed her case?
A Yes.

Q Nothing written by you but on the next day, which is Friday 21st, reviewed by Dr Barton. You wrote:

"Much more peaceful. Needs hyoscine for rattly chest."

A Yes.

Q Nurse Joice:

"Patient's overall condition deteriorating. Medication keeping her comfortable."

Then over the page the same subcutaneous analgesia being administered at the same rate and

so on, and she died that evening shortly after nine o'clock. Is there anything that you would seek to change, looking back at this case and, having heard the evidence of Professor Ford, is there anything else you would seek to change about your view and judgment as to how this lady was cared for by you as her doctor?
A Nothing.

Q There is no record of her being unrousable or in any particular situation as a result of the administration of the subcutaneous analgesia. Do you actually remember what the position was over the last two or three days? Was she rousable at all?
A I cannot remember.

MR LANGDALE: The next patient is patient ---

THE CHAIRMAN: Mr Langdale, we will take a short break there. Fifteen minutes, please.

MR LANGDALE: Yes.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everybody. Mr Langdale, before we hear from you again, an observation I would like to make, please, for our guests in the gallery. We are, as I have had occasion to say before, always delighted to have members of the public, press and others attending and watching the process in action, but the fact is, given where the public gallery is situated, the members there are facing directly into the hearing and if there is excessive movement, talking, gesturing, whatever, it can be extremely off-putting to the parties, the panellists and others that are in this part of the room. I am saying this now really for the record, it is not the first time I have said it and it may not be the last, but can we please ensure that movement and talking and other gestures are kept to the minimum. Thank you.

MR LANGDALE: I am afraid I must begin this session with an apology because we have to go back to the case of Gladys Richards. There is one matter that needs clarification which Mr Jenkins has brought to my attention and I would like to deal with it now.

I am sorry for going back to this patient. Patient E again and, Dr Barton, I am going to ask you to be looking at page 10 of the chronology, first of all. I also need Dr Barton and, indeed, the Panel if they would, please, to look at Dr Barton's statement with regard to this patient. Do you have a file with your statements in it to hand?
A Yes.

Q Looking to the statement with regard to Patient E, looking at the statement, first of all, I would ask everybody to go to paragraphs 21 and 22 in the statement and, bearing in mind that page 10 of the chronology shows the note made by you on review when she was transferred back from Haslar on Monday, the 17th, we can see in your statement you set out what it was had been said in your clinical notes:

> "Readmission to Daedalus from RHH. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Plan: Continue haloperidol. Only give Oramorph if in severe pain. See daughter again."

Then your statement goes on:

A

> "At the time of her arrival back on the ward Mrs Richards appeared peaceful and not in severe pain. This was however an initial judgment made on an assessment shortly after her arrival on the ward. I was concerned that she should have opiates only if her pain became a problem, and I altered her drug chart accordingly. I was not aware at that time that she had been having intravenous morphine at RHH until shortly before her transfer. This would have explained why at this time she appeared to be peaceful and not in pain."

B

We appreciate that you made that statement quite some time ago. We know from the records that we have looked at and which are set out on the chronology that, in fact, she was not given intravenous morphine at RHH, so that, clearly, is an error in your statement. All right?
A Yes.

C

Q In the light of that I need to try and piece together the history. When she was readmitted into Daedalus one of the daughters, as I recall it, I think it was Lesley O'Brien, was present and she was obviously in pain. This is what I have described as the "ham-fisted" transfer back, and we have heard the evidence of Nurse Couchman as to her coming on the scene at about half past one, or one o'clock, something like that, which is recorded over the page in the chronology at page 11:

> "13.05: In pain and distress - agreed with daughter to give her Oramorph ..."

D

It appears you were not present at the time she was readmitted, although her readmission was round about lunch-time, something like one o'clock or something of that kind. All right? I am just trying to piece together the history so we can make sure we have it right. So it would appear that when you saw her to review her, in terms of the clinical notes, she was at that time peaceful. Right?
A Yes.

E

Q Which must mean some time after her arrival and perhaps it is a situation which had been achieved as a result of the Oramorph she was given. Does that make sense? If you look at page 11, Nurse Couchman records:

> "1305: In pain and distress - agreed with daughter to give her Oramorph 2.5 mg. Daughter reports ... Dr Barton contacted and has ordered an X-ray."

F

Does it look then like you came in later to deal with the readmission?
A Yes.

Q By the time you saw her she appeared peaceful?
A The Oramorph had kicked in and she was more comfortable.

G

Q Yes. Then I wonder if we could just look, please, because it may help in piecing this together, in the file itself, the notes, at page 47. Page 47 in the nursing records, the medical notes, shows the contact record completed by Nurse Couchman, timed at 1305:

> "In pain and distress - agreed with daughter to give her mother Oramorph", and so on.

We can see the sequence:

H

A "Dr Barton contacted and has order an X-ray."

P.m. another nurse records:

"Hip X-rayed at 1545",

– seen by another doctor in your practice –

B "... For pain control overnight and review by Dr Barton in morning."

Does that seem to be the sequence of events?
A It seems to be the sequence of events.

Q Indeed, you did see her the following morning, as we have already looked at.
C A Yes.

Q As we know, the Oramorph had been stopped on the 14th, I think it was. I am sorry. It was last administered on the 13th.
A Then it was reinstituted.

Q Yes, and there had been the earlier cessation before the fall?
D A Yes.

Q That is all I am going to deal with there but I thought it right to clear up that particular part in your statement, which, obviously, was an error. Having dealt with that, may we move on, please, to Patient F. Patient F, Ruby Lake, another case where one had a fracture. If you look, please, at page 2 of the chronology, into Haslar following a fall at home and a fractured left neck of femur, and we have already looked at the history with regard to this patient more than once. Also, I am going just to call it heart problems, or heart concerns. All right? Then
E we can see the various notes covering quite a period of time in her case at Haslar, setting out the problems and so on. Then perhaps we can move on to page 9 of the chronology, where there was a referral on 13 August to Dr Lord, asking her to assess the lady. She was then, I think, 84 years old. Over the page we have Dr Lord's review which we heard from Dr Lord about yesterday, hemiarthroplasty on 5 August, and so on, ischemic heart disease:

"Overall she is frail and quite unwell at present";
F

Last sentence:

"Uncertain as to whether there will be a significant improvement."

As Dr Lord puts it, there were a number of medical concerns about her.

G "Unable to mobilise at present due to chest pain. Notes to physio in relation to the Haslar."

Then we can go on to the transfer to Dryad, which is shown on page 14 of the chronology. That transfer takes place on 18 August, that is a Tuesday. The review at Haslar describes her at the top of the page as:

H

A

"Well, comfortable and happy. Last pm spike temp, now 37.3. Mobilising well. GWMH today."

At 2 o'clock in the morning there is a note:

"Recommenced on oxygen therapy."

And so on. Then the transfer. The transfer letter describes her as:

B

"Has had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload, now resolved, it appears. Presently she is slowly mobile with Zimmer frame and supervision."

Last two or three lines:

C

"Usually lucid, only very occasionally seems confused at night. Hearing aid appears to have gone missing."

Then your review of her on that day, your notes record:

"Transfer to Dryad Ward continuing care."

D

And you set out the position and the previous medical history – CCF and so on:

"Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death."

Professor Ford indicated that she had had a very variable medical course and in his view, albeit he was not there at the time but looking back on it – she was not really fit for transfer.

E

When she came in and you reviewed her did you carry out your usual examination?

A I did.

Q Did the nursing staff carry out their usual tasks, checking blood pressure, pulse and so on?

A Yes.

F

Q What view did you form, bearing in mind the prescriptions that you wrote on that date at page 16, as to the picture with regard to this patient? You had of course put "get to know; gentle rehabilitation". And we know in relation to what was prescribed, either immediately or anticipatorily was Oramorph and 5 mgs were administered at 2.15 that afternoon – and certain other things I am not going to trouble you with, but other medications for other situations – and a proactive or anticipatory prescription for diamorphine, 20 to 200; midazolam 20 to 80. Professor Ford indicated that that was inappropriate in his view and

G

potentially hazardous and so on.

In that context – and I am sorry, that was rather a mouthful from me – what is the picture as you saw it and why are you prescribing those drugs either immediately or anticipatorily?

A My impression of this lady was that although her Barthel was 6, which would have meant that she was suitable for nursing home, this was not a medically stable lady; this was potentially and quite quickly a very unwell lady, and that was borne out in the message in

H

A Dr Lord's transfer letter. Although she had not had a temperature since the night before and she had not actually gone into congestive cardiac failure the night before she arrived she was quite likely to be going to do so fairly shortly.

Q What was the real problem? What was the worst of the problems, as you saw it, that she was facing?
A Not her repair to her hip, unfortunately, but her incipient congestive cardiac failure B and the likelihood that she would go downhill very quickly, again following a transfer on top of major surgery.

Q You said Dr Lord's transfer letter – to what were you referring there? The transfer letter on the day I do not think is Dr Lord.
A Had Dr Lord not seen her earlier on? We would try and mobilise her.

C Q This is the one on page 10.
A Yes, that her feeling was ---

Q If I can just interrupt, that is on 13th, the Thursday.
A "Uncertain as to whether there will be a significant improvement." And that would have been borne out by my examination of that lady when she arrived.

D Q That is what you are referring to?
A That is what I am referring to.

Q But it looks as if you would have seen the transfer letter as well, perhaps.
A Yes. "Slow recovery; bouts of angina, breathlessness. Confused at night."

Q What is the Oramorph for? Not in immediate pain.
E A Again like the previous patient, likely to be in some considerable pain when seen to by the nurses, so it was written up "prn" for their use if they felt that she was uncomfortable and distressed and they wanted to give her something for pain relief.

Q What about any possible with regard to opiates, whether Oramorph or otherwise in relation to a patient with these heart problems, as I am describing it?
A Likely to be of benefit rather than detriment to somebody with incipient congestive F cardiac failure.

Q Why not send her back or contact the hospital, Haslar, and say, "This lady should not be here; she should not have been transferred"? I would like you to deal with that suggestion if it is being made.
A It was not my place to turn down acceptance of a patient who had been accepted by my consultant into one of my beds. I was responsible for the day to day care of these patients G but I was not responsible for the politics behind why they came to me.

Q Can we just deal with that while we are on the point with regard to this particular patient in a more general way. What if a patient who you clerked in at Gosport had a problem which, in your view, needed some kind of medical intervention – a medical intervention that you could not provide at Gosport? Assuming that the patient was not so unwell in your view that they could not go back? I would like to ask you about what it was H that you could do and would do.

A A The majority of these patients, particularly this lady, came into the category that they were already too frail to go back and if they did go back there was nothing further that could be done for them.

Q I am trying to see in terms of what powers you had or what you actually could achieve, given the fact that the consultant had said, "This patient is to be admitted to Gosport"? Assuming it is a patient who is not too frail to be transferred back and your view B on admission is that there is a problem which needs a medical intervention – an acute intervention, whatever one properly describes it as – which you cannot provide at Gosport?
A It was open to me to contact the duty geriatric consultant or the consultant who had been responsible for the transfer of this patient and say, "I wish you to take them back."

Q So it is the consultant in effect, or the duty geriatrician who says, "This patient is to go back"?
C A Yes.

Q You cannot just send a patient back yourself?
A No. They were not my beds. I was responsible for the day to day care of them but the beds did not belong to me, and I would not under normal circumstances have arranged a transfer without consultation with my consultant or a consultant in the department.

D Q What about the case of Gladys Richards when she went back as a result of the fall?
A I contacted the consultant under whom she had been at Haslar directly because that was a slightly different problem.

Q But that consultant was the person who had to say that it was all right for her or it was proper that she comes back?
A Yes.
E

Q I appreciate in this particular case with the patient we are dealing with at the moment that it was not your view that she should be sent back, although your view was that she was not medically stable.
A I understood from the assessment that Dr Lord had made of her, albeit several days earlier, and how frail she was when she arrived with me that it would not have been appropriate to put her through a journey again. And, to be honest, what further could they F have done for this lady other than made her comfortable?

Q Again, would you deal with this patient when it is in your mind, what else could be done? What were you thinking as being something which could be done?
A There is not a further problem with her surgical procedure; that seems to have been relatively successful. Her problem is that she is at the end of her life due to her cardiac problems.
G

Q Are you thinking at this time, if we can try to give labels to this, that this lady is likely to be on the palliative care route before too long?
A Yes, and more than that – that she is likely to be on the terminal care route before too long.

Q You had written "get to know; gentle rehabilitation".
H

A A A slightly tongue in cheek remark, to imply that any rehabilitation would have to be gentle; she was not fit for or capable of anything very active in the way of rehabilitation.

Q Does that mean that you are giving a slightly over optimistic view in reality?
A Yes.

B Q In terms of the nursing staff seeing that, would they understand that nonetheless, of course, if it was possible that gentle rehabilitation could take place then they should pursue it?
A Yes.

Q We can see what the nursing staff wrote. Nurse Barrett:

C "Communicates well. Compliance – yes; pain – yes; skin – leg ulcers and sacral pressure sore."

Collins:

D "Settled and slept well 22.00 until midnight. Woke very distressed and anxious. Says she needs someone with her. Oramorph 10 mgs given at 15 minutes past midnight with little effect. Very anxious during the night. Confused at times. Patient's understanding of condition to mobilise slowly and feel better all round. Diet normal. Appetite poor. Needs encouragement."

Professor Ford criticised the administration of Oramorph and suggested that it would have been more appropriate to give her something like temazepam or haloperidol; what do you say to that?
E A If as I suspect she was going into heart failure that temazepam is likely to have made that worse. Oramorph would have been a very appropriate intervention at night for somebody going into congestive cardiac failure.

Q Over the page, other records made, not yours, "Slow post op recovery" and so on:

F "Pleasant lady happy to be here. Complexion pale, sin dry. MI 3 years ago. Renal failure.

PM: Seems to have settled quite well. Fairly cheerful this pm."

We have dealt with the prescriptions that you wrote up on that day. In terms of the diamorphine with no particular indication of the pain in any particular fashion at that time, did you have in mind any other purpose for diamorphine being administered when you wrote up anticipatorily or was it just pain?
G A To relieve distress, restlessness, fear, anxiety when approaching death.

Q We can look at the sequence of events after that. On page 17, Wednesday 19th is the note by Nurse Hallmann:

H "Complaining of chest pain, not radiating down arm – not 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."

Nurse Hallmann's evidence was that she thought she would have had permission from you, or authorisation from you, to commence the syringe driver. Are you able to remember, yourself, one way or the other?
A It says in my statement that I well may well have been in the hospital for a meeting that lunch time and I would have been happy to give my permission. I would have probably have called in to see the lady and examine her myself, but I would have been happy to sanction that prescription for that lady.

Q There is something we may need to take note of at this stage. I am not asking anybody to turn it up, in case anybody wants to note on the chronology, at page 384 in this file, it is part of the nursing care plan which on the 19th, on this same day, says something about an assisted wash, but we need not worry about that, "patient very breathless". That is so that we know what the nursing care plan says at page 384. What is the significance to you of the complaint of chest pain, "Not radiating down arm, no worse on exertion, pulse 96, grey around mouth"?
A "Grey around the mouth" would tell me that it was quite a severe pain. Shirley Hallmann was thinking that possibly it was not a full blown myocardial infarction in which case the pain might have referred down the arm or up into the jaw. "No worse on exertion", I do not know, she was thinking perhaps, was it musculoskeletal or a pulmonary embolus. This lady had suffered something fairly major cardiovascular wise.

Q That was your view?
A That was my view.

Q In terms of this decision to start subcutaneous analgesia, there does not appear to be any mention of any kind of particular agitation. Why is midazolam appropriate to administer as well as the diamorphine?
A Because she had been very anxious during the previous couple of nights. She did become very restless when she was short of breath, and I felt it was quite appropriate, in addition to treating with an opiate, to give an anxiolytic with it to relieve her symptoms. She was now in the terminal phase.

Q Are we talking about palliative care with subcutaneous analgesia or are we in this case talking about end of life care?
A We are now talking about end of life care.

Q Is that a decision you yourself would have been making in your head at the time?
A Yes.

Q Would you have communicated that to the nursing staff in the ordinary course of events?
A I would, and I would have attempted, or we would have made an attempt, to contact the family to tell them that this had happened.

Q We can see what happened on the following day. I will come to that, but I would like you to deal with this. Why not make a note of some sort in the clinical notes as to that change in terms of her treatment and care?
A Again, the necessity to be chairing a meeting in another part of the building five minutes ago, I left writing up the encounter rather than examining the patient and making sure that she was comfortable.

Q So, there would have been an examination if you are right in your feeling that you were there in fact, albeit not coming in to see her specifically?
A Yes.

Q We can see what the drug charts indicate. Oramorph had been administered in the early hours of that morning also at 11.50. The diamorphine and midazolam are started at 4 o'clock in the afternoon, so there had been some kind of assessment by you?
A Yes.

Q Professor Ford indicated that he thought it would have been appropriate to get a chest X-ray, consider pulmonary embolism and in his view the dose of diamorphine was excessive and no clear indication for midazolam. What do you say as to the suggestion that there should have been a chest X-ray?
A It would have been very uncomfortable and alarming for this lady to have been wheeled down to the X-ray department. We did not have a portable machine. The chest X-ray was not going to add anything to my clinical judgment of what had happened to her and how I was going to look after her. Her pulmonary embolus would not have made any difference to my management of her, neither would congestive cardiac failure.

Q Can you tell us why pulmonary embolism would not have made any difference to your management of this patient?
A Because I was not going to anticoagulate her.

Q We move to the following day, Thursday 20 August:

"Condition appears to have deteriorated overnight. Driver recharged 10.10. Family informed of condition.

Night: General condition continues to deteriorate. Very bubbly. Suction attempted without success. Position changed frequently. Ruby rousable and distressed when moved. Syringe driver recharged at 7.35am."

Which was obviously the first the following day. What about the suggestion that, in fact, her deterioration was brought by the administration of the diamorphine and midazolam. What would you say to that?
A I would say her deterioration was caused by the underlying reason that she had gone into heart failure.

Q Obviously it appears that she was rousable and distressed when moved. If we look over the page, in terms of any drug administration on that day, the diamorphine remains the same, the midazolam remains the same, hyoscine is added. Why is that?
A Because she is now very bubbly and we want to relieve the discomfort and distress of have excess secretions in her mouth and the back of her throat.

Q Would that be something where the nursing staff would have to ask you whether to start the hyoscine or would, in the ordinary course of events, would they, or were they free to, start it if they felt it was necessary?
A They were free to start it if they felt it was appropriate.

Q That was started at the same time, as we have seen, 9.15 that morning. Would you have seen this patient again on the Thursday, assuming that you did an ordinary visit in the morning?
A Yes.

Q With a patient on a syringe driver, you would always see the patient?
A Yes.

Q Although there is no record, that, in the ordinary course of events, is what you would have done?
A Yes.

Q The following day, the Friday, the diamorphine is increased from 20mg to 60mg, so it is trebled, the midazolam is also increased from 20mg to 60mg, so it, too, is trebled. The hyoscine is doubled from 400mcg – sorry, it had been increased to 800mcg the day before. The hyoscine remains the same as it had been the latter part of the previous day. Why triple the doses of diamorphine and morphine?
A Because there is a step in between if you look on the previous chronology. The syringe driver was changed. Having initially been put up at 9.15, it was changed at 16.50 to reflect an increase to 40mg and 40mg of diamorphine and midazolam.

Q Hold on, I have lost you in terms of what you are referring to?
A The top section of page 18, the drug charts indicate diamorphine increased to 40mg at 16.50, which is a perfectly appropriate doubling of the existing dose in the syringe driver, and exactly the same thing with the midazolam, 20mg put up to 40mg.

Q The previous day the diamorphine and the midazolam had been doubled. It is my misreading of the drug chart information there?
A Yes.

Q Why would that have been done?
A Because her symptoms were not appropriately controlled by the 20 and 20, a reassessment had been made of her and an increase started.

Q Would that have been something your nursing staff in the ordinary course of events would have checked with you?
A Yes.

Q Did they have authority in such a circumstance to double the dose without checking with you?
A If they could not find me, yes, but I would have agreed in this case that that was perfectly appropriate to do that having seen her in the morning.

Q Were your nursing staff in the habit of increasing doses of subcutaneous analgesia without a good reason in your experience?
A Never.

Q I ask the same question of you because it has been suggested that there is no good reason for increasing the doses in this way. Were you in the habit of authorising or prescribing the increased doses unless there was a good reason in your mind?

A A Never.

Q Mr Jenkins reminds me we have looked at these particular prescriptions showing it had gone up from 20 to 40 and from 40 to 60, so it is not a tripling from the previous day?
A A three-fold jump, no, it is a logical increase owing to the increase in her symptoms.

Q What about the consideration that this increase in the diamorphine and midazolam,
B first 20 to 40 then 40 to 60 over a period of two days, was in fact going to bring about over sedation and respiratory depression?
A She was not over sedated because she was rousable and distressed when moved and when having her position changed, so she was definitely not deeply unconscious, she was just comfortable.

Q On Friday 21, looking at that last drug chart picture, the increases from 40 to 60 in the
C case of diamorphine and midazolam and the maintenance of hyoscine at the same level as the previous afternoon, would that have been a day when you, yourself, would have reviewed this patient in the ordinary course of events?
A Yes.

Q I appreciate you cannot specifically remember, but you would, if you had done a visit on the Friday morning, have seen this patient?
D A Yes.

Q It being 7.35, does that help you at all as to whether you would have specifically authorised that increase?
A They would have been just drawing up and changing the syringe driver as I arrived on the ward and I would have been happy to sanction that dosage to continue.

E Q If that is right in terms of the ordinary course of events, the nursing staff have told you that in their view ---
A She was still uncomfortable overnight.

Q --- they were thinking it was appropriate to increase the dose?
A I would have sanctioned that.

F Q Then we can see it says:

> "Condition continued to deteriorate slowly. All care continued. Family present all afternoon."

This lady died at just about half past six in the early evening. Once again, you have heard the criticisms in relation to this patient of Professor Ford. Does that give you cause to review or
G question your own actions in relation to that patient?
A Not at all.

MR LANGDALE: That is all I want to ask about Patient F. Thank you.

Sir, I can start on Patient G. I do not know what time the Panel is thinking of sitting until?

H THE CHAIRMAN: I think you had indicated yesterday that we would go on to 1.30.

MR LANGDALE: I think in those circumstances, I know that everybody is anxious not to lose some time unnecessarily but it is only five minutes to go. It may be just to pick up a few preliminary matters I do not think is going to help anybody.

THE CHAIRMAN: Very well. We will break here and resume at 9.30 on Monday.

MR LANGDALE: Thank you.

THE CHAIRMAN: Thank you very much, ladies and gentlemen.

(The Panel adjourned until 9.30 a.m. on Monday 20 July 2009)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 20 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-EIGHT)

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. Welcome back. I trust everybody has had a restful weekend. You are looking reasonably rested, Mr Langdale, but poised also.

MR LANGDALE: No comment. It is a pleasure to be back.

JANE ANN BARTON
Examined by MR LANGDALE, Continued

Q Before I move on to the next patient, Dr Barton, Patient G, there are two matters I want to clear up with you, please. One relates to the patient we were dealing with at the conclusion of Friday's proceedings, Patient F. I want to draw your attention to a particular matter with regard to that patient. If we look at the chronology for Patient F, I was asking you questions about the sequence of events with regard to 18 August when she was admitted, which appears at page 14 of the chronology, and the history in relation to 19 and 20 August, those three days. We were looking at what had been administered to the patient and so on. It is a question of just seeing what the picture was with regard to the effect of the medication. In relation to 19 August, on page 17 of the chronology we can see that the first administration of diamorphine and midazolam took place. Do you have that on page 17?
A I do.

Q That is on Wednesday 19. I would like you to turn, please, and I invite the Panel's attention to a document inside the patient file with regard to the medical records. At page 388 we can see on the Nursing Care Plan sheet three dates set out. The first is the date of her admission, 18 August. This particular note is reflected on the chronology at page 15. We can see that it is a note made with regard to the evening or night:

> "Settled and slept well from 22.00 until midnight. Woke very distressed & anxious, says she needs someone with her. Oramorph 10 mg given 00.15 with little effect. Very anxious during the night. Confused at times."

The next night I want to draw your attention is in relation to what effect the diamorphine or midazolam was having that was administered on the afternoon of 19 August. The note reads:

> "Comfortable night. Settled well. Drowsy but rousable this AM. Sips of oral fluids tolerated. Syringe driver satisfactory."

That appears to be the note made with regard to the night of 19 August. Does that follow?
A Yes.

Q But it does not appear on our chronology. I just wanted to ask you about it in connection with the questions as to what effect the syringe driver was having. The next note – we might as well complete it – is again made by a member of night staff, this is Nurse Turnbull from whom we heard evidence. On the night of 20 August the patient's condition continues to deteriorate and the rest of that note is summarised on the chronology at page 17. All right?
A Yes.

Q We bear in mind, when we look at the chronology, the notes with regard to 19 August. That is all that I wanted to ask you about that patient. Before moving on to Patient G, I will deal with one other matter. The Panel made a ruling with regard to

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

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

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

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

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

E

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

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

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

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

> "Very frail. Tablets found in mouth ..."

H

The diagnosis is set out – and I am not going to read it out again – indicating "Prognosis poor." So far as that patient is concerned, do you remember his admission to Gosport? What actually happened?
A I was on Dryad Ward at the time that the word came down from the Dolphin Day Hospital that Dr Lord wished to admit him, so Sister Hamblin and I walked up to the Day Hospital and met her and him there. We then transferred him ourselves down to Dryad Ward and admitted him.

Q In terms of your admission at page 10 of the chronology, it is brief. Did you examine him when you arrived on Dryad, or had you already examined him when he was in the Dolphin Day Hospital?
A I had been with Dr Lord when she had examined him, but my nursing staff insisted that I look at the sacral ulcer and smell the sacral ulcer, so I did examine him again on the ward.

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

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

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

Q What about the possibility in terms of his ulcer being treated successfully, even if it took weeks, possibly even months?
A There was a remote possibility that with adequate protein drinks, with proper local treatment to the sore, it might improve, but I had never in my clinical career seen one survive. I was aware how disastrous this sacral sore was.

Q We need to follow through the history and try to piece it together from the records with regard to what happened on the day and evening of admission. You set out the position when you reviewed him on arrival. You have told us as to what your view was as to the future course of events so far as you could determine them. Did your view of the unlikelihood of this man being successfully treated in relation to his sacral sore – or more than sore, ulcer – affect your treatment of him in any way to his detriment?
A No.

Q To your view that he was unlikely to progress sufficiently well in that regard?
A My course of treatment was exactly as it would have been, even if I thought we could heal the sore. I was minded to keep him comfortable, reduce any anxiety and distress he may have had. I was not considering him at that point in that afternoon as being terminal. I was, however, aware that he had just finished a course of antibiotics issued by the Day Hospital, and that despite that the sore was very much worse, so I was not very optimistic about his prognosis but I was not going to do anything to hasten his death or to his detriment.

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

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

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

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

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

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

Is that blood sugar?
A It is.

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

Q Right.

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

Presumably that means 22 September.
A Yes.

Q Then:

"Sacral sore oozing but left exposed as requested."

Then over the page,

"Requires assistance to settle for the night."

That is still the night of 21 September.

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

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

Q It continues:

A

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

Then Nurse Shaw records:

B

"Catheterised on admission."

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

C

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

Q Because you were not there.
A No.

D

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

Q Then the agitation at 17.30. If we look over the page, just to complete this part of the history, on page 12 we can see what had been prescribed, first of all by Dr Lord,
E the Oramorph that she dealt with in her evidence. All right?
A Yes.

Q And then by you. On the day of his admission, you prescribed – anticipatorily, it would seem – diamorphine, midazolam and hyoscine. Diamorphine: 20-200 PRN by subcutaneous infusion. Midazolam: 20-80 by subcutaneous. Hyoscine: 200-800 micrograms, again obviously subcutaneously. Why did you write up for this man coming in,
F on the day of his admission, the anticipatory prescription, first of all?
A First of all, I was aware of how very ill he was and that he would possibly very shortly be on an end-of-life pathway rather than purely palliative care. I was also aware when I saw him at the Day Hospital with Dr Lord that there had been problems with his tablets, difficulty swallowing them, and that if we were going to give adequate analgesia we might well need to give this subcutaneously rather than as tablets or orally. I know he had taken milk overnight but his eating and drinking, and his taking of tablets, was possibly a bit
G suspect.

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

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

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

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

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

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

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

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

Q You were not there. That is all we can say that those notes show. What would be the rationale – I appreciate you were not there – for commencing the administration of diamorphine and midazolam that evening shortly after 11 o'clock? When I ask you that question, I would like you to deal with what Professor Ford was saying about how something should have been given to this man to deal with the psychotic episode, if that is the right way of describing it – something to relieve and deal with his agitation. What in your mind is the rationale for starting the syringe driver then?
A In my opinion there were two main reasons for starting the syringe driver. My advice to my day staff, when I saw Mr Cunningham that afternoon, would have been, "Start with the Oramorph, but you do have a pro-active prescription for the syringe driver should his distress and pain deteriorate and you feel you are going to be able to manage it with oral medication. Both the diamorphine and the midazolam would have been ideal medication to control his discomfort, distress, anxiety overnight, as well as the pain he was receiving. What was the other thing I was going to say? So that was what the pro-active prescription was for.

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

Q There is no record of your having been contacted?
A No.

Q Do you have any recollection of being contacted?
A I do not.

Q So it may be that the nursing staff commenced the syringe driver without specifically getting authorisation from you at the time that it happened?
A It is possible, but in view of the fact that we had just admitted him that afternoon, and the concern we had all had about his general condition, it is quite possible that they actually made a phone call to me at home and I spoke to them. That would have been fairly standard procedure.

Q Can I approach it in this way: had you been there, and had you been aware that the Oramorph, which had been given at 20.20 – twenty past eight or thereabouts – that that had been followed not long afterwards by an incident where he had been acting in the extreme fashion, I am going to describe it as recorded at the top of page 13 – had you been there why not, with this patient, have administered to him something to deal with his agitation, psychotic behaviour, whatever one describes it as, as opposed to administering subcutaneous analgesia?
A Because if you felt that the underlying cause for this behaviour, which was not typical of him, was the pain and the toxicity of the sacral sore, it would seem more humane to treat it using the subcutaneous analgesia and anxiolytic, rather than giving him a major tranquiliser.

Q The anxiolytic being ---
A Midazolam. He was on a palliative care pathway. It seemed perfectly reasonable to give him adequate palliation.

Q There is no record of him actually being in pain. Obviously the sacral sore, the sacral ulcer, would have been very painful in any event. There is no record of him being in pain. Why not say to yourself, had you been there, "This sort of thing happens from time to time with patients of this kind." This is what Professor Ford was suggesting was appropriate. You come across this sort of thing with patients like that, an acute episode which may not necessarily last. Why not treat with haloperidol?
A Because it was not just an acute episode that was not going to last. In my opinion it was all related to the toxic state and the anxious state he was in due to the sacral ulcer and the indignity of being brought into the ward and the dressings being done, it was a whole picture of that man in that bed, not the theoretical elderly medical problem of somebody suddenly becoming anxious and behaving badly.

Q That, you would understand, leave aside whether you were informed or not, was what the nursing staff would have approached it as. When you saw him the following morning, there is no record, but would you have seen him the following morning, the Tuesday?
A I would, and I would have been very content with the improvement in his state of comfort overnight.

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

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

Nurse Shaw records:

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

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

A I have no recollection.

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

A Yes.

Q Nurse Hallmann recalls:

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

Is that something you would have instructed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A He was not.

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

A None at all.

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

A At what stage did that happen?

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

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

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

A Yes.

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

A Community Psychiatric Nurse.

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

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

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

A No.

Q Let us just look at the note:

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

That would be Sister Hamblin, presumably?

A Presumably.

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

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

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

Carrying on on that left hand side;

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

C

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

D Q Why was it you increased the dose of diamorphine or asked that it be increased and why did you ask for the midazolam to be increased?
A On the basis of that report from the night staff given to me by Sister Hamblin that he was in pain when being attended to, so that he was becoming inured, he was becoming tolerant of the diamorphine he was receiving and we needed to increase the dose a little bit to give him the same level of comfort.

E Q Dealing with mention of Mr Farthing, I have reminded you that on the 23rd he said that when he saw his stepfather he was unconscious; that was the Wednesday. In his evidence to the Panel he said that on the Thursday, the 24th, he had seen you and said that he wanted to speak to his stepfather – that is speak to the patient – you had refused and said something about not being able to authorise the stopping of the syringe driver because of the pain, and he claims that he said something to you like "You are murdering him". What do you recall of seeing Mr Farthing in relation to his stepfather?
F A I have absolutely no recollection of the meeting with Mr Farthing and I have no recollection of being accused of being a murderer.

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

G Q He says also that you had said – he described it in this way: "She told me quite bluntly he was dying from the poison or poisons in the bedsores." Might you have said that to him?
A I would have attempted to explain in a manner to be understood by a lay person that the toxins from the bedsore were now spreading around the body and were giving him his bronchopneumonia.

H

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

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

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

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

MR LANGDALE: Thank you. If we just take a moment, Dr Barton, to register what that says. It is the general information sheet, we have Mr Cunningham's name top left, next of kin underneath, "Shirley Sellwood" whose statement was read to the Panel. There are details of her address and contact number and then underneath that "Stepson, Rodney Farthing" with a telephone number and then another telephone number as from a certain date for him. The rest of the details I do not think I need to trouble you with. You said there was a problem with regard to his position; would you just explain that, that he was not next of kin.
A In those days I think any major decisions to be made on behalf of or with the patient would only be considered with the next of kin that we had down as notified, so if anything should have been discussed with anyone it should have been with Shirley Sellwood.

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

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

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

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

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

If we can move on to page 17 and deal with Friday, 25 September, it was Dr Brook who saw him that day, not you. How would it come about that you would not have seen this patient on the Friday?

A If I was not available, if I was away, if I was on leave. My partners visited the wards, B the duty doctor for the practice would go. She would only go if requested to see a patient by the staff, I do not think she did a routine ward round.

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

A I did not see him that morning.

Q "Condition appears to be deteriorating slowly" and so on, diamorphine 80 and midazolam now up to 100. The midazolam has gone up on the Saturday shortly before midday. Whose decision would that have been?

D A Presumably that was on the say-so of the duty doctor.

Q He continued to deteriorate and his death is recorded shortly after 11 o'clock that evening. Again, you have heard the comments and criticisms made about your treatment of this patient from Professor Ford; do you stand by what you did on those days in September 1998 or does his evidence or view cause you to change your mind about anything?

A I totally stand by what I did for Mr Cunningham that week.

E

Q Patient H, Mr Wilson. This gentleman, the patient with a background of alcoholic liver disease, taken into Queen Alexandra following a fall which fractured the left humerous. He was somebody who did not want surgery to do anything about the fracture. Analgesia administered, which plainly was not controlling pain generally speaking throughout the period of time that we are concerned with. Then if we move on, please, to when he is admitted, the best page for us to start is page 23. We have seen in the history that his F prognosis was poor, that he was at times not eating or drinking, at other times he was, the pain control was not working, on paracetamol a lot of the time which does not appear to have stopped the pain, and that picture really continues as we go through the history up until the time that he is transferred to Dryad. He is transferred on 14 October, having been admitted to Queen Alexandra on 21 September, so something just over three weeks since he was admitted to Queen Alexandra. On page 23 you saw him, the 14th was a Wednesday, "Transferred to Dryad Ward, continuing care." You set out the fractured humerous, alcohol G problems, recurrent oedema, CCF (congested cardiac failure).

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

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

H

A A The features were that he was not really medically very stable. He had a lot of oedema, he had put on an enormous amount during his time in the Queen Alexandra, he was obviously teetering on the edge of congestive cardiac failure and he had this still unstable fracture of the arm, which was obviously extremely painful, particularly having undergone a two-hour trip down to my hospital in a minibus.

Q Yes. What about the background alcohol problems and the liver disease problem; did
B that register with you?
A It did. I imagined that, poor man, he had been dry for approximately three weeks while in Queen Alexandra so that probably from that point of view unless somebody gave him alcohol he was relatively stable.

Q I was going to ask you in terms of any bearing that that medical background or that medical context had for you in terms of thinking it appropriate to administer opiates. What
C was your view about that, a patient who has got a liver disease problem, somebody who was obviously very alcohol dependent before going into QAH, how does that affect your thinking with regard to administering opiates?
A You have a problem with any analgesia which is handled by the liver. One gram of paracetamol four times a day obviously was not giving him pain relief, you could not go any higher than that because of the toxic effects of the paracetamol, codeine you could not go above a certain level, it was equally toxic to the liver. Any analgesia you gave him had a risk
D to the liver function, but on the other hand you had to weigh against that the discomfort that the man was in.

Q Just staying with that in terms of any analgesia, does what you have just said apply also to co-dydramol?
A Yes.

E Q All the other kinds of step two analgesia we have been looking at. Why is there a maximum for paracetamol in terms of possible toxic effect in terms of the liver?
A Because it is toxic to the liver, it is as toxic as Oramorph is.

Q How high can you go with paracetamol in relation to ---
A You can only give four grams of paracetamol daily, above that you are running into danger.
F

Q We can see, for example, that he had paracetamol on 11 October in hospital; he was getting one gram of paracetamol four times a day so it appears he was on the maximum appropriate dose of paracetamol at that stage, and indeed on page 23, the last time any hospital administration of drugs is set out, codeine phosphate 30 mg, paracetamol one gram four times in the day.

G If we look on, please, at what is shown in terms of drug charts at pages 24 and 25 of the chronology. We just have to see what is there. He had been admitted on Wednesday 14 October and it appears that on the day of admission you prescribed the same thing, paracetamol one gram every four hours – is that the same thing or is that something more?
A That is the same thing, yes.

Q One gram every four hours.
H A Except that you only give it four times a day so it works out as nearer six hours.

Q In fact that was not administered.
A No.

Q Then we can see also prescribed a collection of drugs, frusemide, spironolactone, bendrofluazide and so on. In general terms, what is the picture there with what you were aiming at in terms of those prescriptions?
A I was continuing the medication to attempt to control his congestive cardiac failure, which was the frusemide, spironolactone and bendrofluazide. I was continuing the antidepressant that Dr Luznat had started while he was an inpatient at QA to hopefully keep his mood improved on how he had been when he first arrived at QA, thiamine, multivitamins are for his poor dietary intake and previous liver problems. Magnesium hydroxide and senna are laxatives.

Q Right. Then over the page the date is unclear but a doctor other than you prescribed hyoscine subcutaneously if requested. It was not administered on that day. Then looking at the section below that, again date unclear:

"Drugs charts indicate: Oramorph: Dr Barton prescribes -10mg four hourly PRN."

Oramorph was administered shortly before three o'clock in the afternoon, 14.45, on the day of admission, and shortly before midnight on the night of the admission date. Then proactively or anticipatorily you wrote up diamorphine 20-200, hyoscine 200-800 micrograms, midazolam 20-80. Let us deal first of all with the Oramorph. I do not know that there was any real criticism of this by Professor Ford although he indicated that he would have preferred a second stage, to start off with second stage analgesia. Why did you prescribe and indeed see to it that Oramorph was administered that day?
A Because I felt very strongly that having undergone that journey his arm would be extremely uncomfortable and that he was entitled to adequate analgesia for that condition as he settled into the ward. He had a dose at quarter to three and did not need another dose until quarter to midnight, that seemed to keep him quite comfortable.

Q We do not know exactly at what time you saw him on that day, it may be that it was something like the middle of the day but we do not have the precise time.
A It must have been before 14.45; it would have been the lunchtime visit I imagine.

Q It rather looks like that. Then the anticipatory prescribing. Why that, in a man with the alcohol problem he had, the congestive cardiac failure problem and so on? Why did you anticipate he might need those?
A Because this gentleman was not medically very stable and I felt it was quite possible that this gentleman, despite all the diuretics he was receiving, could go into congestive cardiac failure at any time.

Q What is the significance of the weight that he had put on? He had put on something like ten and a half kilos, I think, since he had been in Queen Alexandra. What impact is that having on your decisions about his treatment?
A He is retaining an enormous amount of fluid in his body. There would have been two reasons for that. His albumen was low because of his liver disease, so that would have caused him to retain fluid in his tissues, but also his kidneys were not diuresing and draining

A the fluid adequately, so this was building up and building up and eventually it would get to the point where his heart would not be able to cope with it.

Q The fact that this patient had a heart problem – I am going to use that expression to cover the position – would that affect your prescription of opiates? What impact does that have on your decision to prescribe opiates?
A It would be very appropriate, to my mind, to give somebody going into congestive B cardiac failure an opiate to reduce the distress and reduce the oedema slightly.

Q Going back to page 24 and looking at what happened – we have now looked at what you prescribed – we can see that Sister Hallman records,

"Long history of heavy drinking. LVF" –

C That is left ventricular failure.
A It is.

Q Then:

"... chronic oedematous legs. Seen by Dr Barton. Oramorph 10mg given. Continent of urine – uses bottles.

D

Barthel 4.

Patient's understanding of condition: fully comprehending. Bladder normal. Restless at times. Used urinal with assistance ..."

and so on. Oramorph again given for pain control at 11.45 that evening. On the day and E night of admission, he has had, at that stage, a total of 20 mg of Oramorph. All right?
A Yes.

Q Can we move on, please, to the following day, Thursday 15. Nurse Shaw records on that date:

"Commenced Oramorph 10mg 4 daily for pain in left arm. Wife seen by Sister F Hamblin who explained Robert's condition is poor.

Settled and slept well. Oramorph 20mg given at 12 midnight with good effect. Oramorph 10mg given at six o'clock in the morning. Condition deteriorated overnight. Very chesty + difficulty swallowing mediation. Incontinent urine ++ WSP to sore groins.

G

Bed bath ..."

and so on. In relation to that deterioration overnight, first of all dealing with Thursday 15 October, would you have seen him that day?
A Yes.

Q It looks as though you did, because you prescribed on that day.
H A Yes.

Q Oramorph 10 mg four times a day, and you also prescribed 20 mg at night. So on that prescription, he would be up to, on a 24-hour basis, 50 mg in the 24 hours, is that right?
A Yes.

Q Professor Ford has indicated that in relation to the deterioration overnight that is recorded you would have to consider that the deterioration was due to the opiates. He was not saying it was, but he thought that was a likely cause. What do you say to that?
A It is much more likely that it was due to congestive cardiac failure developing.

Q When you saw him on 15 October, did you consider in any way that he was receiving too much by way of opiates?
A I would have considered it, but I would have been told by the nursing staff that he was comfortable from the analgesic point of view and that the oral morphine would not have had a deleterious effect on his heart failure. It would have been helpful to his heart failure.

Q May we move on, please, to 16 October, on page 27 of the chronology. On 16 October, this patient was seen by Dr Knapman. It seems you were not at the hospital that day. Is that right?
A Yes.

Q The 16 October being a Friday. Dr Knapman, when he saw this patient, recorded:

"Declined overnight with SOB."

A Shortness of breath.

Q Then:

"On examination bubbling. Weak pulse. Unresponsive to spoken orders. Oedema in arms and legs. ?Silent MI. Liver function down. Frusemide up."

What is the significance of that to you?
A That Dr Knapman, on examination of the patient, felt that he had probably had a myocardial infarction or a cardiac event which had increased his degree of heart failure, increased the amount of oedema and given him a very weak pulse. He noted the previous reduction in liver function and he ordered a stat dose of frusemide to try to reduce the oedema.

Q We can see what the other nursing notes show:

"Seen by Dr Knapman am as deteriorated overnight. Increased frusemide to 80mg daily. For ANC."

Shirley Hallman noted in the afternoon:

"Very bubbly chest this pm. Syringe driver commenced. Wife informed of patient's continued deterioration."

In relation to the commencement of the syringe driver on 16 October – and we can see over the page that diamorphine – no midazolam – was administered at ten past four in the afternoon, as was hyoscine. Whose decision was it to do that?
A I would anticipate that it was a decision made between the duty doctor and the nurses. I was definitely at a meeting at the health authority that morning. I cannot say whether I came back that afternoon but it is unlikely.

Q The duty doctor would be Dr Knapman, would it?
A It would be Dr Knapman and he would have discussed it with the nurses. He would have seen that the proactive prescription was there and available and was appropriate and he would have started it.

Q I appreciate that you were not there and you were not making the decision immediately as to what was to be put into the syringe driver, but why no midazolam so far as you can tell?
A Dr Knapman must have felt that there was no need: there was no particular anxiety or distress in this particular patient and that really he wanted to focus on the opiate and the anti-secretion drug.

Q The other note is from Nurse Florio:

> "Has been on syringe driver since 16.30. A little bubbly at approximately 22.30 when repositioned. More secretions = pharangeal during the night, but Robert hasn't been distressed. Appears comfortable. "

Does that signify to you that he had any liver problem that was causing that condition, or something else, so far as you can judge it from that note?
A There was no sign of any hepatic encephalopathy in his behaviour over that last couple of days. Judging by my examination on the Thursday and Dr Knapman's on the Friday, this was a picture of congestive cardiac failure.

Q If we look at the dose of diamorphine that was administered on page 28, which was the lowest in the dose range that you had anticipatorily prescribed, I think there was really not much dispute, but 20 mg diamorphine was not identical to (it is an increase) but broadly commensurate with the 50 mg of Oramorph he had received in the previous 24 hours.
A And it was an appropriate level to choose.

Q That was on Friday 16 October. The following day he is seen by another doctor from your practice who recorded on the Saturday,

> "Comfortable but rapid deterioration. Nursing staff to verify death if necessary."

That doctor's evidence given to the Panel was that it seemed that he was very severely ill or close to death. The evidence was, "I have seen enough patients who have been dying to recognise that." Again, you are not there on that day but this is what occurred. If we look over the page, on page 29 we can see that the diamorphine which had started at 20 mg was increased shortly before four o'clock in the afternoon to 40 mg. The hyoscine is increased at the same time, from 600 micrograms to 800 micrograms. Midazolam then starts to be administered at the same time. The doctor who attended that day said in evidence that the hyoscine was not excessive. You were not there. We have heard evidence from the doctor

who dealt with it, but what, in the ordinary course of events, would have made it sensible to administer midazolam, to add it to the drugs in the syringe driver?
A Terminal restlessness.

Q What is shown in the nursing notes on page 28 is the hyoscine being increased as a result of the oro-pharangeal secretions increasing. Sister Hamblin recalls, "Slow deterioration in already poor condition ..." and so on. Nobody seems to have recorded anything to do with agitation. If we look at the top of page 29: hyoscine and diamorphine increased; midazolam added.

> "Night: noisy secretions but not disturbing Robert. Suction given as required during night. Appears comfortable, hot at times."

There does not appear to be any record of any kind of terminal agitation or restlessness requiring midazolam. Do you have any comment you can make on that? I appreciate you were not there.
A I think if I was having frequent suction during the terminal phase, I would be quite grateful of some midazolam in order not to become frightened and terminally agitated and restless. I think it was a very reasonable addition on their part at that point in time to make sure that he was not made very anxious and uncomfortable while they were seeing to him, and particularly the suction.

Q Looking at that general sense, was that something which you had observed yourself from your own experience over years with these patients?
A Yes.

Q On page 29 we move on to the Sunday, the day on which this patient died. Sister Hamblin records further deterioration and so on.

> "Wife remained overnight – seen by Dr Peters" –

that is the same doctor who had seen him on the Saturday, who spoke to Mrs Wilson. The syringe driver was renewed, apparently at the instigation of that doctor, going up to 60 mg. The midazolam – 40 mg – goes up.

> "Continues to require regular suction ..."

and so on.

> "Condition continues to deteriorate."

Over the page we can see the prescription, the administration of the diamorphine and midazolam. Death recorded at 23.40. In terms of what caused his death, the death certificate showed congested cardiac failure, renal failure, liver failure. Professor Ford indicated that it was his view that the drugs had led to his deterioration and therefore played a part in his death, but of course with other comorbidities he could not say if they were the only cause of his death but they were likely to be a contributory factor. What do you say to that, so far as you can judge it?

A A Judging by the condition of Mr Wilson when he arrived with us on our ward, the drugs we gave him to relieve his symptoms at the end of his life did not contribute to his death. His death was caused by his serious previous comorbidities.

Q We bear in mind that after, as I say, October 15, it is other doctors who are dealing with this particular patient. May I ask you this in terms of anybody speaking to you: as to any encounter in terms of relatives, I think it was Gillian Kimbley who indicated that you – B and it seemed to be you she was suggesting – had said when he arrived something like, "Get straight into bed" and were not very nice about it. Does that ring any bells with you at all?
A It is very unlikely that I was directly involved in making him comfortable after that horrible journey down form the hospital. I may have arrived to clerk him in at that point and wanted to see him on his bed, but I would not have told him, "Get into bed." That is a nursing job.

C MR LANGDALE: That is all I need to ask you about Patient H.

Sir, I am turning to another patient.

THE CHAIRMAN: Yes, thank you, Mr Langdale. We will take a break now and return at five past 11, please.

D (The Panel adjourned for a short time)

THE CHAIRMAN: Yes, Mr Langdale.

MR LANGDALE: Dr Barton, we will turn to Patient I, Enid Spurgin. This lady went into the Haslar in March 1999 following a fall. She of course had the operation that we are all familiar with, and we have seen the history of the painkilling steps that were taken with regard from E her: some morphine from time to time, paracetamol and so on. We can move to page 7 of the chronology. We heard from both Dr Lord and Dr Reid about this lady before of course she ever got to Gosport. On page 7 of the chronology, the referral to Dr Lord. Halfway down that little section we see the difficulty about getting her mobilised and her post-op rehabilitation proving somewhat difficult and "consideration of a place at GWMH."

Then reviewed by Dr Reid and he sets out what he found in a letter which was sent.

F

> "Even a limited range of passive movement in the right hip still very painful. Would like to be reassured that all well from orthopaedic viewpoint. If all is well, happy for transfer to GMWH for further assessment and hopeful remobilisation."

Dr Reid in his evidence said that he had considerable doubts that she would get back on her feet. This is the patient in respect of whom we heard evidence from Mr Redfern on the G orthopaedic side, although he personally had not dealt with this lady. He talked about a matter of grave concern being her compartment syndrome, the fact that that possibility did not appear to have been investigated in hospital, and he said that if he was the doctor involved when Dr Reid sought that assurance, "I would not have been able to give Dr Reid the assurance he was seeking."

Over the page, Dr Reid in his clinical notes, at the top of page 8, says, "

H

A

> "Still in a lot of pain, which is main barrier to mobilisation at present – could her analgesia be reviewed."

It appears that if it was reviewed it brought about no change, because it continued with just paracetamol being administered. Then at the bottom of page 8, 25 March, we note "haematoma developed" and "broken down" and so on. She is the lady with very, very thin fragile skin. Over the page to page 9, we come to 26 March, a week after she had been
B admitted to the Haslar following the fall and six days after the operation. The transfer letter talks about her being mobile:

> "... from bed to chair with 2 nurses and can walk short distances with a zimmer frame."

At the bottom of that section, her only medication is analgesia, paracetamol PRN. Dr Reid,
C we will recall, indicated that the contents of that letter were really quite at variance with regard to her mobility, with what he found two days before. I think it is accepted in this case that she was transferred before she was ready for it?

A Yes.

Q If we look at page 10 we can see her being reviewed by you on admission to Dryad on the 26th. You set out the background. It says:

D

> "Not weight bearing. Tissue paper skin. Not continent. Plan sort out analgesia."

The next note down, significant events, not compiled by you says:

> "Admission for rehabilitation and gentle mobilisation. In Haslar she was mobile with zimmer frame and 2 nurses – short distances and apparently transferring satisfactorily.
E However, transfer has been difficult here since admission. Complained of a lot of pain for which she is receiving Oramorph regularly now, with effect. Has very dry, tissue paper skin to lower legs, with small break on back of right calf."

And so on.

> "Eats and drinks with encouragement. Can feed herself."

F

Nurse Turnbull recorded at night:

> "... much assistance with mobility at moment due to pain/discomfort. Oramorph 10 mg given ..."

shortly after 11 o'clock and, indeed, 5 mg in the morning shortly before seven in the morning.
G Just following the history over the page:

> "Oramorph given for pain in hips
> Experiencing a lot of pain on movement..."

And so on. Waterlow score – I think about the highest we have seen in relation to these patients – of 32?

H A Yes.

Q You, on the day that she was admitted, prescribed Oramorph PRN. The word "subcutaneously" has been crossed out, because it is wrong. You prescribed 2.5 or 5 mg four times daily and 10 at night, so a total of 30, if I am doing the maths right. Can we take it that you examined this lady when you admitted her?
A Yes.

Q First of all this: what was your view as to the plan and prospects for this lady? We have seen that in the significant events documentation she was recorded as being admitted for rehabilitation and gentle mobilisation. Was that something that was in your mind on admission?
A I was hopeful that we would be able to mobilise her. I was well aware, as Dr Reid was, that there was a variance between what we had been told by the discharging ward she was capable of doing and what she was doing did not seem to apply to the same person, but we were going to attempt to get her more comfortable, and if she was more comfortable it would then be possible to mobilise her.

Q So the priority is to sort out analgesia, as you put in the note. Is that what it is?
A Make her more comfortable, give her time on the ward, of which we had plenty, and hopefully then mobilise her.

Q Did it occur to you, because you will remember Professor Ford's evidence that not necessarily initially, but fairly soon after her admission to the War Memorial Hospital, what one should have been asking, why is this pain continuing, and seeking to do something to try to analyse what the source of the pain was. First, on admission, on 26 March, were you puzzled or surprised at the fact that she was still in pain?
A I was unsurprised by the fact that she was still in pain. It was very early after the surgery had been performed and she had been through the trauma of a transfer to our hospital, so her pain was not out of proportion to what she had been through in the preceding week.

Q Why not prescribe a less powerful opiate than Oramorph. Why not prescribe co-dydramol or any one of the other codeine alternatives? Why go on to Oramorph? How would you deal with that?
A I think that post-operative pain and transfer pain in these elderly people is just as real as it is for younger people having surgery. I could never see why a lady like this should be denied that benefit of a decent low dose analgesia with a slight bit of euphoric effect to it in order to help her pain and get her moving.

Q And indeed, Dr Reid gave us his opinion that that prescription of Oramorph by you was perfectly sensible. Over the page, please, to page 12. We move on the day after her admission, 27 March. The Oramorph is then increased by you, in terms of prescribing 10 mg four times daily, and 20 mg at night, so that is a total of 60 in 24 hours. Yes?
A Yes.

Q And you also prescribed co-dydramol, two tablets, four times daily. We can see what the administration was of the Oramorph: two 20mg doses were administered and one 20 mg dose. Why did you also co-dydramol which on that day was not actually administered? We can see what happened the following day. The Oramorph stops and the co-dydramol takes over.

A A It was reported to me by the nursing staff that the Oramorph had been giving her nausea and, in fact she had been vomiting with it, so I was minded to step down to co-dydramol, to see if at that point that was going to give her adequate analgesia otherwise I was going to have to think of something else.

Q We can see that, I think, recorded on the following page of the chronology, page 13, the record in the nursing care plan:

B

> "Has been vomiting with Oramorph. Advised by Dr Barton to stop Oramorph. Is now having metoclopramide TDS [three times a day] and co-dydramol. Vomited this afternoon after using commode. Refused supper."

That is on the 28th. We can see what the picture was, and we can see your prescription, although the date is unclear, for the metoclopramide, which is for sickness and nausea. Is
C that right?
A Yes.

Q The following day, the 29th, co-dydramol continues to be administered. The nursing notes say:

> "Please review pain relief this morning."

D

It deals with the dressing of the wound. Over the page, we move on to the 30th. co-dydramol continues:

> "Two tablets four times daily administered."

The nursing care plan shows what the picture was with the redressing of wounds, and so on.
E She sat out in a chair for an assisted wash/dressed, and so on. Then the following day, the last day in March, the 31st, Oramorph is then administered. We will just follow through the picture with regard to the notes on page 15, where it says:

> "Now commenced on 10 mg MST bd [twice a day]. Walked with physiotherapist this am but in a lot of pain. Physio demonstrated how to get Enid from chair onto zimmer frame.
>
> F
>
> Both wounds redressed."

That is 31 March. She was admitted on the 26th, so five days later. We have her still in pain. Oramorph was administered on the 31st shortly after one o'clock in the afternoon. Co-dydramol continued. Then you prescribe the MST – two doses were administered. Would you explain that, please?
G A The Oramorph was still on her chart as a PRN and the nurses obviously felt that her pain was not being controlled by the co-dydramol, and they would have been going to ask me the next time I came on to the ward to consider something else, so they continued the co-dydramol in the meantime, with a top-up of Oramorph until they saw me, and I changed the prescription.

Q Why change to MST?
H

A Because I was hoping that that presentation of the morphine would not make her feel so sick and unwell as the Oramorph had done, and would give her adequate pain relief.

Q I think, in fact, it did not have the effect of causing nausea or vomiting, or anything like that?
A She seemed to tolerate that much better.

B Q I do not think there is any criticism of that. Dr Reid said that there was nothing he would criticise, and I do not think Professor Ford criticises the decision for her to be on MST. Can you just deal, please, on page 15 with the situation with regard to pain and what a physiotherapist in the ordinary course of events would or would not do in your experience? The physio, at the end of March – 31 March – is there pointing out or helping the nursing staff with how to get her from a chair onto a zimmer frame. The following day you can see 1 April, the physio reviews her again. It says:

C "Please nurse Mrs Spurgin on bed over weekend rather than in chair, but she will need to walk x 2 daily [twice daily] using frame."

In the ordinary course of events, if a physiotherapist in dealing with a patient of this kind is aware of the pain and the problems, would you expect a physiotherapist, if they suspected a dislocation (or anything of that kind), to point it out?
D A They would. This physiotherapist, I suspect – as was I at that point – was thinking in terms of a wound infection rather than a dislocation, hence "Nurse her on the bed." Try and keep her moving, try and reduce the risk of pulmonary embolus, and deep vein thrombosis – all the other risks of keeping somebody on a bed – but she was also aware that the pain was out of proportion to what there should have been at this time, and I think she was thinking of infection, as I was.

E Q If you look at the previous days, there is no record – apart from the fact that if you prescribe something it is clear that you were at the hospital – but there is no record of your having seen her. Would you in fact have been seeing her each morning?
A Yes. I would not necessarily have seen the actual dressings. That would have been reported back to me on 1 April, that the wound was now beginning to ooze.

Q We can pick up that entry:
F

"Wound in right hip oozing large amounts of serous fluid and some blood. Hole noted in wound. Still having pain on movement."

And we can see the administration of MST on 1 April. Let us deal with this point. There she is. She is still in pain. You had formed the view that it was probably deep seated wound infection?
G A Yes.

Q Why not another possibility, that there was something that may have gone wrong with the hip operation, and why not yourself ask for an X-ray?
A Because at that point in time, an X-ray would have been extremely uncomfortable for her to go and have it done and it would not have altered my management of her.

H

Q Why would it have been uncomfortable for her to be wheeled along to where the X-ray department was? I think it was down one floor, but it does not matter – in the same building?
A Down the end of the corridor, and then humped onto the X-ray table in order to have the pictures taken, and then the reverse journey back up again. Very uncomfortable for her, hanging about waiting in the X-ray department, going down, coming up again, and it would not have altered my management of her at this point in time.

Q I would just like you to deal with that question. Why not, albeit it is uncomfortable and exactly what you have explained is the case with regard to discomfort to her, why not nonetheless go ahead to get the X-ray done, to see if there was something that could be attended to with regard to her hip?
A If I had suspected a dislocation, as we found in one of the previous cases, then there would have been a case for transferring her back to the parent unit.

Q And apart from somebody else pointing it out to you, what would have indicated a dislocation? What sort of thing would you have expected to see?
A I would have expected my physiotherapist to have said, "There is something wrong here. This hip is shortened and she will not weight bear on it. Could it be dislocated?"

Q What about something having gone wrong with the operation that might benefit from some kind of surgical intervention? Why not get an X-ray to consider that?
A Because at that point in time I was definitely thinking of the possibility of infection and I would not have transferred her back, with or without an X-ray, at that point in time for an infection. I would have dealt with it on the ward, which is what we did.

Q Why not? If the infection is such that it is deep-seated and it is causing this pain to continue, why not perhaps ---
A Because it would not ---

Q Why not send her back?
A It would not at that point in time have involved any surgical intervention. No orthopaedic surgeon would have wanted to open that hip at that stage with infection in it.

Q So what is your way of treating it, if you are right in your ---
A I am waiting to get something that I can swab, something that I can see if I can grow an organism. With or without knowing what the appropriate organism is, I am going to in due course give her antibiotics.

Q Perhaps I had better ask the question this way. This lady is now five days in to her stay in Gosport, having arrived on the 26th?
A Yes.

Q And she is something like a fortnight after the operation, something like that. Would you expect there still to be pain from a hip operation of that kind if nothing had gone wrong, or would you not expect pain that long after?
A I would expect there still to be quite a lot of pain. She was 91. She was quite frail. She had very oedematous legs. It would have been very uncomfortable for her to attempt to mobilise, even without this added complication going on.

A Q But you, by this stage, were thinking that it is infection that is the problem?
A I am beginning to think that it is infection.

Q Now it does not appear so far that she has been seen by any consultant, and normally would a consultant see her once a week on the ward, or once every fortnight on the ward? At this stage. We will come on to Dr Reid's actual visits, but she has now been in Dryad since 26 March/
B A It was not unusual at that time for there to be periods of several weeks in a row without a consultant visit because of his other duties elsewhere.

Q Carrying on until the early part of April, on page 16, the MST continues. There is no complaint about that. The complaint is, one should have been trying to analyse the source or cause of the pain. Onto April 2, 3 and 4 – she is still complaining of pain. The hip is still oozing the serous fluid and blood, and so on. We move on to the 5th, at the top of page 17;
C MST continues and there is a record of you seeing her on 6 April:

"Reviewed by Dr Barton."

This is not your note. It is in the significant events section. Shaw records the MST, and so on.

D "Nephew has visited, if necessary once Enid is discharged home (she is adamant about not going to a nursing home) he will employ someone to live in. Enid has been incontinent of urine a few times over the weekend. I have spoken to her about a catheter and she is going to think about it."

We see what Nurse Henning recorded just below that.
A So that is the point at which we took a swab. We were now seriously thinking about
E an infection inside the wound site, or deeper within.

Q Is that day, 6 April, the first time a swab was taken?
A Yes.

Q Why not have a swab taken earlier at the time that you were beginning to think that this may be the problem? Would you deal with that?
F A Because the nurses must have felt that they would not get an appropriate sample from what was leaking from the wound on 4 April, say, but by the time we got to the 6th, then there was something they could take. Also it was a weekend, and there is no point in taking swabs to sit in the fridge over the weekend.

Q Right. So swabs are taken, how long for the results from those swabs to come back normally speaking?
G A Two or three days, but having got the swab under way I was quite happy to ...

Q There is a reference to a microbiology report at page 57; is that something which would give you results on that day?
A Yes.

H

A Q Can we just look at that and see if it exists. If we go to page 57 it may be, Dr Barton, that you will be able to point something out to us because Mr Redfern referred to this. Looking at page 57 and looking at the dates at the bottom from the card ---
A It was collected on 6 April and it was reported on 9 April, and it was stamped as coming back to the ward on 12 April.

B Q We can take it that this result is back on the 12th, we can see your initials as the person who has asked for this to be done in the bottom right hand corner and Mr Redfern gave his view that the drugs that were being administered at Gosport for this were maybe not perfect but satisfactory "a reasonable best guess" I think was the expression he used.
A Yes, the sample was taken on the 6th and I went blind with the antibiotics to use. I was not going to wait until I got that report back on the 9th to choose an antibiotic, so I went blind with that.

C Q We can see that over the page on page 18 of the chronology where the MST continues and then on 7 April, "Fracture site red & inflamed. Seen by Dr Barton. To commence Metronidazole + Ciprox".

Are those both antibiotics?
A They are.

D Q The note is for the nursing care:

"Commenced antibiotics as hip wound may be infected."

On 7 April when you prescribed the antibiotics this lady was seen by Dr Reid:

"Still in a lot of pain and very apprehensive. MST increased to 20mg twice a day
E yesterday. Try adding flupenthixol" –

Which was, I have forgotten I am afraid.
A An anxiolytic.

Q An anxiolytic; that is to deal with the apprehension is it?
A Yes.
F
Q

"For x-ray R hip as movement still quite painful – also, about 2" shortening R leg."

It does not appear that you were actually present with Dr Reid carried out that ward round. I will just follow through the history a little bit more and we can pick up on one or two points that need dealing with by you. Dr Reid has indicated he wants an x-ray taken. Just looking
G at the chronology for a moment, drug charts indicate the MST on 8 April on page 19, the MST continues and it is increased, there is a note, with the wound oozing slightly overnight, and then on 9 April we reach a point where the MST is continuing. I will come to that note on page 19 in a moment.

What we have no doubt all noted is that in the nursing summary at page 134, if we might just turn that up, please, page 134 in the medical records, we can pick up the date 7 April. The
H

first date on that page is referring to this lady being seen by you and you putting her on the antibiotics and then later on in the day:

> "Seen by Dr Reid. For x-ray tomorrow at 15.00 hours. To commence the anxiolytic ... to be reviewed on Monday."

What is the significance of that entry to you? I appreciate you did not make it, but just dealing with the procedure and what you understand that to convey?
A The significance was that he could see from the drug chart that I had commenced her on a broad spectrum antibiotic. He got his nursing staff to arrange for the lady to have an x-ray the following day, that an appointment was made for that and that he was going to review it on his next round on the following Monday, by which time she would have finished her antibiotics and he would have the x-ray in front of him.

Q We know from the chronology that the last entry with regard to the x-ray is on page 19 on 9 April where the nursing care plan has recorded, "To remain on bed rest until Dr Reid sees x-ray of hip." In the ordinary course of events, bearing in mind again that this is not your note, what does that indicate to you, does it convey anything to you as to whether an x-ray had been taken or had not been taken?
A It does appear from that sentence that an x-ray had been taken and that it was quite appropriate, whatever he was expecting to see on the x-ray, for her to remain on bed rest.

Q But you yourself cannot say one way or the other.
A I have no recollection either way.

Q What we know of course is that Dr Reid did see her a week later on the 12th, and I will come on to that in a moment. What I would like you to deal with is this: you are the doctor who has day to day medical responsibility for this patient. The patient is as it were under Dr Reid; why did you not first of all make sure that an x-ray had been taken and, secondly, why not make sure that you yourself saw the x-ray in order to check on this patient's treatment with regard to it?
A I felt it was quite appropriate if he wanted an x-ray of the hip for it to be organised and to be booked and to be done, but an x-ray – whatever it showed at that point of time – was not going to alter my management of that lady during that week.

Q Why not seek to see the x-ray yourself, to satisfy yourself that there was nothing which required any alteration?
A Because, again, anything that was visible on that x-ray was not going to alter. She was now on what I hoped was an appropriate antibiotic, she was on bed rest until he saw her again, there was no necessity or urgency for anybody to look at that x-ray until the next ward round, there was no decision to be made that week.

Q First of all this: if Dr Reid had wanted to know what the x-ray showed himself as a matter of urgency, what could he have done?
A He could have had it done that afternoon.

Q In the ordinary course of events when a consultant asks for an x-ray to be taken when would the consultant see that x-ray?
A As soon as they made themselves available to look at it again. It would be there in the x-ray department waiting to be reported.

Q Why not, as the doctor responsible for day to day management of this patient, in the interim – which might be as much as a week or it might be more – do something yourself about looking at the x-ray?
A Because I felt that what I was doing was entirely appropriate. The x-ray was not going to alter my management.

Q To understand your process of thought, the consultant had thought it was worth having an x-ray taken.
A Yes.

Q Did it register with you that there must be some purpose in that?
A Yes.

Q What did you think would have been Dr Reid's purpose in wanting an x-ray?
A He would have been thinking that possibly it was not infection and that it was a dislocation or a collapse of the prosthesis that had been put in which would, if she had been well enough, have meant that she should be transferred back to the unit where the original operation was done.

Q Can I just follow through the process if you had been involved in this specifically yourself, leave aside Dr Reid for the moment. If you had checked first of all whether an x-ray had been taken and if you found that an x-ray had not been taken, despite what the consultant had asked for, what would you have done about that?
A I would have chased it for him.

Q Assuming there was an x-ray available, either then or after you had chased for it, would you in the ordinary course of events have sought to look at it anyway just out of interest?
A Possibly not; I would have waited for it to come to be available on the ward round the following Monday.

Q Bearing in mind this patient and the realities of what we are dealing with, what might the x-ray have shown, what were the possibilities?
A There were three main possibilities, one that the prosthesis had dislocated as in the case of the previous patient we have looked at.

Q So dislocation, yes.
A Disintegration, that the head had collapsed down.

Q As Dr Reid I think described.
A Yes.

Q The third possibility was that there was infection. I am not sure that that would show anything because I am not an orthopaedic surgeon and I am not absolutely certain that you would be able to see anything on an ordinary lateral AP x-ray if there was a deep-seated infection. I think you would be more likely to find something on the swab and clinically.

Q Supposing you had seen the x-ray and it had shown that the ---
A The actual prosthesis had collapsed.

Q That there had been that problem, the disintegration of part of the femur itself, as I remember it from Dr Reid's description, is that right?
A Yes.

Q And there in effect being nothing for it to be fixed into. Supposing you had seen that, what would you have done in terms of contacting the orthopaedic team or anything else, before Dr Reid came round again on the 12th?
A I personally, bearing in mind the general state of health of this lady and her general frailty and her general pain level, would not have made the transfer back to Haslar.

Q Would you have contacted Dr Reid about it if you had seen the x-ray and with a patient who was less frail, less unwell?
A Yes.

Q There might have been a transfer back.
A Certainly.

Q Would you have told him what you had seen on the x-ray?
A I would.

Q So that --
A He could arrange or he could get me to arrange a transfer back, if he felt it was appropriate in that particular hypothetical patient, and I am sure there must have been occasions over the years that we had to do that. This lady, even at that time during that week, was not well enough to go anywhere.

Q Can we take it that although you would not have been present when Dr Reid it appears did his ward round on the 7th you would have been aware that he had asked for an x-ray by seeing notes later on?
A I would presumably have been aware. It was written certainly in the nursing notes if not in the medical notes. He must have written that he wanted an x-ray.

Q Would you have been seeing this patient every day on the days that you went into the hospital in the morning?
A I would.

Q Would you have seen the nursing notes with regard to 9 April shown on page 19 of the chronology where it says, "To remain on bed rest until Dr Reid sees x-ray of hip"; is that something that you would have seen in the ordinary course of events?
A I am sure they would have made me aware of it.

Q If an x-ray had been taken.
A If an x-ray had been taken.

Q Your evidence is that if you had been aware that an x-ray had been taken you yourself would not have specifically sought to look at it.
A No.

Q Then over the page, please, to page 20, 10 April, MST still being administered.

A

"Very poor night. Appears to be leaning to left. Does not appear to be as well and experiencing difficulty in swallowing. Stitchline inflamed and hard area. Complaining of pain on movement and around stitchline. Oramorph given."

There is the Waterlow score and Barthel.

B "Enid not drinking despite encouragement and help."

What is the significance of that note to you?
A Something has happened to this lady on Saturday, 10 April. I was under the impression when I came to see her on the Monday that she had possibly had a stroke.

C Q Do you take that note "appears to be leaning to the left" as meaning when she was standing?
A No, I do not think they would have tried to stand her. She was on bed rest as strictly ordered by Dr Reid. I suspect that her swallow had been affected and the left side had been affected and the wound was still very inflamed, despite nearly being at the end of the antibiotics. They must have decided that she needed additional pain relief over and above the MST and they gave her Oramorph.

D Q Supposing it was the case that she had had some form of stroke, what was the appropriate treatment for that in the circumstances?
A Palliative care, to make her comfortable, to relieve her symptoms.

Q Can we take it that you would have seen her on the following Monday? If that is a Saturday then the Sunday which we will go to now is the 11th. Take note of the fact that the 11th is a Sunday, take on board what the nursing care plan showed,

E

"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 given. Commenced antibiotics a few days ago. Wound not leaking today but hip feels hot and Enid complains of tenderness all round site. Enid very drowsy and irritable."

F A This is a very unwell lady now. This lady possibly has infection other than in the hip but possibly has had a cerebrovascular event, some sort of transient ischaemic episode, and had I seen her over that weekend I would probably have done what I did on Monday morning one or two days earlier. I would have moved on with her analgesia.

Q Let us just make sure we have the days of the week right because if you look on page 21 which appears to be 11 April, which you thought was a Sunday, it shows you reviewing her.
G A I do not think that entry in the nursing records is correct. I saw her first thing on the Monday morning, the 12th.

Q The 12th is also the day when Dr Reid reviews her.
A Sees her in the afternoon, yes.

Q If that is right we should be putting beside that 12.4.99, the Monday.
H A Yes.

Q Thank you. Let us just look at that. The significance please, just before that entry, of Enid being very drowsy; what is the significance of that?
A She would be drowsy if she had had a stroke, she would be drowsy if she was becoming toxic from her wound infection, so either was a possibility.

Q That Sunday is before any subcutaneous analgesia.
A It is.

Q You then review her on the Monday. "Nephew telephoned at 19.10" – on the Monday evening.
A Sunday evening.

Q That is referring to the Sunday.

"... 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 around wound on rt hip red and inflamed. Asked about her pain. Enid denies pain when left alone but complaining when moved at all. Syringe driver possibility discussed with nephew who is anxious that Enid be kept as comfortable as possible."

A That tells you that my nursing staff were obviously aware of a major deterioration in her condition. They were not going to start the syringe driver without my say-so but they were thinking of it in terms of appropriate analgesia.

Q "Seen by Dr Barton", the note goes on. "To commence syringe driver." This was after it had been recorded that the nephew was anxious that Enid be kept as comfortable as possible. Then looking at that same day, it appears to be the Sunday.
A The Monday.

Q The Oramorph being administered at 7.15 and the MST two 20mg doses administered, are we thinking of that as the Sunday or the Monday?
A We are thinking of that as the Sunday. We are having to give top-up Oramorph in addition to her regular MST.

Q If we look then at page 23 of the chronology, we can see that on the Monday diamorphine is prescribed by you at 20-200 mg; that 80 mg is administered at eight o'clock in the morning; and then after Dr Reid had intervened – and we will come to that in a moment – 40 mg at 16.40 in the afternoon. Hyoscine you prescribed, but it was not administered, and you prescribed on the Monday 20-80 mg of midazolam, with 20 mg being administered at eight o'clock in the morning and 40 mg administered – and again we will come on to that later – at 16.40. There is also another form of medication by subcutaneous infusion that was not administered. What was that cyclizine?
A That was in case she vomited or felt very nauseated with the diamorphine.

Q Why on the Monday morning when you saw her, did you first of all prescribe diamorphine and midazolam?
A Because she was dying. She was having difficulty taking tablets over the weekend. She was only having sips, she was refusing food and drink, and she was in an enormous amount of pain when I saw her on that Monday morning.

Q If you prescribed the diamorphine for pain, with a lowest dose range of 20 mg, does it follow that at that time you thought 20 mg might be the appropriate starting dose?
A It was the lowest dose of the range that I usually wrote up, but it became apparent when I saw her that she was going to need considerably more than 20 mg to control her symptoms.

Q Would you have seen her before you wrote up the prescription?
A I possibly wrote the drug chart up and then went in to look at her.

Q We notice, obviously, that the first administration is 80 mg.
A Yes.

Q Whose decision was it to administer 80 mg by subcutaneous infusion as opposed to 20?
A Mine.

Q Because it is four times as much.
A Mine.

Q Why?
A Because she was in severe pain.

Q Since the subcutaneous infusion takes a bit of time to work, to get up to the desired level ----
A Yes.

Q -- why not in her case administer a single injection, an intravenous injection of diamorphine to deal with the pain immediately, and then set up the syringe driver to build up gradually – the method that Professor Ford spoke of?
A I think she probably had her MST on the Monday morning. It is not clear from the chronology.

Q If the MST had continued, it would seem to be that the MST would be something she would get in terms of her general programme at that time.
A I would have been minded to give an adequate dose of diamorphine with midazolam that would build up during the day and make her comfortable. I did not usually use stat doses of subcutaneous diamorphine if I was setting up a syringe driver.

Q Why not, in order to achieve relief from pain as quickly as possible, and then the pain being kept controlled by the subcutaneous analgesic coming in?
A With the benefit of hindsight, perhaps it would have been kind to give her a stat dose, but I did not do it as a routine in those days, and on that occasion I did not. She had had MST. I put the syringe driver up in the hope that during the morning she would become more comfortable.

Q The midazolam is administered at the lowest dose range prescribed by you.
A Yes.

Q In the ordinary course of events, what monitoring would there be by the nursing staff, after you have prescribed subcutaneous analgesia, to make sure the patient is not over-sedated or suffering from any form of respiratory depression?
A There would be monitoring of her condition every time they saw to her. Every hour or so, somebody would be looking at her, checking that she was comfortable, not too sedated by the drugs, and that they were able to see to her with relative comfort on her part.

Q At some stage in the early afternoon, it seems, the patient was seen by Dr Reid, who formed the view that she was over-sedated, or "very drowsy" as he has described it, and reduced the diamorphine. How come the nurses did not pick up on that, if that is the case?
A I think she was dying. I think she was becoming very drowsy and unrousable because she was dying. I think it was difficult for Dr Reid, seeing her as a snapshot on that ward round, to make the distinction between why she was drowsy. I think it was the natural process of her death occurring – yes, contributed to by the diamorphine, but not totally caused by the diamorphine.

Q In any event, we know Dr Reid reduced it to 40 mg.
A He did.

Q Nobody asked for the midazolam to be increased, but a nurse apparently did increase the midazolam in a way that was not sought either by Dr Reid or indeed by you.
A No.

Q "If pain recurs," Dr Reid wrote, the dose could be increased to 60 mg. Have you seen that?
A Yes.

Q He has told us ----
A But it was relieving the pain, as he was able to move the hip without pain.

Q Yes. He has told us that that was something that he thought was appropriate. He noted with an exclamation mark "patient not rousable!" The nursing staff have recorded,

> "Diamorphine to be reduced to 40 mg over 24 hours. If pain recurs the dose can be gradually increased as and when necessary."

Dr Reid has explained how he made his calculation to get to the figure of 40 mg as being appropriate. The Nursing Care Plan goes on to say in respect of her:

> "Appears to be in some discomfort when attended to. Breathing very shallow."

Indeed, the following day, in the early hours of the morning, this lady died. It follows, I think, from what you have already told us that when you prescribed the diamorphine and the midazolam, this lady was really receiving in relation to the administration of those drugs ----
A End-of-life care.

Q -- end-of-life care rather than palliative care.
A Absolutely.

MR LANGDALE: Thank you.

THE CHAIRMAN: Thank you, Mr Langdale. We will take a short break now and return at 12.15, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everyone.

MR LANGDALE: Dr Barton, Patient J, Geoffrey Packman, please, the gentleman who was very large, trapped in the bathroom and so on, who went into Queen Alexandra on 6 August 1999. There are various matters referred to in the chronology. Can we go on, please, to page 7, where there is an entry which is about eight or nine days after he went into QAH. Obviously some consideration was being given on 15 August, at page 7, to whether he should go into Dryad. He had been seen, in terms of any consultants, by Dr Reid before this, who had spoken about the possibility of him going into Gosport War Memorial. The position is set out there very much in accord with the earlier entries about his problems: serous fluid from sacral ulcers and the amount of nurses required to try to move him for dressing changes and so on. This is the man whose sacral ulcer or sore was described by a witness as being "horrendous". Dr Tandy sees him on 16 August. Dryad Ward bed unavailable. On 18 Dr Tandy reviews him and we have seen the position there already with regard to the sores and so on.

> "Black stool overnight ... Check on his haemoglobin."

As Professor Ford said, that could be an episode of maelena. We move on to page 10 of the chronology, when he is admitted to Dryad. This is the patient who was admitted by Dr Ravindrane. We have his notes, and we have been through them with him in his evidence.

> "Problems: obesity, arthritis, bilateral knees, immobility, pressure sores. On high protein diet. MTS = very good."

MTS?
A Mental test score.

Q Yes.

> "No pain. Better in himself. Legs ... Need review later this week."

Dr Reid said that he would disagree fundamentally with any suggestion that this patient had been sent to Dryad because there was a potential for mobilisation. He had no such prospect was Dr Reid's view. You would not have admitted him, as we know. Are you able to say when you first would have seen him? If we go on to 24 August, page 11, you certainly prescribed some drugs, temazepam, so it seems you would have seen him on that day – or does that not follow?
A It would ------

Q I am sorry, perhaps I can interrupt you. So that I do not confuse you, let us follow through the history in terms of the notes. The previous medical history is set out on page 10. Shirley Hallman:

A

"Admitted from Anne Ward following episode of immobility and sacral sores. Catheterised. Able to feed himself."

Over the page, Dr Ravindrane has prescribed doxazosin, frusemide, Clexane and paracetamol (1 gram four times daily). We can see the paracetamol is administered between 23 August and 26 August. A blood sample is sent for analysis – and this is the haemoglobin that we have looked at, reported on 25 August as being 12. You prescribed temazepam on
B 24 August, the day after his admission If we move on over the page, on 25 August Dr Beasley gives a verbal message and so on. You do not prescribe any drugs and do not see him, but you do see him the following day on 26 August.

A Yes.

Q Can you help us with regard to the circumstances of your prescribing temazepam, if you can recall?

C A I would imagine that the nursing staff said to me that he was having difficulty sleeping, and that I was happy to write up a dose of a benzodiazepine in order to try to help him sleep.

Q So you may not have seen him on 24 August?

A I may not have seen him. But I possibly did see him and wrote up his temazepam that day.

D

Q Looking at page 12 of the chronology, coming on to 25 August: "Verbal message from Dr Beasley" – that is another doctor in your practice.

A It is.

Q "To withhold Clexane dose" and to review with Dr Barton the following day. The nurses not:

E

"Passing fresh blood PR [per rectum}. ? Clexane. Verbal message from Dr Beasley to withhold 1800 hours. Dose and review with Dr Barton mane. Also vomiting. Metoclopramide 10 mg given intramuscularly at 17.55 with good effect.

Transferred to heavy duty bed. Patient slide and six members of staff used."

F Carrying on, we can see that temazepam was administered. Gaviscon was administered. It looks like Dr Beasley prescribes that.

A Anti-sickness drugs.

Q And metoclopramide – by Dr Beasley again. Looking at 26 August:

G "08.45. Visited to ensure no problems with moving and handling. Discussed situation with sister. Agreed to encourage Mr Packman to do as much as he can himself. Physio to see patient today with a view to starting pressure physio."

On that day in the morning Dr Ravindrane was consulted with regard to Clexane. Hamblin notes:

H "Fairly good morning. No further vomiting. Dr Ravi contacted re Clexane. Advised to discontinue. Repeat haemoglobin today and tomorrow. Not for resuscitation."

Pausing there, this appears to have been telephone contact with Dr Ravindrane. Nobody is criticising the discontinuance of the Clexane because it is an anticoagulant and so on. Would your reading of that be that anything had been said with regard to Sister Hamblin and Dr Ravindrane about resuscitation, because we saw the QAH records showing that he is one of the people described not as "555" but anyway as not for resuscitation? What does that signify to you?

A My reading of that, when I visited at lunch time, was that the senior registrar, standing in for the consultant, had discussed the case with the senior nursing sister and that this gentleman was not for resuscitation and, in the same vein, would not be suitable for transfer back to the main unit.

Q Help us with that: why would you read that into it? If Dr Ravindrane had felt that he should be transferred back, did he have the power to do so?

A He did.

Q Would he be senior to you in the pecking order or not?

A He would – and he was, in effect, acting as the locum for Dr Reid, so he was the acting consultant. When I came on to the ward at lunch time, my understanding was that he had discussed the patient with Sister Hamblin and that this gentleman was not for any further transfer and not for resuscitation – not that we could do resuscitate anyway, but not for resuscitation.

Q What is the significance of repeat haemoglobin today and tomorrow?

A He wanted to see whether Mr Packman had lost any blood, a small amount of blood, a substantial amount of blood, and a repeat haemoglobin would give him a feel for how much blood loss there had been since the last one was done.

Q Who do you understand is asking for the haemoglobin tests and results?

A It was my understanding that Dr Ravi had asked for them.

Q We will come on to what you do with regard to them, but if in the ordinary course of events a doctor in the position of Dr Ravindrane wanted to know the results, he has asked for the nursing staff to get these tests done, what would he have to do to get the results himself? How does he get to know what the results are?

A There was not a computer system that you could tap into in those days, so he would have had to wait for the blood result to come back to the ward or he would have had had to directly ring the haematology lab and ask for the result himself.

Q Then we come to the situation where you come into the picture. He is unwell at lunchtime.

> "Seen by Dr Barton this afternoon - await results of Hb [haemoglobin]."

We will come on to your note in a moment.

> "Further deterioration – c/o [complaining of] indigestion, pain in throat, not radiating – vomited again this evening. Verbal order from Dr Barton diamorphine 10 mg stat...".

What does that signify?
A That I wanted him given pain relief there and then.

Q This would be diamorphine given how?
A Intramuscularly. I would not have used intravenous.

Q That is given at six o'clock that evening.

"Metaclopramide 10 mg ... Mrs Packman will visit this evening.

[Shirley] Hallman: 1900: Dr Barton here. For Oramorph 4 hourly. Wife seen by Dr Barton, explained Mr Packman's condition and medication used."

Just following through the history, still on 26 August, on page 14:

"Blood sample sent for analysis.

Reported on 26/8/99: Hb [haemoglobin] 7.7. Many attempts made to phone these results, no answer from GWMH switchboard."

Help us with that, please?
A The laboratory has an automatic procedure, that they will contact the clinician ordering the blood test urgently if they are concerned about the result, and that result was quite low. I am unable to explain why the porters were not answering the phone at the Gosport War Memorial Hospital switchboard unless the phone lines were down. I have no explanation for why the result did not get through to the ward. The result of the haemoglobin, in view of his general condition, would not have altered my management of him at that time.

Q Let us just deal with the significance of that. What does that signify? We have seen a level of 12 – I think 12.2 - earlier?
A That he had dropped his blood count quite substantially since the previous blood test had been done. He had had a bleed.

Q And what is the significance of that?
A The significance of it is that he is bleeding somewhere into his bowel. Clinically he is settled that night, but under normal circumstances if you were faced with a fit young person who dropped their haemoglobin like that, you would want to transfer them back to an acute unit and resuscitate them and institute curative measures.

Q I will come on with what you decided to do with this patient in a moment. Did you in due course get that result – the 7.7 result? Perhaps we can just check page 210 in the bundle with regard to this haemoglobin because I think it gives you a precise date to answer the question I was just about to ask you. Would you therefore look at page 210 in the file? This is the haematology report. Over on the left hand side, very near the bottom, can we pick up on this slightly poor photocopy the 7.7?
A Yes.

Q It is the bottom left. That is the result that note we were looking at earlier on is talking about, and we can see about two-thirds of the page down the page on the right what look like your initials?
A Yes.

Q In handwriting. Is that right?
A Yes.

Q And does that signify that you yourself will have seen this?
A The report would have arrived on the ward a couple of days later.

Q We have a date there ---
A I do not normally date them when I have ---

Q No. We can see there is a date, 26 August – the date we have been looking at?
A Yes.

Q And the result comes through, and it is printed on that in the centre of the document.

"Comments:

Many attempts were made to phone these results, no answer from Gosport War Memorial Hospital switchboard."

But you therefore would have seen them yourself?
A Two days later.

Q So we call that the 28 August, do we, you would have seen them?
A Yes.

Q We are going to deal with one other page in case it needs clarifying. The following page is page 212, just following through these reports, the dates and so on. Page 212 shows your initials again, the same position. Is that right?
A Yes.

Q And over on the left hand side towards the bottom, haemoglobin then 12?
A Yes.

Q All right? And the date of that is 24 August, followed by the 25th, and there is then a stamp over on the right hand side at the bottom, 26 August. What is the significance of that?
A I imagine that is the day they send the report out. It is not our stamp, I do not think.

Q It is not right. In any event, you became aware on, you think, about 28 August ---
A That he had ----

Q --- that the haemoglobin had dropped.
A Quite markedly, yes.

Q To 7.7. Let us follow through the history, still on 26 August. Does that mean you were called to see him, or you called in to see him? Or maybe it does not matter?

A A It does not matter.

Q All right.

"Pale, clammy, unwell. Suggest ?MI treat stat diamorphine and Oramorph overnight. Alternative possibility GI bleed but not haematemisis. Not well enough to transfer to acute unit. Keep comfortable. Happy for nursing staff to confirm death."

B

I need to ask you a number of questions about that. You saw him, it would appear, I think in the afternoon, you said?
A Yes.

Q The significance to you on what you knew of this patient from any records or other information of "pale, clammy unwell": what is that signalling to you?
C A He was having a cardiac event, possibly myocardial infarction, possibly a severe angina attack.

Q Why not the paleness, the clamminess and the being unwell, why not the result of a GI bleed?
A And that I put: "Alternative possibility GI bleed", but he was not vomiting blood. If he was bleeding into the bowel, it was going downwards and not coming upwards.

D

Q Professor Ford indicated that it was a suggestion of perhaps a number of problems, including MI?
A Yes.

Q What balance were you striking, if any, between the cause of this being MI, or the case of it GI bleed?
E A My management would have been exactly the same, whichever had been the primary cause for the paleness and clamminess.

Q But what balance were you holding between them. Were you thinking "More likely MI, or more likely GI bleed" or "I really don't know"?
A I was thinking more likely MI.

F Q Would you help us as to why?
A Because of the appearance of him and the paleness and the clamminess and my examination of him, but I was aware that there had been a suggestion of melena during his time in the acute unit, and I was also minded that that possibly could have recurred.

Q Why the immediate dose of diamorphine intramuscularly?
A To give him pain relief.

G

Q How does that have any bearing, if it has any bearing at all, on the fact that there may be this heart problem?
A It will help with cardiac pain. It will make him more comfortable, it will make him a little bit euphoric and it will not do any harm to his cardiac status.

Q Would there have been in terms of your examination of him some check on his blood
H pressure, pulse rate and the other things normally taken care of by the nurses?

A A As I remember, they found it extremely difficult to find a cup large enough to find a cuff large enough to take his blood pressure, but they should have taken his blood pressure.

Q Would you have taken that into account in terms of your examination?
A It would have made no difference to my management of him.

Q Why the Oramorph overnight? I am directing this question because he does not
B appear to be in any pain according to your note.
A To keep him pain-free, but to him settled , peaceful, comfortable overnight.

Q Would there be any down-side to treating this patient with diamorphine by means of the intramuscular injection, and then Oramorph overnight, if it was a GI bleed that was the problem?
A The downside was that he was not going to be resuscitated, so it would not stop the
C bleeding. On the other hand, it would not cause bleeding, so it had neither an up nor a downside.

Q No haematemisis, you noted. You were considering the possibility. Would you just explain that?
A He was not vomiting blood. There was no blood coming upwards, so it suggested that if there was bleeding, it was a site lower down in the bowel and he was not vomiting blood
D back. I knew the Clexane had been stopped. There was not really anything else that we could do.

Q Just to come back, the matter you were mentioning in your evidence. If this patient was not the patient that he was, morbidly obese and so on, what would have been the appropriate thing to do about a possible GI bleed?
A He would have gone straight to the A and E department at your local district general
E hospital. He would have had a drip put on. He would have had blood cross-matched. He would have had the theatre booked in order to have an endoscopy to see if they could identify the site of the bleeding and, if possible, treat it.

Q This patient was the youngest of the patients we are considering. I think he was somebody who was 67 at the time, if I am remembering correctly. I would like you to address this: "Why not send this man back to hospital, despite the problems with moving
F him and weight, and so on and so forth?" Why not send him back so that can be – my words – "checked out"?
A His chronological age does not reflect his morbidity age. He had a series of major comorbidities and he was probably not well enough to transfer even then, even at that stage, having just had this bout of chest pain and discomfort.

Q You recorded "not well enough to transfer to acute unit." What was the problem?
G A I did not think we would survive, with disclosure people getting him onto a gurney, the ambulance ride, the weight on a trolley in A&E. Also in the face of this discussion with the senior registrar about "not for resuscitation".

Q Why not at least take the chance just to see whether anything could be done. I would like you to address that question?
A I did not take chances with my patients.
H

Q What about the question of a blood transfusion which is one of the things that was just suggested. I would like you to deal first of all with this. Can a blood transfusion be done at Gosport?
A No.

Q So what would have had to happen?
A Again, he would have had to undergo transfer in order to have that done.

Q Since you had formed the view, indeed you recorded in your record of this patient, "Not well enough to transfer to acute unit," what was the situation now so far as he was concerned? Palliative care only?
A Palliative care only.

Q This patient was not unconscious. He was conscious and able to communicate. Did you consider whether you should discuss that with him? I am raising this because Professor Ford indicated that it was one of the things that ---
A I cannot at this remove of time remember whether we discussed with him. I would not have been offering him the option of going up to the acute unit. I did not think that the option was open to him, so I was minded to talk to his family and discuss as a medical and nursing team how we were going to manage him.

Q It is clear obviously that the wife was brought into the discussions but because of something said by Professor Ford, I would just like you to deal with the patient himself. Obviously there is on record of it. In the normal course of events, if you had discussed with the patient, "My clinical view is that there is really no point in shifting him back to QAH because..." and then give the reasons?
A Yes.

Q "And I think the right thing to do is simply deal with your sentence as best we can"?
A Yes.

Q If you had said something like that, would you normally record it, that you had spoken to the patient, in this case, himself?
A Yes.

Q Had there been other cases, turning aside from these twelve, when you had discussed with patients at Gosport War Memorial Hospital, the course of treatment that was to be pursued in the sense of palliative care?
A Yes.

Q When they had been conscious enough and able to communicate for you to do so?
A Yes.

Q If it is right that your note does not record it happening, and therefore it means that it did not happen in the case of Mr Packman, would you help us as to why in his case, casting your mind back as best you can, as to why it is you did not indicate to him what the future held in your view?
A I have no recollection of whether the nursing staff or I sat down with Mr Packman and discussed things with him or not. It was not the culture as much all those years ago to

A involve the patient as fully and as overtly as we do now, I think. I think we tended to be more paternalistic and maternalistic in medical decision than we are now.

Q We will come on to see what happened in discussing things with his wife, and so on. Then looking at page 15 of the chronology, just to look at the drug chart position, we see metoclopramide. Then diamorphine was administered. There is your intramuscular injection of 10 mg at six o'clock in the evening of this day, the 26th. How long would that take to take
B effect very, very roughly – the intramuscular ----
A That is quite quick, is it not, twenty or thirty minutes.

Q Yes, something like that. Prescribed verbally, subsequent prescription by you. Oramorph, you have already told us about. You were prescribing four hourly 10 mg. In terms of the size of the patient, did this influence in any way the size of doses, or is it something we disregard?
C A He got 10 mg written up, 10 to 20 mg written up four hourly. The nurses had the discretion to give the higher dose if they felt he needed slightly more pain relief, but otherwise I did not make much allowance for that.

Q Then Oramorph that is administered, we can see the prescription and it involved administration at night as well. So the total on that prescription in 24 hours would have been, if that was followed, 10 to 20 mg four times a day, and 20 mg at night, so the range might
D either be a total of 60 in the day, or 100 in the day. Is that right? Am I reading it right?
A Yes.

Q It gave that latitude?
A Yes.

Q Certainly 20 mg administered that night, and you prescribed, although it was not
E administered, diamorphine 40 to 200, midazolam 20 to 80. Looking at that anticipatory prescription, why did you have as the lowest dose for diamorphine 40, as opposed for 20 when this patient had not really been tested, if you like, on any opiates apart from the immediate injection of diamorphine and the Oramorph?
A I imagine that I would have taken his size into consideration when setting the subcutaneous dose and knowing by then he would not be opiate-naïve, he would have had
F some Oramorph by the time I used it.

Q Yes. Was that prescription envisaged as being something to cope with the pain that he would be suffering at some future point?
A It was.

Q Midazolam for the same reasons as you have already covered with other patients.
A Yes.
G

Q He is on the palliative care route on that day, 26 August.
A Yes.

Q He was reviewed by you on the 27th, the following day. Nurse Hamblin recorded:

"Some marked improvement since yesterday. Seen by Dr Barton this am – to
H continue with Oramorph 4 hourly – same given, tolerated well. Some discomfort this

afternoon, especially when dressings being done. Wife has visited this afternoon and is aware that condition could deteriorate again. Still remains poorly."

I just want to ask you about this in terms of the way you approached this sort of situation. There is a patient who is able to communicate, apparently able to take in information. His wife has been informed as to what the view is but what would your view be of the expectation with regard to the wife, what the wife would do or might do in terms of speaking to her husband about the situation?
A I did know that the family were going through an extremely difficult time. She was waiting to go in to have major surgery for breast cancer; I do not think that there was a great deal of communication at any level going on between them. I think they were both colluding with the other.

Q Would you have expected in normal circumstances the wife to speak to her husband about it if that was the position, in normal circumstances?
A I would.

Q Did you know one way or the other whether this lady was going to speak to her husband or not?
A No.

Q Maybe she did not, as we will discover, but did you know one way or the other whether she was going to?
A No. We also knew that she in theory knew that she would never be able to have him back home again because he was too dependent and too difficult for her to ever nurse at home again. Whether that was another reason why they were not communicating – that was quite possible.

Q She was aware that his condition could deteriorate again. "Still remains poorly."
A Yes.

Q Then the Oramorph continues on that day, 60mg administered. The next day, 28 August, is the day that you were aware at some point that the haemoglobin was down to 7.7.
A Yes.

Q Reviewed by you:

"Remains poorly but comfortable. Please continue opiates over weekend."

What was that an indication for the nursing staff to do, continue the Oramorph, is that right?
A Yes, it was an indication that I felt that if there had been bleeding – and I knew by the 28th that there had been bleeding – that it had stopped, or certainly slowed down sufficiently for his overall clinical condition to stabilise and for him to be reasonably comfortable on that dose of opiates.

Q Help us with that, how could you conclude that it had stopped or slowed down sufficiently not to be an immediate problem?
A Because he would have continued to deteriorate quite markedly. If it was already down to 7.7 and he continued to bleed he would become very poorly quite quickly.

Q What would the signs of the bleeding have been? We saw that at the time that Dr Ravindrane was contacted on the 26th, if that is the right date ---
A He was pale and clammy.

Q So what would you have expected the nursing staff to have noted if he was continuing to bleed?
A They would have begun to pick up melaena, black stools, being passed again.

Q Or literally bleeding from the rectum.
A Or literally fresh bleeding from the rectum. Also his clinical condition would have deteriorated as he became weaker due to severe anaemia.

Q So he remained poorly but comfortable on the information given to you – again, you would have seen him yourself that day, is that right, where you reviewed him on the 28th?
A Yes.

Q I think we will find the 28th was a Saturday.
A Yes, I wrote in the notes on the Saturday.

Q Nurse Hallman records:

> "Remains very poorly – no appetite, has refused all food. Wife visited – very distressed as she is having surgery this coming week."

We have heard about that in evidence.
A Yes.

Q

> "Oramorph given as prescribed, condition remains poorly and variable ..."

Then the drug charts show the administration of the Oramorph and over the page, on page 17, Sunday 29 August, the Oramorph continues, he slept for long periods in the night of 29/30. "Oramorph given as prescribed." As we know, there is no further note by the nursing staff of any particular symptoms.

Then on Monday, 30th, Nurse Hamblin records:

> "... left abdominal pain. Condition remains poor. Syringe driver commenced at 14.45. No further complaints of abdominal pain. Very small amount diet taken, mainly puddings. Recatheterised. When possible encourage fluids ..."

We can see at the bottom of that page the diamorphine was administered at the lowest of the range you had provided, 40, and midazolam the same.
A Yes, 20.

Q Whose decision was it to commence the syringe driver at a quarter to three in the afternoon of that Monday?
A It is a difficult one that because we thought it was the Bank Holiday Monday. I might have been on duty, I might well have gone in on that day and written up the syringe driver, or

A the duty doctor might have been contacted and asked to start the syringe driver – I cannot say at this remove of time.

Q Very well. There is no note to help us on that.
A There is no note from anybody, no.

Q What about the use of opiates by means of subcutaneous infusion to treat abdominal
B pain? That is the only pain that is recorded – I would like you to help with that.
A My feeling is that we were now using the opiates to control end-of-life symptoms together with the midazolam rather than strictly speaking for abdominal pain, for which opiates would not be particularly appropriate.

Q I was going to ask you about that because Professor Ford gave that as his view. You do not disagree with that.
C A I do not disagree with that.

Q Not for abdominal pain ---
A Per se.

Q As a symptom.
A No.
D

Q Supposing a nurse telephoned you and said "This patient is now suffering and complaining of abdominal pain. His condition remains poor, shall we start the syringe driver", what would you have said?
A I would have agreed?

Q Why not say "Keep going with the Oramorph" or advise more Oramorph rather than
E going on to the syringe driver because he can take oral medication it seems, when possible encourage fluids and so on. Why not say "Increase the Oramorph, see how he does and hold back on the syringe driver for the moment." I would like you to deal with that possible situation.
A I can only think that whoever discussed the use of the syringe driver with the nursing staff agreed that he was coming to the end of his life, he was now on a terminal care pathway and that it would be quite appropriate, despite the fact that he was still taking puddings,
F despite the fact that he was still conscious, to give him his opiates and his anxiolytics subcutaneously rather than orally. There is no obvious reason in that last nursing entry for doing it, but the nursing staff must have felt it was appropriate or they would not have asked to do it.

Q We will move on to 31 August at page 18 in the chronology, the 31st.
A That is the Tuesday.
G

Q The Tuesday.

"Appeared to have comfortable and peaceful night. This morning has passed a large amount of black faeces. [At night] Comfortable night – continues to pass tarry black faeces."

H What does that signify, black stools?

A A Black stools means that at some stage previously he has bled. Either this represents what was going through on the previous Wednesday/Thursday when he dropped his haemoglobin from 12 to 7 or it represents the bout of abdominal pain on the previous day, depending on at what level of the bowel this is happening. This is altered blood now appearing to the outside world.

Q Would that be consistent with him having a large GI bleed?
B A Yes.

Q Professor Ford indicated that it was extremely unlikely that the surgical team would have intervened because of his condition and situation but the key was to replace the blood by transfusion, and he expressed the view that he should have been transferred back or at least discussed with the on-call team at the hospital. What do you say to that?
A That it was inappropriate to have that discussion and it was inappropriate to try and
C transfer him.

Q Alternatively to speak to the consultant, somebody more senior than yourself, saying "I do not think it is really feasible or in the patient's best interest to transfer him back to hospital. I think he has got a large GI bleed" and consult with somebody more senior as to what should be done. What would you say to that?
A I could have passed the responsibility for that decision further up the line. I took the
D decision, based on the conversation with the senior registrar on the Wednesday and the nursing sister; I felt that nothing had changed between them having that discussion and the picture of him on this Tuesday morning.

Q Dr Reid himself said he did not think you had acted inappropriately but I wanted you just to deal with that because that is one of the other things that Professor Ford suggested should have occurred. Then if we can look at the drug charts, the administration of
E diamorphine in the afternoon of the 31st, 40 and 20 with the midazolam, and then the next day, which would have been Wednesday, 1 September, Dr Reid sees the patient and sets out in his note there:

> "Rather drowsy but comfortable. Passing melaena stools. Abdomen huge, but quite soft. Pressure sores over buttock and across posterior aspect of right and left thigh. Remains confused. For TLC – stop frusemide and doxazosin. Wife aware of poor
F prognosis."

Dr Reid gave his opinion that he was obviously terminally ill and so on and expressed this view: had this been recognised earlier, the GI bleed, it is possible something could have been done for him but it is important to state that his pre-existing problems would remain. With regard to the drowsiness he said it may be that the amount of sedation was entirely appropriate because sometimes it is not possible to relieve a patient's distress without them
G becoming drowsy. We have been through that already.
A Yes.

Q And he has expressed his view about the course of action that is taken. It appears, Dr Barton, that you did not see him on that day, 1 September, or do you remember it, thinking back to the patient?
A No, I have no recollection. It does not sound as if I was on the ward round with
H Dr Reid.

Q We can see on page 19 Sister Hamblin recording the situation, the diamorphine and the midazolam have gone up as not controlling the symptoms.

"Mrs Packman has visited and is aware of poor condition. Incontinent of black tarry faeces at night. Peaceful night ..."

We can see the diamorphine and the midazolam going up in the way that is described, ending up at 60 on that day in the early evening. The following day the diamorphine has gone up again, the midazolam has gone up again and you have prescribed hyoscine. It looks then as if perhaps you were there on that day, 2 September.

A He was beginning to develop a death rattle so I added hyoscine to the syringe driver.

Q Can I ask you the same question as I asked you before, would you have done so if there was no reason to do so with the hyoscine?

A No, not at all.

Q Similarly, the increase in the dosages of diamorphine and midazolam on that day to 90 and 80 – in fact the hyoscine was not actually administered. Those increases, would they have been something checked or cleared with you or what?

A Absolutely.

Q Why was it appropriate to increase the dosages of those two drugs?

A Presumably he was suffering some form of terminal pain and distress and the nurses felt that it was appropriate to increase the dose.

Q Again, we cannot say because there is a dearth of nursing notes as to precisely what the symptoms were, correct?

A Correct.

Q Death recorded the following day, shortly before two o'clock in the afternoon. Looking back on the history with regard to this patient and the matters that have been raised by Professor Ford, do you stand by your course of action during that period of time with this patient?

A Totally.

Q Just before we stop in relation to that patient perhaps I can get you to deal with this: the wife, Mrs Betty Packman, indicated that you had told her that her husband was going to die and said something about all his organs were not working properly and he was going to die, something along those lines, and she remembered you saying that you liked her coat. Do you remember any meeting or discussion with her?

A I cannot remember. Perhaps as a means of trying to put the poor woman at ease at the beginning of the interview I would have admired the coat she was wearing but it was not said in any derogatory way.

MR LANGDALE: That is all I am going to ask you about that patient. Sir, perhaps I could turn to the next one after lunch.

THE CHAIRMAN: Yes, indeed. We will break now returning at five past two, please.

(Lunch adjournment).

THE CHAIRMAN: Welcome back everyone. Yes, Mr Langdale.

MR LANGDALE: Sir, before I move on to Patient K may I have handed to the Panel the remaining reference sheets, giving the individual page numbers in the individual patient file of documents referred to by Dr Barton in her statements. The remaining two relate to Mr Packman, Patient J, and Elsie Devine, Patient K. There are two pages per Panel member for filing wherever you find it convenient. (Pages distributed)

THE CHAIRMAN: In common with the earlier ones, we are putting these in for free filing and there is no exhibit number for them.

MR LANGDALE: Yes, exactly.

(To the witness): Patient K, Elsie Devine, born in Code A and so aged 88 by the time we get to the period of time you are responsible for her care. If we look at page 6 in the chronology, we can move on to the point where she was transferred to GWMH, she having been in Queen Alexandra Hospital, admitted with an episode of acute confusion and so on, a lady who had multi-infarct dementia, CRF (chronic renal failure) and a history of renal problems which we have been through more than once. From page 6 she is transferred to Dryad Ward on 21 October. We can see at the top of the page the review by the consultant geriatrician two days prior to the transfer, and we can see what is set out there: "Suitable for a rehabilitation programme." You saw her on 21 October. Your review says,

> "Transfer to Dryad Ward continuing care. Acute confusion .. Dementia, myeloma, hypothyroidism. Transfers with one, so far continent, needs some help with ADL. MMSE 9/30"

As Professor Ford said, that is quite low, in keeping with severe dementia.

> "Barthel 8. Get to know. Assess rehab potential. Probably for rest home in due course."

That speaks for itself, perhaps, in terms of what you were envisaging at that time. Just in relation to myeloma, first of all can we remind ourselves: what does myeloma mean?

A It is an auto-immune condition where the body attacks its own kidney cells but that diagnosis was not, as it turned out, correct, as I wrote it that day. I had taken it from the transfer letter when she came down from Queen Alexandra, and using that expression upset the family later on in the story, so it was not myeloma, it was a form of paraproteinaemia.

Q Thank you. I will come on to the matter you have just mentioned in a moment, but you are quite right to mention it. We can see over on page 7, still in relation to 21 October, that was written on the nursing side:

> "Very pleasant lady. Appetite not good. Can be a little unsteady on feet. Both feet swollen. Seen by Dr Barton."

Let us look at what you prescribed on the day of her admission. Thyroxine for ----

A Underactive thyroid gland.

Q Frusemide.
A A diuretic to reduce the oedema in her legs.

Q Temazepam.
A To help her sleep.

Q And then Oramorph is prescribed but not administered. Let me ask you the question directly: Why, with a lady with no sign of any pain, prescribe Oramorph 5-10 mg?
A At some time in the future, during her admission, I imagine that she might suffer from pain from her chronic renal problem or pain and distress at the end stages of her dementia, and I wanted to have it there on the drug chart should we need it in the future. I was not anticipating using the drug at that time.

Q Professor Ford indicated that in his view Oramorph was not a suitable treatment for confusion or dementia. What do you say to that? Do you agree with that or disagree with it?
A We did use it in the confusion that we saw in end-stage dementia, because it was very difficult to find something to make somebody comfortable at that end of their life, even in terminal dementia.

Q What about confusion? Quite where the line is drawn between the two of them, I do not know, but those were the two expressions used.
A Confusion, mental distress, agitation, fear: all a spectrum of emotions with or without an element of psychological pain behind them, very difficult to distinguish, very difficult to treat, very difficult to look after. Sometimes these people deserved a small dose of opiate.

Q Over the page, four days later, reviewed by Dr Reid. There do not appear to be any notes of any consequence between the day of her admission and 21 October and Dr Reid reviewing her on 25 October. How could that come about?
A Possibly because as a very stable, continuing care patient with no major problems or changes in her medication, it would not be a high priority to write in her notes, "ISQ. No change. Patient just the same."

Q Is this lady the sort of patient you would have seen on your morning visits, or might it be that she was one of those you would not need to see because there was nothing, as it were, going on?
A I would probably see her in passing anyway. She was quite often looking in someone else's locker or in the day room or wandering about.

Q You might see her.
A I might well see her, even if I was not asked to go and examine her as such.

Q Looking at Dr Reid's review on page 8, 25 October, we see:

"Mobile, unaided, dressed self. Continent ... Chronic renal failure" –

having noted blood pressure. He said in his evidence that, in his view, because she was likely to have vascular dementia and chronic renal failure, which was itself an extremely poor prognostic marker, and – in a later period of time when he saw her – because of the multiple problems and having excluded other physical causes, it was unlikely that anything more

A could be done from a renal perspective, when he was dealing with the question as to why he either then or later had not referred her to a renal consultant.
A Yes.

Q Then he saw her again some six or so days later, on 1 November, and mentions:

"... needs supervision of washing and dressing. Continent. Quite confused and
B disorientated. Unlikely to get much social support at home, therefore try home visit to see if functions better in own home."

Over the page, we can see that he prescribed amiloride. Might we just remind ourselves as to why that was.
A It was a diuretic to use in addition to the one she was on, to try to reduce the oedema in her legs.
C

Q On 10 November: confused and wandering around the ward and so on. On 11 November: Temazepam, trimethoprim and thioridazine. What was the purpose of the trimethoprim?
A That is a urinary antibacterial, because we thought clinically she had a urinary tract infection at that time. Thioridazine is a major tranquiliser. The wandering around the ward became quite difficult to manage on an open geriatric ward – quite invasive for the other
D patients and difficult for the staff – and that was an attempt to keep her behaviour more in keeping with the rest of the ward. Not a chemical cosh in any way, but just to make her a bit less restless and agitated.

Q Professor Ford advances no criticism of that prescription at all.
A No.

E Q I wonder if you could just deal with the point which came up earlier in his evidence as to whether these were locked wards or not. What was the situation on Dryad and Daedulus?
A You had to press a buzzer to get into the ward, but of course if Elsie was following down the ward behind somebody else, it was perfectly possible that she could pop out and would have to have to be fetched back from the main corridor, so it was not a locked ward as such.

F Q Within the ward itself ----
A It was all completely open.

Q But you could get through the outer door, as it were, and into the corridor if that sort of thing happened.
A Without much difficulty, yes.

G Q On page 11, please, 15 November, Dr Reid saw her again and requested a review by Dr Lusznat: "Very aggressive at times. Very restless." 16 November, the following day, you referred the patient to Dr Lusznat. Over the page to page 12, the picture remaining pretty much the same. On 17 November a note that she did not require thioridazine that day. Then we move on to 18 November, where she was reviewed by Dr Taylor:

"This lady has deteriorated and has become more restless and aggressive again."
H

A This is a Thursday, incidentally, 18 November.

"She is refusing medication and not eating well ..."

and so on. There is a reference to her being,

"Aggressive, wandering, moving other people's clothes, refusing medication, poor
B appt ..."

A Poor appetite.

Q Thank you.

"Reviewed on ward. Happy, no complaints. Waiting for her daughter. Says tablets
C make her mouth sore."

Looking at that different picture in the note made that day, we go on to see what happened in terms of prescription and administration of any drugs. At 9.15 on the morning of 18 November you prescribed fentanyl, and at 9.15 it was administered. What was it that made you prescribe and indeed have commenced the administration of morphine by means of a fentanyl patch?

D A She was aggressive, wandering, moving other people's clothes, refusing medication, so anything that I was going to give her to make her more comfortable and peaceful would not be an oral agent because she would refuse it or spit it out. I was looking at a parenteral preparation to ease these symptoms. In my mind at that point she was becoming end-stage dementia – which are the most difficult patients to look after and make comfortable because of all those things you talked about: What is the pain? Where is the pain? – superimposed on her deteriorating renal function. So she had two major comorbidities, she was becoming very
E unwell, and I thought that a transdermal patch at that point in time was a kinder way of controlling her symptoms. Subcutaneous infusion would have been very difficult to administer in somebody who was that restless and aggressive.

Q If she had not had a problem with taking medication, what would you have had in mind?

F A I think I probably would have gone for the Oramorph and carried on with a higher dose of the thioridazine, but that was becoming impossible to give because she did not want to take the tablets.

Q I would like you to deal with a point made by Professor Ford. He said in relation to significant renal failure that there would be a "susceptibility to opioids with regard to the metabolites." That is my note. Was that something which registered with you, that with somebody with a renal problem opioids might not be a good idea?

G A There was something about fentanyl, a synthetic opioid, being rather better for people with renal function problems than would perhaps be diamorphine. So fentanyl, in a way, was quite appropriate for somebody who had poor renal function.

Q When you were saying there was something about that ----

A Something in the manufacturer's leaflet or something in the literature. I was aware that fentanyl might, if it worked, be quite appropriate for this lady.

H

Q Right. We can check on that if necessary. Dr Reid indicated that in his view it was appropriate to use fentanyl with a patient who was in pain and/or distress, and he said that it was often used where it was unclear whether the patient's distress was physical or mental or a combination of the two. In relation to this lady, was there any demonstration or exhibition of pain?
A Not physical pain but not happy, not comfortable, not easy to look after. Restless, wandering, climbing into other people's beds: not a picture of a lady who was at peace with herself, although there were no physical signs of pain.

Q Fentanyl having been commenced on 18 November, what was it necessary for the nursing staff to do in terms of the fentanyl patch and how it was working?
A They knew, as I knew, that it would take up to 24 hours to get to its peak level, so that would mean she would need fairly careful monitoring throughout that day and the subsequent day to see if the dose was too much, too little, or appropriate. Dr Taylor would have seen that lady as the level of the drug was building up, because generally the psychogeriatricians came to visit after their morning work. They generally came in the afternoon, so Elsie would already have had perhaps up to half the maximum dose of fentanyl that she was going to get when Dr Taylor found her happy, waiting for her daughter.

Q Would Dr Taylor have had available to her the records showing that she was on medication?
A The drug chart would have been available at the end of the bed. She should have known that she was on a fentanyl patch.

Q In any event, Dr Taylor certainly did not say anything to anybody about fentanyl being inappropriate.
A She did not.

Q What about this as a possible adverse effect from the administration of fentanyl via the patch – confusion? Was there a risk that the fentanyl might cause confusion? Because later on she is confused.
A There is a possibility it could cause confusion, but she was quite confused before we started.

Q Looking at page 14, the date of 19 November when you reviewed her the following day,

> "Marked deterioration overnight. Confused, aggressive. Creatinine 360. Fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs subcutaneous analgesia with midazolam. Son seen and aware of condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death."

Running through the picture of the events of that day, the other event made in the significant events documents:

> "Marked deterioration over last 24 hours. Extremely aggressive this morning. Refusing all help from staff. Chlorpormazine 50 mg given intramuscularly at 08.30 – taken 2 staff to special. Syringe driver commenced at 09.25. Fentanyl patch removed. Son seen by Dr Barton .... He will contact his sister Mrs Reeves & inform her of Elsie's poor condition.

A

20.00: Daughter [Mrs Reeves] has visited – seen by Dr Barton. All care given to Elsie.

Nocte: Peaceful night. Syringe driver satisfactory."

Over the page, can we just taken on board before we move on what you prescribed:
B chlorpromazine, diamorphine 40-80, midazolam 40-80 and both of them administered at 9.25 in the morning, the chlorpromazine having been injected at 8.30. What had happened? Apart from deterioration overnight, what had happened when you arrived at the hospital that morning, Friday the 19th?
A Elsie was half way down the main corridor of the ward, hanging on to the bars and it was impossible for any of them to move her.

C Q We heard a description of what happened that day from, I think ---
A Lynn Barrett.

Q I am not going to go over that again, but were the nurses still trying to deal with her when you arrived?
A They were.

D Q So why chlorpromazine?
A Major tranquiliser, sedative. She was not safe standing there in the corridor. She needed to be in her bed, and it was going to take a major tranquiliser to peel her off the wall and get her into her own room.

Q What was the significance of creatinine 360, which you noted down on your review. What was that signalling to you?
E A That, as I suspected, her renal function had deteriorated quite quickly and quite markedly, and was probably contributing to the end stage dementia state that she was in.

Q Did any of the behaviour that you saw exhibited on the morning of the 19th seem to you to have anything to do with the fact that the fentanyl was being administered?
A I did not think that it was related to the fentanyl. I thought that the fentanyl was not doing anything to make it better.

F Q So why, faced with this problem with her being in such a state that she required an injection of chlorpromazine, why prescribe and have administered subcutaneous analgesia, diamorphine and midazolam, when there is no active sign of pain as such?
A Because I wanted the midazolam. I needed the sedation and the anxiolytic properties of the midazolam in order to calm her down once the chlorpromazine wore off, and I was minded to continue an equivalent amount of diamorphine to replace the fentanyl dose that she
G had been having.

Q What do you say about the amount of diamorphine, bearing in mind that she had been on fentanyl for, if not 24 hours, certainly ---
A Nearly 24 hours.

Q --- nearly 24 hours. We can see how the nursing staff recorded that the fentanyl patch
H had come off, but what allowance were you making for the fact that fentanyl had been, as it

were, building up and maintaining a certain state in her body after the 24 hour period? What allowance did you make when you decided that diamorphine should be administered at the lowest range of 40 mg, as opposed to 20 mg?
A I understood that the equivalence of the fentanyl was 90 mg of morphine in 24 hours, so using my conversion factor which was to halve it, the equivalent in diamorphine in 24 hours would be 40. I also knew that when you took the fentanyl patch off the level of fentanyl in the blood stream slowly reduced.

Q Yes?
A At the same time, the amount of diamorphine in the syringe driver would slowly increase and that you would get to a steady state, probably by the evening.

Q In other words, the same process that you were giving evidence about on either Friday or the day before with the other patient who had had fentanyl?
A Yes.

Q Was this lady now on – what – a palliative care route? How would you describe it with the administration of those drugs subcutaneously?
A She was certainly receiving palliative care, but she was also terminal.

Q If that change had occurred, if that situation had been reached, why not have some words with, or contact, a consultant to see whether this was the right thing to decide at this stage? The answer may be obvious from what you have already told us, but I would just like you to deal with it.
A I had in front of me the evidence of her behaviour on the ward. I had in front of me the evidence of the marked deterioration in her creatinine. It was obvious that Elsie's condition had become terminal and I did not feel that Dr Reid, had I contacted him, would have managed the case any differently. There was no question of a transfer, there was no question of treatment for the renal condition or for the dementia. She now needed palliative care.

Q Then on the Saturday, 20 November, the bottom of that same page, the diamorphine and the midazolam continue?
A Yes.

Q Over the page, nursing staff record condition remains poor.

"Family have visited and are aware of poorly condition.

Nocte: Peaceful night. Skin marking. Position changed regularly. Extremities remain oedematous."

There is another similar note made in relation to the same night. That being a Saturday, would it be likely that you were not visiting the hospital that day?
A It was likely that I was not visiting the hospital that day.

Q Similarly the Sunday, the 21st, on page 16 of the chronology. Sunday 21st, the same drugs being administered in the same way. Eight o'clock in the evening:

"Condition continues to deteriorate slowly. Family have visited..."

and she died that evening. It would follow, then, that probably the next thing you knew about this is when you came in on the Monday and would have learned that this lady had died.
A Yes.

Q Was there anything to indicate to you when you arrived on the Monday that she had in any way been over-sedated or had respiratory depression caused other than was necessary in the course of proper treatment of her condition?
A Nothing.

Q Just this in relation to this particular patient, at the time you made the decision to start the administration of subcutaneous analgesia, what was it that made you think this lady was entering the terminal phase? What was it about her condition, as opposed to her being maybe in a similar confused and agitated state the next day, but no worse in terms of overall condition? What is the judgment you are making, so far as you can describe it?
A It is the most difficult judgment to make in dementia, because your overall impression of the patient and the fact that I had known her then for over a month and knew what she was likely normally; I knew what her patterns of behaviour were; I knew that this behaviour pattern she was now in was totally extreme for her, and signified that something fundamental was happening. It was not the confusion. We had just finished treating a urinary tract infection. It was not that sort of confusion. This lady was entering the terminal phase. It is not something you can measure. It is just that we knew her well enough to know how fundamentally she had changed during that time.

Q Then, looking again at page 14 of the chronology, Friday 19 November, the record is that at eight o'clock in the evening, the daughter has visited – that being, I think Mrs Reeves, "... seen by Dr Barton. All care given to Elsie." Do you remember having a conversation or conversations with Ann Reeves, the lady who gave evidence to the Panel some weeks ago?
A There was only, unfortunately, one conversation ever with Ann Reeves. Again, the problem with this case was she was not acting as next of kin. The understanding was that because her husband was in the Hammersmith having a bone-marrow transplant, that responsibility for communicating with the family was handed over to her brother.

Q That is the person described as "the son"?
A The son.

Q In the notes – yes. Who came into the ward regularly during the time that Elsie was there. We got to know him. He got to know us. Information was passed – we thought – through him.

Q Yes?
A To her daughter.

Q If we look in the same note, we can see that in fact earlier on that same day, at about one o'clock, you had seen the son and discussed the situation with him. Is that correct?
A I explained that Elsie's condition had suddenly and deteriorated and that I had put up a syringe driver and I felt that his mother was terminally ill. I was not aware that the previous conversations that we had had with him about her deterioration, a gradual deterioration before that, had not been being fed back to his sister, so that when he contacted her on that day they came down in a fairly agitated frame of mind.

Q In relation to what you can recall of speaking to Mrs Reeves, Ann Reeves, was anything said about myeloma?
A I did mention that the original diagnosis was myeloma, at which she said "She did not have myeloma", and I apologised. That was my mistake. Again, from that admission note and from my initial note, I got that diagnosis wrong.

Q She says that you did say something about multiple myeloma, and she said that she had spoken to Dr Cranfield too, or you said you had spoken to Dr Cranfield too, or you said you had spoken to Dr Cranfield. Which way round was it? Do you remember now?
A No. Somebody spoke to Dr Cranfield.

Q She says that nothing was said by you about the prognosis. Is that right or wrong?
A By Ann Reeves?

Q That is my note in relation to Ann Reeves. She said that nothing was said about the prognosis. What you agree with that or disagree?
A No, I would not agree with that. The reason that I came back in that evening at the end of a duty surgery was to explain to the daughter the prognosis, and how had it was.

Q Is there anything else you can remember about your discussion of matters with her?
A I can remember that it was probably the most difficult discussion about a relative's health and prognosis that I have ever had. They were extremely hostile.

Q "They" being whom?
A Ann, and I think the son was with her. I cannot remember if the daughter was with her as well. They did not wish to hear what I had to tell them. They were very, very angry with me.

Q Did you, despite that, explain what the position was as you saw it?
A I did.

Q Thank you. I am going to turn now to Patient L. I am reminded that Ann Reeves indicated that you had this conversation with her in a small, cluttered room. Would that be a storage room of some sort?
A It was.

Q How did that come about? It may not have helped. It may have contributed to the general atmosphere, I do not know, but ---
A The layout of the ward, which you have seen on the charts that you have, was that Elsie was in a single room near the entrance on the right-hand side, and directly opposite that is a small room with a couple of chairs in it that had spare zimmer frames and things stored there. Patients were still sitting in the day room. Somebody else was sitting in the kitchen, which was the other place where we had to see patients when the ward was full. So the little storage room was the obvious place to take them, which was private. There was no one else in the room to give them the bad news. I did not have another room. I did not have an office to use to go and talk to them.

Q Thank you. Patient L, Jean Stevens. This was a lady who was admitted to Haslar in April 1999 after experiencing chest pain and collapsing at home. We have seen the history

with regard to her in some detail. We can just remember, perhaps, looking at page 6, the problem that there was with regard to the nasogastric tube, the "no tube" seen on the X-ray with the tube in, and the problem with regard to feed being placed directly down the nasopharynx and therefore the problem with aspiration, and then we move on to page 7 when she was referred to Dr Lord in early May.

> "Nothing more we can do for her on acute medical side."

The problem with regard to her heart, we can just take note on page 8 where at a particular point she was being treated with oxygen and diamorphine for respiratory failure and, indeed, there is a record at the Haslar of her receiving diamorphine but not for pain, but obviously for other purposes, to keep her comfortable. Page 8 is an example. At the top of page 8, top left:

> "... small doses of diamorphine to keep comfortable, CXR."

And similarly below, a repetition of the administration of diamorphine:

> "..... pt [patient] agitated and complaining of discomfort/non-specific – unable to position her comfortably."

That in any event was what at Haslar they thought appropriate for that situation – matters obviously I raised with Professor Ford. Page 9, 6 May, for review by Dr Lord:

> "Admitted with left hemiparesis and anterior myocardial infarct as well as atrial fibrillation. CT scan confirmed right parietal infarct. Also asthmatic and has had sigmoidcolectomy. Extremely unwell. Very dense left hemiplegia, left ventricular failure and aspiration pneumonia."

We have taken note of that before.

> "Swallow not safe. ... Too unwell for transfer to GWMH. Overall prognosis poor."

Dr Lord suggested that diamorphine should be given, as we can see in the bottom left hand corner, if she was distressed. Indeed, she was given diamorphine intravenously, we can see at the top of page 10. Then over to page 11, she was seen by Dr Tandy later. Dr Tandy took the view that she was not stable enough to transfer to Gosport. I am going to ask that we go on to page 12 where, on 12 May, she is recorded as feeding well through the nasogastric tube. Mrs Stevens' husband and daughter were spoken to. The prognosis and the rationale behind why the patient would be allowed to die naturally rather than be resuscitated or put on ITU if she had a further MI or respiratory failure or arrest was explained.

The picture continues at page 13. On 14 May she still at Haslar. On 14 May:

> "Very uncomfortable this evening."

That is the last entry on the left.

> "Diamorphine ... given to assist settling with good effect."

Again this would be something that would be consistent with your view of the use of diamorphine on occasion?
A Yes.

Q And that carries on, over the page, on page 14. She then has a better night and slept well without diamorphine. Paracetamol is given and then the situation arrives where she arrives at Daedalus Ward on page 17. I am not going to go over all the problems. We can see what you had by way of a transfer record. We can see what the nursing referral says, and on page 18 we can see what you yourself recorded.
So aware that she was on PRN subcutaneous diamorphine, the history is set out in more than one place and at the top of page 18, "Significant events" dealing with again the same problems with regard to myocardial infarct and so on.

Let us look at your review on page 18 which was in fact 20 May.

"Transferred to Daedalus ward 555K".

A I think that is probably slow stream stroke rehab – SSSR rather than 555K.

Q Thank you. We can check that, 1292, just take a moment and see if that helps. You had better look at it yourself. I have to say it looks to me like 555K but it is your handwriting, 1292.
A Yes, slow stream stroke rehab which were the eight beds that Dr Lord had on the ward.

Q So SSSR as opposed to 555K.
A Yes.

Q Thank you for that. Slow stream stroke rehabilitation – that was the aim if everything had gone well.
A Yes.

Q Again, she would have been examined by you, is that right?
A Yes.

Q Similarly, the nursing staff would have carried out their normal checks with regard to blood pressure, pulse and so on, would they?
A Yes.

Q What was the problem with regard to lung disease or any kind of obstructive pulmonary disease or anything like that and the topic of aspiration pneumonia. Would you help us with that?
A I think the insult of a whole lot of liquid feed over the top of already damaged lungs containing more mucus cells than they should and less capacity for recovery than they would with COPD – it is a fairly explosive mixture if it comes to getting a chest infection. You have less reserve in order to recover.

Q Apart from the words "Aspiration pneumonia" what else in your note indicates a problem with the lungs?
A COPD asthma.

Q Right. Over the page,

"Unable to answer on arrival. But husband says whilst in Haslar she knew she had been unwell."

It sets out a number of things with regard to the situation and we will come on to the prescriptions in a moment, and then the next note on the chronology on page 19:

"Requires assistance to settle and sleep at night. Oramorph 5mg given. Complaining of pain in the stomach and arm. Condition poor."

That page 1334 in the nursing notes which are referred to as a group by that entry, 1324 to 1337. Looking at 1334, Professor Ford was asked to look at this and on the 20th, that same day, on page 30 and 34, the nursing care plan shows "NG tube re-passed O/A [on admission] this am as Jean pulled it out. Bolus this pm."

Then what is the rest of it?
A

"55mls per hour due to patient pulling at NG tube. Also due to recent history of aspiration pneumonia. For referral to dietician tomorrow."

Q Thank you. You prescribed, on the day of her admission, not only the medication we can see at the top, digoxin and enalapril, aspirin, isosorbide. The isosorbide was not administered – actually I do not think any of them were. What were the purposes of those drugs?
A Digoxin is to regulate the heart rate, enalapril is to lower the blood pressure, aspirin is to make the blood vessels less sticky and isosorbide is a drug for angina.

Q Yes, it looks as though that is the one that is not administered. Similarly the Suby C was not administered.
A Suby G that should be – that is for washing out an indwelling urinary catheter, it is not for oral administration.

Q Thank you. Then Oramorph, why did you prescribe Oramorph, which was administered at half past two, half past six and quarter to 11 at night.
A Again, this was a lady who had had very serious medical problems while in Haslar and had just about survived the transfer across to Daedalus Ward, so she would have been very uncomfortable and probably quite distressed when she first arrived on the ward.

Q We bear in mind, do we, that of course she had been on PRN subcutaneous diamorphine.
A And it was quite appropriate to continue to give her an opiate with all her problems.

Q Then an anticipatory prescription for diamorphine, hyoscine and midazolam, 20 to 200, 200 to 800 micrograms, 20 to 80 midazolam. Again, would this be right, without us going over it again, the same reasons as to what might develop in the future for that prescription.
A Yes.

Q That is the day of her admission on the 20th. The 21st shows that the digoxin, enalapril and aspirin were administered, GTN spray not. Oramorph administered and then a prescription of 10mg four times daily and 20mg at night, which would be 60 in total, is that right, if that had been followed through?
A Yes.

Q Then 10mg four times daily plus 20 at night would be a total of 60.
A Yes.

Q Diamorphine 20 and midazolam 20, both administered at 7.20 in the evening. Just following the picture through for that day, 11.30 – we have mentioned the GTN spray. Then Philip Beed at six o'clock in the evening:

> "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. 19.45 commence syringe driver."

Whose decision was it to actually start the syringe driver on the 21st in the evening?
A It was not my decision because I was not by then in the country, so there were two possibilities. One was that Philip Beed contacted the duty doctor and explained that there was an anticipatory prescription in existence and he would like to start it, or that Philip Beed started it without reference to a duty doctor knowing that I had seen her earlier and that I would have been comfortable with that prescription.

Q Why not, if the Oramorph was leaving her still uncomfortable, just increase the amount of Oramorph as opposed to going on to the syringe driver?
A I imagine that he was uncomfortable about continuing to give her oral agents if she deteriorated any further and I imagine that if she reached a point of terminal distress he wanted the anxiolytic properties of the midazolam in the syringe driver.

Q In relation to the conversion where he had indicated to the son that the pain relief would be at an equivalent dose to the oral morphine, if the oral morphine – by then she would have had 40 as well as whatever had been given to her in the previous 24 hours, which would appear to be perhaps another 10mg. Let us assume that it is 50mg in all which she had had in the previous 24 hours, or 40, one would be halving that.
A In our day we would have been halving that and that would be an appropriate conversion factor.

Q Assuming that approach is right it would seem to be that that was an equivalent dose.
A Yes.

Q But with the midazolam added, obviously.
A Yes.

Q Over the page the nurse has recorded: "Remains poorly but comfortable." On the 22nd diamorphine is administered subcutaneously at the same rate and midazolam at the same rate in the morning. Dr Beasley is obviously contacted and verbally prescribes hyoscine as

well. Can we take it that in the ordinary course of events Dr Beasley would have been aware of what this patient was on in terms of subcutaneous analgesia?
A He would have been told by the ward staff when they contacted him that morning.

Q At 10.20 in the morning,

"Still very bubbly. Dr Beasley contacted and verbal order to increase hyoscine ..."

What do you say about that record of the situation being that she was still very bubbly in relation to aspiration pneumonitis or pneumonia, or indeed congestive cardiac failure. What is the picture there?
A It could have been either or both that she had on that Saturday. I did not examine her but the nursing note would indicate that for whatever reason there were a lot of secretions in her lungs.

Q What is the significance of that aspiration pneumonia or pneumonitis, how important is that in terms of a patient in this sort of condition?
A Desperately important.

Q Would you just explain why?
A Because with her previous lung damage caused by her chronic obstructive pulmonary disease she would be unlikely to survive a further bout of aspiration pneumonitis.

Q Dr Barton, that is the last of the patients I need to ask you about and indeed it is the last of the matters I wish to raise with you in examination-in-chief.

THE CHAIRMAN: Thank you very much, Mr Langdale. Mr Kark, we would be taking a break at this point; I do not know if you would propose to start your cross-examination after that break or if you wanted to start it tomorrow morning.

MR KARK: I am perfectly content to start this afternoon if Dr Barton is still up to it as it were and if the Panel are still up to it.

THE CHAIRMAN: Doctor, are you up to a change in gear for this afternoon?

THE WITNESS: Yes, of course.

THE CHAIRMAN: Very well. We will take a 20 minute break now to give you time to prepare yourself and then we will start again with Mr Kark.

(The Panel adjourned for a short time).

THE CHAIRMAN: Welcome back everyone. Mr Kark.

Cross-examined by MR KARK

Q Dr Barton, obviously you are going to be there for a while longer and if at any stage you need a break, as you know, you only have to ask.
A Thank you.

Q I want to start, please, by taking you right back to the beginning when you took this job on. Would you turn up tab 2 of bundle 1? As we can see, the duties are set out and they were to visit the units as they then were, because the hospital was on two different sites, I think.
A Three.

Q Three.

"... on a regular basis and to be available 'on call' as necessary.

To ensure that all new patients are seen promptly after admission."

That did not change, obviously, did it?
A No.

Q "To be responsible for the day to day medical management of the patients" and that is relevant to the period that we are considering.
A Yes.

Q "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."

That was relevant to the period which we are considering.
A Yes.

Q Then if we go over the page, paragraph 8:

"To prescribe as required drugs for the patients under the care of the consultant physicians in geriatric medicine."

Does that pertain to the consultants under whom you were acting in 1996 through 1999, so Lord, Reid and Tandy?
A Yes, I do not think that position had changed.

Q So you applied for this job. You were apparently the only applicant and certainly at the beginning you were paid appropriately, you felt, for the work you were doing.
A I was paid a reasonable sum.

Q At the time that you started the time that was allowed to you was sufficient properly to care for your patients, is that right?
A I could make sufficient time available outwith my working day in the practice to make sure that all the patients were seen regularly and appropriately.

Q Okay. Can I just ask you about the time when the wards moved to GWMH so that they were all within the main hospital complex, and I just want to ask you about the relation of Sultan Ward. That was a GP ward and presumably any time that you spent on Sultan Ward would be in relation to your GP patients.
A Yes, I had admitting rights for that ward like all the other GPs in the area and I would go up there if I had a patient who I had admitted.

Q That obviously would be time separate from Dryad and Daedalus time.
A It did not count towards the session I worked for elderly medicine.

Q Apart from your regular GP job and your job at GWMH were you undertaking any other work between 1996 and 2000?
A I became Chair of what was known as the Primary Care Group for Gosport when the Government decided that purchasing and providing of care was going to be devolved down to localities and I stood down from that in 2002.

Q How much of your time did that take up?
A Probably another half day a week.

Q Would that come out of your GP practice time?
A It came out of my own time.

Q Apart from that, was there any other regular work that you were committed to?
A No.

Q As time went on, as we have heard, you found that you had less time to devote to the making of notes – yes?
A Yes.

Q Does that mean that you had less time on the wards or that your patient requirements were greater than they had been before?
A I had exactly the same amount of time to do the job but I had more patients who required a great deal of thought and consultation and effort to look after them properly.

Q You tell the Panel that as a consequence of that your note-keeping suffered.
A My note-keeping suffered.

Q But listening to your evidence over the last four or five days, that lack of time does not seem to have affected your management of the patients.
A Well, I am delighted to hear that, because I had the stark choice in front of me as to whether to sit down and write every interaction with the patient in the patient's notes or to get on and deal with the management of the patient and I chose the latter.

Q What you are telling this Panel is that, although the amount of work you had to do with the patients was greater than it had been before, the actual management of the patients did not suffer.
A I hope not.

Q And you did not do anything in relation to the management of your patients that you would not otherwise have done.
A I am sorry, would you say that again to me.

Q Yes. If you had had more time, other than it might have affected your note-keeping, would it have affected your management of any of these 12 patients?
A No. Well, yes it would. I would have been able to attend more ward rounds. I would have been able to start to attend the multidisciplinary meetings that were held on the

ward. I would have been able to spend more time talking to social workers and physiotherapists and things like that, which I was unable to do due to the time constraints.

Q But would it, do you say, have affected your decisions in relation to these patients?
A No.

Q If you had felt that the time that you had available to you in 1996 and 1997 and 1998 was in fact undermining the job that you could do in the care of these patients, presumably you would have complained about it then.
A I did complain about it then. I did not ever want it to affect the quality of management that I gave these patients. I was frightened that it would do so if allowed to continue as it was.

Q When do you say you first complained about lack of time?
A Probably 1996.

Q To whom?
A I spoke to Dr Lord informally. I spoke to Bill Hooper informally. I spoke to Isabel Evans informally. I spoke to various people, but, because of my political connections I knew that the healthcare trust did not have the money to invest in more clinical care for a cottage hospital.

Q Are you telling this Panel that from 1996 onwards you knew that you were providing a substandard service to your patients?
A I knew that I could potentially provide a substandard service to these patients but that I was not.

Q Right. Let me turn to the issue of your training in the use of morphine and diamorphine. You, I think, did some training at the Countess Mountbatten Hospice in Southampton. Is that right?
A I did.

Q Was that in 1991?
A Well, I would have attended several seminars throughout the years. I do not know which one you are referring to.

Q At page 4 of tab 1 we have you attending the Department of Geriatric Medicine to attend half a day's session. I am sorry, that is not -----
A That is not palliative care, no.

Q That was particular training in geriatric medicine, was it?
A That was a week set up by myself to familiarise myself with all the different aspects of elderly medicine in the district: the doctors and nurses with whom I would be working, the kinds of wards they worked on, the patients I was going to be receiving. That did not contain any palliative care. I may have looked on Charles Ward but I did not talk to anybody on Charles Ward.

Q Can you help us, please: what specific training you had in relation to palliative care?
A General practitioners have to do a total of 30 hours each year for their postgraduate education certificate. Generally I did something called the Portsmouth Refresher Course,

A which it was still running, which would be a whole week. At least one of the sessions of that would be some aspects of palliative care. A couple of years I went to two-day seminars at Countess Mountbatten. I took one of my district nurses with me. Over the two days we discussed all sorts of aspects of palliative care, including end-of-life care and the use of syringe drivers.

Q Did you apply your training to the care of your patients?
B A Yes.

Q At Gosport War Memorial?
A Yes.

Q We are going to look in due course at the *Palliative Care Handbook* that you say you kept in your pocket.
C A Yes.

Q Did you mean that literally?
A Yes.

Q Or figuratively?
A No, literally. It was a nice little book to keep in your pocket while you were on the
D wards.

Q All right. Before we turn to that, I want to ask you about another aspect of the general care of your patients. We just saw that part of the job description allowed for other general practitioners within your practice to cover you – yes?
A They had to cover me.

E Q How many partners were there at your practice in 1996?
A There were six of us.

Q So far as your practice was concerned, did that mean that you were able to provide seven-day cover?
A We were contracted to provide seven-day cover, so that included the two partners in the practice who did their own out-of-hours and weekend cover and those who deputed that
F to Healthcall and its successors and used the commercial service out-of-hours.

Q So far as the Gosport War Memorial Hospital is concerned, what percentage, if you can assist us, of the time when you were not on duty would be covered by regular partners of your practice and how much would be covered by on-call staff?
A In the ratio of the other partners, two out of five would have done their own out-of-hours and the other three used commercial deputising.
G

Q Apart from times when you were on holiday or at weekends you would be covering the hospital yourself.
A Yes.

Q So if a nurse needed assistance, would you be relatively on hand to provide it?
A Yes.
H

Q The use of opiates. You would know, would you not, from your medical training, from your GP training, that opiates are capable of causing severe harm to patients?
A Yes.

Q They can cause potentially serious adverse consequences, including, of course, death.
A Yes.

Q Over-sedation with opiates can lead to depression of the respiratory system – yes?
A Yes.

Q And hypoxia?
A Yes.

Q And hypotension?
A Yes.

Q The overuse of opiates can itself lead to agitation and restlessness.
A It is said so in textbooks.

Q Is it something you disbelieve?
A I have never knowingly seen it happen, but it is said to happen in the textbooks.

Q If you see agitation and restlessness in a patient whom you are treating with morphine, can we take it that you are not going to recognise that as being the result of an overuse of opiates?
A I am going to consider it to be one of the factors that might be contributory, but there might well be others contributing.

Q Have you, to your belief, ever seen it, though? Have you ever looked at a patient who is agitated or restless after you have started them on opiates and thought, "Perhaps I had better reduce the opiates"?
A I have never done it but I have thought it.

Q You have thought about it.
A I have thought about it and decided that that was not the reason for the restlessness and agitation.

Q There are several groups who require particular care in the prescription of opiates. The elderly is one of those – yes?
A Yes.

Q Those with renal impairment is another – yes?
A Yes.

Q The purpose of anticipatory prescribing, as I understand your evidence, was to give the nurses the capacity to alleviate pain immediately.
A Yes.

Q We heard from Professor Ford about the efficacy of the syringe driver for that purpose.

A A Yes.

Q Do you agree that in fact one thing a syringe driver does not do is relieve pain immediately?
A I do agree.

Q Let us start with the *Palliative Care Handbook.* We will find that behind tab 4,
B where we have the fourth edition, I think, which was published in 1998. We have the handbook copied, but did it always look something like this? (holding up copy)
A Yes.

Q A little green book.
A Yes, pocket-size.

C Q Pocket-size, and you kept it in your pocket. Were you ever one of the co-authors of this book?
A Yes. Well, not the co-author, but I was asked to comment on various articles that were put into it on symptom control.

Q Did your name appear in one of the earlier versions?
A No. I was not that important, but I was asked to read the articles and comment on
D them.

Q The reason I asked you that was because at the Coroner's inquest you said, "My name appeared in a previous edition, the third edition, as being one of the authors helping with the contents of various of the headings."
A Yes, but I have never been able to find my third edition.

E Q All right.
A And it may not have been true that my name actually appeared in it.

Q All right. You also described yourself as having a lot of experience in general palliative care usage, as well as these patients with their particular problems. And you described this handbook as: "This is guidelines. This is theoretical good practice" – yes?
A Yes.
F

Q Let us have a look at what theoretical good practice provides. Can we start, please, at page 3. I am going to suggest to you that during the course of your evidence you have adopted what are effectively two fallacies: one is that the conversion rate for an equivalent dose from oral to subcutaneous is one half; and the second is that the normal incremental increase, where the previous dose has not controlled the pain, should be to double the dose. That has been your evidence throughout, has it not?
G A That may have been proved by somebody, although I have never seen it, so that it is a fallacy now, but it certainly was not a fallacy then. It was accepted practice both to do half for the conversion for oral to subcutaneous and to double the dose if pain relief was not adequate.

Q Let us have a look at the book that you apparently kept in your pocket through this period. At page 3 of the internal numbering and also page 3 of our file, do you see in the
H third paragraph down:

A

"This handbook contains guidelines to help GPs, community nurses and hospital staff as well as specialist palliative care."

You will forgive the term, but it is no noddy handbook is it?
A No.

B Q Then:

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

A Yes.

C

Q Would you have appreciated that to go outside the guidelines might be thought to be unreasonable practice?
A In general practice and in palliative care we go outside guidelines, outside product licences often, and we accept that it could be recognised as unreasonable.

Q If you are going to do that, would you agree that it is extremely important to keep
D careful notes of your reasoning as to why you are doing that?
A Yes, entirely.

Q Can we go over, please, to page 4 of the file, "General Principles of Symptom Management." You would agree, I suspect with the first heading:

"Accurate and full assessment is essential for both diagnosis and treatment."

E

A Entirely.

Q The fifth bullet point down:

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

F You would have been well aware of that, would you not?
A I would.

Q Then:

"Sensitive explanation and inclusion of patient and carers in decision making are essential parts of a symptom management."

G

Presumably, as a general practitioner you would have particular understanding of that, would you?
A I would.

Q The penultimate bullet point,

H "Consider referral for specialist palliative care opinion:

A - If there is a problem which does not respond as expected"

Yes?
A Yes.

Q And:

B "- In complex situations which may benefit from specialist expertise
- For support for the hospital primary health care team."

Then this:

"Continually reassess."

C Yes?
A Yes.

Q That means, does it not, on occasion stepping back and checking that what you are doing is the right thing to do?
A Yes.

D Q And not simply pursuing a particular course.
A Yes.

Q "Pain" on the right-hand side of the page. This is dealing with pain in cancer.

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

E Putting cancer to one side, because we have to remember that this is the *Palliative Care Handbook*, you would agree, I suspect, that successful treatment of pain, any pain, requires an accurate diagnosis of the cause and a rational approach to therapy – yes?
A Yes.

F Q If we look at the bottom of the page, we see the heading "Assessment":

"1. Identify the site (with any radiation), severity, duration, timing and aggravating and relieving factors.
2. Use a body diagram with the patient's own words."

You were not using body diagrams but it is important, is it not, when dealing with pain, to identify if you can where the pain is coming from?
G A Yes.

Q And what the underlying cause of it is?
A Yes.

Q Over the page, please.
A But you should, before you go over the page, surely look at the message in the box:
H

A "All pains have a significant psychological component, and fear, anxiety and depression will all lower the pain threshold."

Q Yes.
A And –

"… the likely effects of life changes associated with terminal disease…".

B

Q Yes.
A And:

"… existential and religious uncertainties…".

You could not always put the pain into a neat box and say, "This is what is causing the pain."

C

Q No. We shall have to look at each of our twelve patients ---
A Yes.

Q --- to see if we can identify first of all, whether they were in pain at all and, secondly, if they were, what was causing it. Can we go over the page to the analgesia ladder. I take your point, as you have expressed in evidence on a number of occasions, that you cannot always start with paracetamol. Yes?

D

A Yes.

Q Having said that, it is still a principle that you have to bear in mind even when using opiates, is it not, that you should be working upwards, and you should be titrating the dose according to the pain.

A It is a general principle that is used now to the point where people seem to suffer breakthrough pain at every point until they reach, eventually, a steady state level of pain relief. My philosophy in those days, working as a general practitioner and visiting a community hospital, was that I would go in at a higher dose in order to give adequate pain control sooner and then reassess the dosage.

E

Q So you were going in at a higher dose than what?
A Higher than the professor pharmacology suggested as initial dosages.

F

Q I am sorry. At the time, in 1996, before you had ever heard of Professor Ford ---?
A I went in at what I considered to be an appropriate lowest level dose of analgesia for each patient in front of me.

Q We shall have to examine that but when we get to the individual patients. Can we look to the right hand side of the page.

G

"1. Morphine is the strong opioid of choice for oral use."

It talks about the several preparations of it, and then paragraph 2:

"2. Diamorphine is the strong opioid of choice for parenteral use because of its greater solubility – maximum recommended concentration 250 mg/ml."

H

A Then fentanyl patches are dealt with.

> "4. ... Useful especially when there is difficulty swallowing, vomiting or intractable constipation; dose titration is more difficult and expensive. Possibility of withdrawal symptoms when converting from morphine – responds to small doses of immediate release oral morphine."

B Then, in those days, as this sets out, you had only the possibility, I think, of the lowest dose of fentanyl being 25 mcg per hour. Yes?
A Yes.

Q We can see that that converts to something less than 135, or up to that means, I think, 135 mg of morphine. Could we go over the page again, please, to page 6. We can see that the instruction to the patient is set out. We must –

C

> "
>
> - Emphasise the need for regular administration and explain about breakthrough medication.
>
> - Warn about possible side effects
>
> D
>
> - Reassure that when used for pain relief, morphine is not addictive..."

So that is really for patients, I suspect, who are suffering from cancer, is it?
A Yes.

Q And who may be having to medicate themselves?
A Probably more appropriate in the community than in the hospital setting.

E

Q I understand. All right. Paragraph 2:

> "2. 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 2.5 mg to more than 200 mg but only a minority of patients will need more than 30 mg 4 hourly. Give a double dose at bedtime to avoid waking at 2 – 3 am but ensure that at least 5 doses are given per 24 hours.
>
> F
>
> 3. Start with a low dose and increase by 30 – 50 % increments each day until pain controlled or side effects prevent further increase. Doses can be rounded up or down according to individual need."

G Then we see the dose sequence which goes from 5 to 10, which is a doubling of the dose, of course, but then it runs at 50 per cent increments. Yes?
A Yes.

Q Were you aware, first of all, of that guidance?
A Yes.

H Q Did you think it was relevant to any of your patients?

A I quite often gave a double dose at bedtime in order to see them through the small hours of the morning.

Q Yes, we have seen that.
A And I was aware of that dose sequence suggested there but, again, it depends on your individual assessment of the patient in front of you how you make the increase of dosage.

B Q And that would require you, would it, to see the patient yourself?
A It would definitely require you to see the patient.

Q In general terms, unless there are exceptional reasons for not doing so, would you have wanted to stick to 30 to 50 per cent increments?
A Five to ten mg? I do not know how the sums would add up in the 24 hours, but it would be discussion with the nursing staff as to how the patient was responding to that C individual dose over that 24 hours, how you would then make the increase.

Q The danger, of course, if you do go further than this guidance, there is always the danger that you are going to over-sedate the patient unnecessarily?
A Yes.

Q You agree with that?
D A Yes.

Q Paragraph 5.

"5. 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 E side-effects are present, consider other approaches."

Let us pause there for a moment. You were aware, no doubt, of that guidance?
A Yes.

Q Side effects described as drowsiness, vomiting and confusion - yes?
A Yes.
F

Q Did you think that that guidance might have affected your management of any of the 12 patients whom we are considering?
A It did.

Q Did you ever reduce the dose?
A I stepped down on one occasion with one of the patients, came back down from a G strong opiate to a level 2 opiate and then went back up again in a different from because I thought that vomiting might be a side effect of the medication.

Q We shall come to that in due course.
A I was always thinking of these side effects.

Q You were always thinking of these side effects?
H A Yes.

A

Q Then we should deal with paragraph 6:

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

So the concept is, use relatively small increments until you get to the point where pain is
B controlled, and then use a 24 hour or 12 hour slow release morphine pill. Yes?
A Yes.

Q The next paragraph:

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

C - that is difficulty swallowing?
A Yes.

Q

"... vomiting or weakness, consider changing to diamorphine by subcutaneous infusion using a syringe driver. The conversion from oral morphine to subcutaneous diamorphine (total daily dose) varies between 1/3 – 1/2 allowing
D some flexibility depending on the requirement for increased or decreased opioid effect."

First of all, were you aware of that guidance?
A Yes.

Q Do you agree that if you halve the dose you are, in fact, increasing it by a small
E increment?
A Yes.

Q And so if you wanted to give the same dose, you would have to give something slightly less than half?
A If you wanted to give the same dose you might have to use slightly less than half.

F Q And on the right hand side of the page, we can see the opioid equivalence, and we can see morphine is shown at 30 mg and diamorphine is shown at 10 mg. Yes?
A Yes.

Q Again, all of this you were well aware of?
A Yes.

G Q Indeed, you had the book in your pocket as you practised medicine?
A Yes.

Q Can we go, please, to the BNF, tab 3. Again, I am going to focus on the one that we have at the beginning, which is 1997. Can we start at page 2, please, at the first paragraph. I am not going to read right through this document, I promise you, but the first paragraph reads:

H

A "In recent years there has been increased interest in providing better treatment and support for patients with terminal illness. The aim is to keep them as comfortable, alert, and free of pain as possible."

Would that be one of your intentions too?
A Yes.

B Q So you want your patients to be alert, comfortable and free of pain. Yes?
A Yes.

Q Can we go down, please, to the heading "Drug Treatment."

"The number of drugs should be as few as possible, for even the taking of medicine may be an effort. Oral medication is usually satisfactory unless there is severe nausea
C and vomiting, dysphagia, weakness, or coma, in which case parenteral medication may be necessary.

Analgesics..."

and Mr Langdale has pointed this out, I think, to Professor Ford.

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

Dr Barton, is it part of your case that it is legitimate to use analgesics before pain has even started, but you think pain is going to start in the future?
A Are you talking about using analgesics or prescribing analgesics which may be used when pain develops?
E
Q First of all, using them.
A It depends on your definition. It goes back to your definition of pain.

Q Let us ignore restlessness, agitation and confusion for the moment. Is it part of your case that it is acceptable because you believe a patient is going to be in pain, that you should start them administering opiates?
F A You would have to show me a case where analgesia was given in the complete absence of pain or other symptoms that you have just mentioned, like distress and agitation and fear.

Q It deals with oral morphine at the bottom of that page. Could we go to the top right hand column, please, two lines down. It starts "If the first dose of morphine...". Are you with me?
G A Yes.

Q

"If the first dose of morphine is no more effective than the previous analgesic it should be increased by 50%, the aim being to choose the lowest dose which prevents pain."

H Is that a sentiment with which you, at least in principle, agreed?

A A Yes.

Q

"Although a dose of 5 – 20 mg is usually adequate there should be no hesitation in increasing its stepwise according to response to 100 mg or occasionally up to 500 mg or higher if necessary."

B Then I am going to move on to four paragraphs down:

"The starting dose of modified-release preparations designed for twice daily administration is usually 10 - 20 mg every 12 hours if no other analgesic (or only paracetamol) has been taken previously, but to replace a weaker opioid analgesic (such as co-proxamol) the starting dose is usually 20 – 30 mg every 12 hours."

C Again, principles that you are broadly aware of?
A Yes.

Q Can we go down to "Parenteral route". I think all the barristers have been mis-pronouncing that word!

"If the patient becomes unable to swallow, the equivalent intramuscular dose of
D morphine is half the oral solution dose; in the case of the modified-release tablets it is half the total 24-hour dose ....".

Then we can see in bold:

"**Diamorphine** is preferred for injection because being more soluble it can be given in a smaller volume. The equivalent intramuscular (or subcutaneous) dose of
E diamorphine is only about a quarter to a third of the oral dose of morphine;"

Is that simply because diamorphine is ----
A More soluble.

Q --- more soluble and ---
A More available .

F

Q Thank you. A quarter to a third – yes? Again, you would have been aware of that. Yes.
A Yes.

Q Dr Barton?
A Yes.

G

Q I am sorry.
A Yes, yes.

Q It is just that we need your answer.
A I said "yes" as you were speaking. I apologise.

H

A Q Over the page, we can see "Transdermal route" and it deals with fentanyl. I do not think I need to say anything about that. We can see on the top right hand side of the page, "Excessive Respiratory Secretion" is dealt with (death rattle). Underneath that we can see the heading, "Restlessness and confusion." A number of your patient in this case, you feel, did exhibit signs of restlessness and confusion. Is that fair?
A Yes.

B Q

"Restlessness and confusion may require treatment with haloperidol 1-3 mg by mouth every 8 hours. Chlorpromazine 25-50 mg by mouth ..."

And then is it methotrimeprazine?
A Yes.

C Q Which I do not think we need to deal with?
A We use Nozinan but only in the subcutaneous form in one of the patient.

Q Over the page to page 4, please. "Syringe drivers" – we can see the heading on the left hand side of the page. Then, if we go to the right hand side of the page it deals with "Restlessness and confusion". The first drug that is, I think, being suggested is haloperidol?
A Yes.

D Q Which, it says,

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

...

E "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."

Dr Barton, apart from for the very restless patient, in what other circumstances in your view should or can midazolam be used?
A For very restless patients.

F Q In any other circumstances?
A For very anxious patients. I was not as keen on the use of haloperidol as I was on the use of midazolam, as you can see in these cases. Haloperidol, as it says there, is not very sedating and can have extra-pyramidal side effects. You can get dystonic movements of the patient at higher doses. I preferred to use midazolam in these patients and it seemed to make sense to get to know a small number of drugs well, and to be familiar with their use, and use them regularly if necessary, rather than experimenting with a whole number of drugs.

G Q Midazolam has a fairly strong sedative effect, does it not?
A Yes.

Q And you knew that when you prescribed it.
A Yes.

H

A Q Then "Pain Control" we can see, I am going to try and avoid repeating what it says about diamorphine. Over the page, please, we can see again the equivalent doses of morphine sulphate by mouth and diamorphine hydrochloride by intramuscular injection or subcutaneous injection are set out there, and again, all the way down that table we can see it is broadly – not exactly but broadly – a third.
A 10mg of morphine equals ---

B Q You have got this slightly complicated because you have got to multiply the figures on the left by six, have you not, because it is ever four hours and we are looking for the 24 hour equivalent which is on the far right hand side of the page.
A So by your arithmetic you would make it a third.

Q We start off – the first one is 5mg or, as we should call it, 30mg over 24 hours, would be a half.
C A Yes.

Q Then the rest are not all, in fact, quite a third but they are all broadly a third, and you would have been aware again of that general conversion rate.
A Yes.

Q All right. Page 6, please. You would have been, before we read through this part of
D the guidance, well aware no doubt that elderly patients react differently to opiates to younger patients, is that fair?
A Yes.

Q They are more sensitive to morphine.
A Yes.

E Q If we look two-thirds of the way down the page we can see "Susceptibility" – this is under the heading "Prescribing for the Elderly –

> "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."

F Again, you were well aware of that as guidance.
A Yes, always use them with caution.

Q Can we look at the right hand side of the page, "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
G commonly used drugs)."

Let us just pause there for a moment, were you aware of that?
A Yes.

Q So mental confusion is regarded as a potential adverse reaction to opiates, yes?
A Yes.
H

Q Under the heading "Hypnotics",

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

Again, you would have been well aware of that.
A Yes, and as far as I am aware midazolam has a very short half-life which is why it was so appropriate for use in subcutaneous analgesia.

Q Is it still capable of producing drowsiness?
A I hope so.

Q And obviously unsteady gait.
A These people I was using it for were not using gait any longer.

Q The hypnotics that we have come across in this case would include temazepam.
A Temazepam.

Q Midazolam and haloperidol.
A Diazepam – not haloperidol.

Q Not haloperidol.
A No.

Q Can we go, please, to page 7? Under the heading "Guidelines", although I suppose this is all guidelines:

"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."

A Yes.

Q

"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."

Let us just pause there for a moment; again is that a principle which you applied in your practice?
A No.

Q Why not?
A I applied the principle of what I felt was an acceptable starting dose for the drugs that I was familiar with in this very specialised corner of prescribing.

Q Are you saying in effect that you ignored this particular part of the guidance?
A I was aware of this guideline.

Q Did you take any account of it?

A I certainly took account of it but I still then used the appropriate dosage of the drug for the particular patient.

Q Can I ask you this, did you at any stage reduce the amount of opiate that you were prescribing, taking into account the fact that your patients were very elderly?
A I took into account the fact that they were very seriously ill and in the terminal phase of their lives.

B

Q I am sorry, I will ask the question again, did you at any stage reduce the opiates that you were prescribing because you were prescribing to very elderly patients?
A No.

Q "Some drugs (eg chlorpropamide)" ---
A It is an anti-diabetic drug which we did not use.

C

Q Nothing to do with this.
A No, nothing to do with palliative care.

Q Then on the right hand side:

"Simplify regimens. Elderly patients cannot normally cope with more than three
D different drugs ands ideally these should not be given more than twice daily."

A That is more appropriate in the community rather than for hospital administration.

Q If we go to page 8, again I am going to try to avoid repeating what we have already seen in palliative care, but side effects of opioid analgesics are set out and we see that the most common side effects include –

E

"Nausea, vomiting, constipation, and drowsiness, larger doses producing respiratory depression and hypotension."

You have already agreed with that.
A Yes.

F Q They can also produce confusion and agitation, yes? Do you agree with that?
A Where have you found that?

Q No, that is not here but it is evidence you have already given I think.
A Yes, it could cause restlessness and agitation.

G Q Finally, I hope, page 9 which deals specifically in the *BNF* with morphine salts. If we look to the right hand side of the page, this is dealing with morphine salts generally, we can see at the top of the right hand side the dose for acute pain.
A Yes.

Q If we read through this part:

H

A "Acute pain, by subcutaneous injection (not suitable for oedematous patients) or by intramuscular injection, 10mg every four hours (15 mg for heavier well-muscled patients)."

Then we can see:

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

B

Why is that?
A I have lost this bit altogether. It is not relevant, we did not use intravenous doses.

Q I am with you, you were using subcutaneous injections.
A Yes.

C Q Very well. Can you go down until you find the words "chronic pain"?
A Yes.

Q

"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
D triple to quadruple corresponding intramuscular diamorphine dose."

Whether it is intramuscular or subcutaneous the guidance seems to be the same, does it not?
A Yes.

Q All right. Is there any learning or piece of education that you have ever seen or received, Dr Barton, that says that the normal approach when converting should be
E automatically to convert to a half?
A No.

Q If you are converting to subcutaneous. No.
A No, it was gained over experience dealing with individual patients over a number of years, in practice.

F Q Nothing of what I have just gone through was novel to you in 1996, 1997, 1998 or 1999, was it?
A No.

Q It was all well known, received learning, yes?
A Yes.

G Q Mr Langdale put this to Professor Ford on Day 22 at page 48:

"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."

H

That, as you know, is not something that Professor Ford agreed with. Was that your sentiment – shall I read it to you again?
A Please, read it again.

Q Certainly.

"Would you agree with this? Where good nursing care ... 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 that what Mr Langdale was trying to compare was the situation on a tertiary care unit or a specialised palliative care unit where Professor Ford talked about having one to one nurse to patient ratios to monitor symptoms, to monitor pain and to give appropriate treatment when necessary. I think in that ideal situation it would be easier to use lower doses and use his method of titrating doses, with small boluses given every four hours, assessments of the patient every hour. We could not in all consciousness ever do that on wards, in the nursing homes I worked for or in general practice, life just was not like that.

Q Let me put it to you in the way that I think he was putting it. Are you saying that at your hospital, first of all, there were inadequate staffing ratios.
A Inadequate staffing levels for specialised palliative care, yes.

Q Are you saying that regular patient supervision and care was lacking?
A Not for continuing care and not for adequate care of ordinary patients, but at the end of life it was very difficult for them to do that to the level Professor Ford expected.

Q Do not worry about Professor Ford.
A But I do worry about Professor Ford.

Q For different reasons perhaps you should, but not for the reasons I am asking you now. At the time in 1996 through 1999 did you have adequate staffing so far as nursing is concerned on Dryad and Daedalus Wards?
A No.

Q Did you recognise that?
A Yes.

Q Is it your view that that therefore caused a problem with the supervision of the prescriptions that you were writing out?
A I think, as you can see through the cases we have considered, it caused major problems with the writing up of nursing notes in the same way that it caused problems with the writing up of medical notes, but I do not feel that the actual physical care of the patients suffered. It was not to the detriment of the patients, it was to the detriment of the paperwork.

Q If in fact there was poor supervision of patients or poor understanding of the use of opiates that would put a greater degree of responsibility upon your shoulders, would it not, to ensure that your prescriptions were clearly defined?
A Yes.

A Q Are you saying in relation to any of our 12 patients that you started them on opiates or you prescribed opiates earlier because of inadequate staffing?
A No.

Q In starting any patient, in terms of your advice about the actual administration of drugs – not the prescribing of them but the actual administration of them – you said "Start the syringe driver at X rate." Did you ever give directions that the rate of opiates should be
B higher because of a lack of staffing?
A No.

Q And it would have been quite inappropriate for you to do so, would it not?
A Quite inappropriate.

Q You were, I expect, aware of the guidance that we heard about from Professor Ford in
C palliative care "start low, go slow".
A I was aware.

Q Sir, I am going to go on to deal with nurses. Perhaps I could deal with that and then stop for the afternoon. As I have understood it – and please do correct me – your case has been that nursing staff would ring you either at home or at your surgery to discuss developments or any problems with particular patients.
D A Yes.

Q They would normally, is this right, discuss increases in medication?
A Yes.

Q But not always.
A Not always.
E

Q Do you accept that there came a point when quite frequently nurses would increase a dose and tell you afterwards that they had done it?
A I would take issue with "quite frequently" but there were occasions when it happened. But it was never done without my tacit agreement that that is what they were going to do.

Q When you say your tacit agreement do you mean because they knew that was your
F practice?
A They knew that on the previous occasion we had discussed a particular problem they might have to do that.

Q Did that policy apply to irregular staff, bank staff, night staff, all the staff?
A It involved the senior ward staff, the ward sister or senior staff nurse in charge of the ward at any given time. It was not devolved to junior staff, bank staff or untrained staff.
G

Q But it would cover night staff presumably.
A In each case there was a senior member of the night staff, if not working on the ward then responsible for all the wards in the hospital.

Q You told us about the policy of starting at the bottom of your prescription range.
A Yes.
H

Q Were there occasions when nurses in fact breached that policy?
A There was one because we have looked at it where the ward manager felt that the patient needed a slightly higher dose than the bottom dose written on the range. I would have been perfectly happy to sanction that.

Q To sanction it after it had been done.
A Before or after.

Q If you sanction it ex post facto, after it has been given ---
A It is still my decision, I am still responsible for that prescription because I am the one who wrote it.

Q After having looked at these 12 cases in some detail where nurses have either increased the dose or they have increased the dose but come back to you thereafter you have not been critical of them on any single occasion, have you?
A I have not.

Q I just want to ask you a little bit about your relationship with Sister Hamblin. Do you remember describing her as the clinical boss?
A I do not remember that remark.

Q If you look at your defence documents – do you have those?
A Do you mean the statements I provided for the police?

Q No, I am sorry, there is a little file of defence documents, D3. I wonder if D3 could be handed to Dr Barton. (Same handed). This is a note of a meeting you had on 7 April – would this have been in 2000?
A Yes, this was during the harassment grievance.

Q Let us look at the last paragraph, please:

"When asked how she viewed Gill Hamblin's professional role, Dr Barton described her as the 'Clinical Boss'.

A That would be that she was very much in charge of how the ward ran from the point of view of nursing care, patient care. To my mind it did not mean that she ran the prescribing on the ward. "Clinical boss" to me in that context would mean how well she ran the nursing side of the ward.

Q It is slightly ambiguous, I think, because if you refer to clinical anything it normally means the medical staff.
A Yes.

Q It should mean the doctors.
A Yes.

Q But you did not mean it in that way.
A Not at all.

Q You did, however, work with her from, what, the late 1980s?

A Yes.

Q And you had complete trust in her, did you not?
A I did.

Q Did you ever query her administration of diamorphine that you can remember?
A No.

Q Did she ever query yours?
A No.

MR LANGDALE: I am going to move on to another topic, and I wonder if that would be a convenient moment.

THE CHAIRMAN: Yes, indeed. Thank you very much. We will rise now and return tomorrow morning at 9.30, please, ladies and gentlemen.

(The Panel adjourned until Tuesday 21 July 2009)

ex Barton 029

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 21 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-NINE)

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

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

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
Tel No: 01992 465900)

INDEX

A THE CHAIRMAN: Good morning everybody. Welcome back. Mr Kark, before we begin, can I for the record indicate that our Panel Secretary, Christine Challis, will be away for a couple of weeks and in that time we are going to be looked after by Lola Babatunde? Thank you.

JANE ANN BARTON, Re-called
Cross-examined by MR KARK, Continued

B MR KARK: Dr Barton, I was going to turn to the issue of note making and I was going to be quite short about it because you have already made admissions in relation to those charges. May I ask you this? When did you first recognise that your note making was a problem? When did you first realise that you had insufficient time to make proper notes?
A I imagine that it started to become apparent to me after the first complaint made by the family in 1998, which resulted in a police inquiry in the year 2000.

C Q Up until then you had not been aware that you had been making inadequate notes, is that right?
A I had not given it thought, otherwise obviously I would have attempted to address the problems sooner.

D Q And you would have been well aware, in broad terms at least, that good medical practice required you to keep – I am going to read it out. It is at the back of our folder, Bundle 1 and you perhaps do not need to turn it up unless you want to. It provides,

> "In providing care you must 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".

E You accept, I think, that there were significant failings in your note making. Is that right?
A Entirely.

Q In some cases we have heard the patients arrived at your hospital without the previous hospital notes. Can I suggest to you that more often than not you did have the relevant notes for the patient and it was a small minority of patients where you did not have the previous hospital notes?
F A Obviously at this remove of time I am unable to give you a percentage, but I would say that probably 75 per cent, everything arrived in order and with the correct x-rays and notes, and possibly 25 per cent meant that the transmitting hospital had to be contacted and they had to be asked for any relevant notes, drug charts and x-rays.

Q Where you did not have the previous hospital notes, it would make it even more important, would it not, to perform a proper and accurate assessment and make a note of it?
G A Yes.

Q It would be important to record the patient's current condition, symptoms and signs, previous diagnosis and a plan of treatment.
A Yes.

H Q So far as assessment of these patients is concerned, the initial assessment would not usually be done as part of your normal ward round, would it?

A The patients tended to arrive at lunch time, or unfortunately sometimes later on in the day, so that too much time would have elapsed to wait to clerk those patients in until the following morning, even if I had had time in that hour and a half to do a full clerking.

Q So you would return, as you told us, at lunch to do that.
A And sometimes later in the day to do that.

B Q When you talk about a "clerking in", would that also mean an assessment of the patient's condition?
A Yes.

Q When you were assessing a patient's condition, are you telling this Panel now that you would have done a full examination in each case?
A I am.

C Q So in every case we have looked at, you would have performed a full and proper examination?
A Except for two of them, one of whom I had watched Dr Lord examine him in the day hospital, and there was one gentleman who had been clerked in by Dr Ravi.

Q Absolutely right.
D A So there are two that I did not actually perform the initial assessment on.

Q But in relation to the other 10, when you clerked them in you would have performed a proper examination.
A Yes.

MR LANGDALE: Just while we are on the figures, may I remind my friend that there is one E other of course that Dr X clerked in. Just so we know.

MR KARK: My learned friend is quite right. I am grateful for the correction. Can you just help us, please, with what your practice was in making a full examination of a patient and assessing their condition? What would you actually go through?
A The same formula that you had done since being a medical student, since being a house officer: examine the patient at the side of the bed; look at their general condition and F then go through a system examination, albeit brief in some areas.

Q If you were aware that a patient had, for example, had a hip operation, would you have examined the wound site?
A If it was uncovered. Obviously I would not have asked the nurses to take the dressing down at that point in time, but I would have made myself available to look at it at another time if it was appropriate.

G Q You would also expect blood pressure to be checked?
A Yes.

Q Heart rate to be checked?
A Yes.

H

Q And you would have performed an examination of the chest and the lungs?
A Yes. I would have a nurse with me to help me sit the patient up or roll them over in order to examine the back of the chest, having listened to the front of the chest.

Q Again, we will look at our individual patients as we go through them and the notes that you made, but do you accept that you failed to make a note on those patients where you did clerk them in, of that examination?
A Yes.

Q If you were assessing a patient on a course of palliative care, would that minimise the necessity to make a full note?
A No.

Q If you were assessing a patient on a course of palliative care, it would be all the more necessary, would it not, to make a note of that decision and why it was made?
A I agree.

Q Can you turn to the 1991 issues raised by some of the nurses, please? These events back in 1991 – and we will look at the notes in a moment – must have caused you considerable concern.
A Yes.

Q You appreciate, I expect, that the matters raised first in July 1991 almost mirror the issues which have arisen in the cases that this Panel is examining? Do you want to have a look at them before you answer that question? Let us go to File 1, Tab 6, page 2.
A I think the issues were quite different in 1991. The issues were difficulties between existing night staff and a new day sister, and attitudes towards care of patients at the end of their lives.

Q Let us have a look at the concerns that were being expressed and see whether or not they are relevant to the issues that this Panel are now considering? Do you have page 2?
A I do.

Q The following concerns were expressed and discussed:

"1. Not all patients given diamorphine have pain".

That is an issue that has been raised in this case, is it not?
A I agree.

Q "2. No other forms of analgesia are considered, and the 'sliding scale' for analgesia is never used".
A I disagree.

Q Let me ask you the question. The issue of the sliding scale not being properly used is certainly an issue in this case, is it not?
A I agree.

Q "The drug regime is used indiscriminately, each patient's individual needs are not considered".

Do you accept that that is an issue that has been raised in this case?
A I do not agree.

Q Why not?
A Because my drug regime was not used indiscriminately. It was used perfectly appropriately in these 12 cases that we are looking at.

Q I understand that that is your case. But you understand that the suggestion is being made to you that in some cases people were being put on opiates quite unnecessarily. You understand that that is part of the case against you?
A Yes.

Q "4. That patients' deaths are sometimes hastened unnecessarily".

That is an issue that has been raised in this case, is it not?
A I agree.

Q "5. The use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients' needs".

It has not been expressed in exactly those terms in this case, but there is the suggestion that once a patient was on a syringe driver, of the 12 that we have looked at, it was never reduced or adjusted down.
A Except in one case.

Q We will look at that.

"6. That too high a degree of unresponsiveness from the patients was sought at times".

You appreciate in this case that the allegation is that some patients were so over-dosed that they become wholly unresponsive, unconscious; yes?
A I do not agree with the fact that they became unconscious and unresponsive purely because of the dosage of the drugs.

Q Those issues were raised, and others, back in 1991, and you presumably were alerted to those quite quickly. Yes?
A I was aware that there was concern raised by the night staff.

Q Did you become aware that what the nurses' representatives wanted was a written policy?
A Not at that time. I thought that the issue had been resolved by Mrs Evans and the management team. It was only when one of the night staff was attending a course at Portsmouth University and came in contact with the Clinical Tutor, Gerry Whitney, that it became apparent that their concerns had not been fully addressed and the issue raised its head again.

Q These concerns bubbled on into December 1991, did they not?

A A Yes.

Q We can see if we go to page 18 of this section of the file that here is somebody called Keith Murray, Branch Convenor for the Royal College of Nursing, writing to Beverley Turnbull saying,

B "I think I have made it quite clear that unless you receive confirmation at your meeting that a policy will be drawn up which addresses all of the concerns that you first brought to Mrs Evans' attention back in July then a grievance will be lodged".

I have to confess that I am not quite clear what the significance of a grievance being lodged is.

A I was not at that time aware of that letter or what he was intending to do or not to do. That letter was not copied to me.

C

Q Were you aware that some of the nurses at least, and those representing them, wanted a written policy?

A No.

Q If we go to page 23, we can see that on 17 December 1991 you were present at a meeting with Mrs Evans, Dr Logan and a number of the nurses. Yes?

D A Yes.

Q And none of the nurses in fact spoke out, did they?

A No.

Q If we go on to page 25, we can see just a summary of the comments raised during the discussion. All staff had great respect for you; did not question your professional judgment.

E The night staff present did not feel that their opinions of patients' conditions were considered before prescribing of diamorphine. The patients were not always comfortable during the day even if they had slept during the night. There appeared to be a lack of communication causing some of the problems. Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying, regardless of their symptoms. All staff agreed that if they had concerns in future relating to prescribing of drugs, they would approach Dr Barton or Sister Hamblin in the first instance".

F A Staff were asked if they felt there was any need for a policy relating to nursing practice on this issue. No one present felt that this was appropriate.

Q So far as you were concerned, did that resolve the issues that had been raised?

A I felt that the majority of the night staff were much more comfortable about how decisions about end of life care were being made on the unit and how they were to be involved in those, if at all possible.

G

Q When we heard from some of the nurses who described how their understanding and perception changed, but the practice did not appear to, would you agree with that?

A Because the practice was appropriate and they now understood what the practice was and what it was aiming to achieve.

Q The practice did not change one jot, did it?

H A No.

Q As a result of these concerns raised in 1991.
A No. If opiates were appropriate at the end of life, they were given to patients.

Q The answer is, I think, that you agree that the practice did not change one jot.
A Yes.

Q Mrs Hallman, in 1999, had a meeting with you, when she came to speak with you because she had been told by Sister Hamblin that she had upset you in some way, and she reported that you said to her, "You do not understand what we do". First of all, I expect you remember that piece of evidence.
A I have a vague recollection of the incident and I have the evidence here in front of me. What I meant by "You do not understand what we do here", was that I felt that Shirley was quite inexperienced in palliative and terminal care. She freely admitted that, that the unit she had worked in previously did not do palliative and terminal care in the same way that we did. I felt that a move back to Queen Alexandra would allow her to receive some training in how to become more proficient in this. It was not an attempt to get rid of her, or belittle her or reduce her grade so that she earned less money. It was a genuine attempt to help her increase her experience in the job that she was doing, and I think that she chose to misunderstand what I said.

Q First of all, I just want to establish with you that those were the words that you used, "You do not understand what we do here".
A I have no recollection at this distance of time what the actual words were, but the sense of the words sounds correct.

Q What you were saying to her in effect was that she did not understand appropriate palliative care?
A She was inexperienced in appropriate palliative care, yes.

Q Before we turn to the individual patients, can I just also put this to you. Do you accept that some people are prepared to live with a degree of discomfort or pain provided they are allowed to stay alive?
A I beg your pardon!

Q Do you accept that some people would prefer to live with a degree of pain or discomfort provided they are allowed to remain alive?
A What an extraordinary question.

Q Could you answer it.
A Are you suggesting that in any of these twelve cases I was instrumental in ending these people's lives?

Q Well, we will come ---
A All these people were dying from the various conditions from which they suffered, and the management that I gave them was palliative and then terminal care for the conditions which killed them. In no way did I contribute to their deaths.

Q Do you agree that some people are prepared to live with a degree of pain?

A A I am just completely flawed by that question.

Q It is not a complicated one, Dr Barton. We know that in one case at least, one of the relatives wanted you to reduce the dose, to discover whether his step-father in fact wanted to remain conscious as opposed to dying in effectively the state of a coma, and I want to ask you: do you accept that some people are prepared ---

A That was not Mr Cunningham's choice. That was Mr Farthing, his step-son's, choice, B who was not his next of kin and who I did not feel that it was appropriate to even ask that question of a dying relative.

Q I understand that is your evidence. Do you accept – I will ask for a final time – that some people are prepared to live with a degree of pain?

A Yes.

C Q You were interviewed in 2005, I think it was, and in fact earlier in 2000, by the police. Yes?

A Yes.

Q You were interviewed over many, many, many hours and days. Yes?

A Yes.

D Q And you chose to answer none of their questions?

A Not on the first occasion. I prepared statements for the police and I felt, under legal advice, that that was the most appropriate way to answer the allegations, by carefully thought-out, prepared written statements.

Q Those statements which you described as being carefully thought out, and I am not going to disagree with you for a moment about that, were they made – and I do not want to E know what advice you actually received – but were they created with the assistance of a solicitor?

A They were created by me.

Q Yes. Were they put to your solicitor before they were handed over to the police?

A They were seen by my solicitor before they were handed over to the police, yes.

F Q Can we take it that you put into those statements everything that you could then remember after having had access to the notes?

A You can. I did.

Q And you did not, and would not have, deliberately left anything out?

A Not at all.

G Q And can we take it that your recollection when you made those statements would, if anything, be slightly better than your recollection now?

A Possibly. It was still a couple of years later. It was still quite difficult to remember, particularly confrontations with relatives.

Q But so far as a patient's condition is concerned, can we take it that you put everything into your police statements that you possibly could remember?

H A I did.

A

Q Can we turn then, please, to Patient A, Mr Pittock. You will need the chronology. You can have his notes as well if you want to, of course. Just to remind you in relation to this patient, you told the police that you had now no real recollection of him?
A Yes.

Q And your comments thereafter in your statement – and I am looking at your paragraph 15 – were all based on comments such as "I believe that I would have"?
A Yes.

Q "I would have", "I anticipate that"?
A Yes.

Q All of which reflect that you could not – and I am not criticising you for this – but all of that reflects that you could not actually remember the patient. Yes?
A Yes.

Q Can we just have a quick look at this patient's admission. I am going to avoid as much as I can going right back through all of the notes, but could we start, please, on the chronology at page 9. This is the day before his admission. He was reviewed by Dr Lord, who made a note that he was suffering from:

> "Chronic resistant depression. Very withdrawn. Completely dependent – Barthel 0. Superficial ulceration of left buttock and hip. Hypoproteinaemia. Suggests high-protein drinks and bladder wash-out of hours. Happy to take him to GWMH. RH [rest home] place can be given up as unlikely to return there.
>
> All nursing care given."

Can we just pause for a moment. Dr Lord was suggesting that he needed bladder wash-outs. Yes?
A Because he had an indwelling catheter by this time.

Q Was that something that could be performed at the GWMH?
A Certainly.

Q And high-protein drinks. Those could be given?
A They could be ordered from the kitchen, yes. Those were both nursing duties to organise for the patient when he arrived on the ward.

Q Yes. If we look below in the correspondence, we see that there is, I think, a transfer letter:

> "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."

Dr Lord told us that she would not have transferred any of her patients unless they were sufficiently stable for her to do so.
A Yes.

A

Q Can we look at what happened to him on admission. You made a brief summary of his conditions. Can I just ask you this. You recorded no plan and no mention of the high protein diet?
A That was a nursing procedure which the nurses taken from the transfer letter and organised. It was not necessary for me to set that up.

B

Q Then, if we can read on, he is given Arthrotec. Then if we go to the bottom of page 12, please, of the chronology, he is reviewed there by Dr Tandy, who records that he is depressed, catheterised, he had superficial ulcers and a Barthel of zero. Professor Ford described this gentleman as nearing the end of his life.

"Will eat and drink. For TLC [tender loving care]."

C

A Yes.

Q Over the page, we can see that he was seen by you and Dr Tandy.

"To commence Oramorph 4 hourly this evening."

Can we also look at the next prescription that you wrote after the Oramorph: diamorphine,
D 40-80 mg. Yes?
A Yes.

Q I am sorry. And midazolam, of course, 20-40 mg. Up until that day this patient, I do not think, had taken any form of morphine at all, had he?
A No.

E

Q He was not, in fact, at this time, recorded as complaining of pain other than, as we see at the top of page 12, saying that he has generalised pain. Yes?
A Yes.

Q And Professor Ford described the use of Oramorph as appropriate, but I want to look at the level of diamorphine that you prescribed.
A Yes.

F

Q This is the first one of these prescriptions, so we are going to have to look at it in a little more detail that we will, perhaps, later on. The purpose of these prescriptions was, as we understand it, to allow the nurses to initiate, if it was necessary, diamorphine and midazolam at the lowest level. Yes?
A Yes.

G

Q Once you have written a prescription like this out, it allows the nurses to initiate it at any stage that they feel right?
A Yes.

Q It allows them to initiate the dose either at the minimum dose, or at any dose along the range?
A Yes.

H

Q The minimum dose in this case would have been – was – 40 mg of diamorphine?
A Yes.

Q Which would have been the equivalent of 120 mg orally?
A By your calculations, using a third, yes.

Q It is not my calculations, no. It is the BNF's calculations.
A Right.

Q And the Wessex Handbook's calculations. It is not my calculations. The equivalent on the BNF calculation would be 120 mg orally, would it not?
A Yes.

Q What would you expect would happen to this patient if the nurses started him on that day with 40 mg diamorphine?
A If he had been in quite an appreciable amount of distress and psychological pain and some physical pain, I hope that it would have relieved his symptoms.

Q Would you have expected it to have a profoundly depressing effect on his vital systems?
A It was possible, but it is in individual judgment looking at a particular patient how they are going to respond to the opiates and anxiolytics and what dose to try for them. At this point in his life, he had left the palliative care pathway, for which you are given guidelines by the BNF and Wessex Handbook. He had entered the terminal care pathway. He needed sufficient analgesia to keep him comfortable, and the estimation of the amount of drug you are going to use would be made by looking at the patient, standing at the bedside, nursing him, tending to him, seeing him, not from a handbook or a BNF.

Q Did you take into account when you wrote out this prescription the Oramorph prescription that you were writing at the same time? In other words, were you presuming that the patient would have started on Oramorph before he started on the syringe driver?
A I was assuming that he would use the oral route if it was appropriate, and he could manage it.

Q You see, if that had happened, let us just look at what you were prescribing on that day, but looking at the Oramorph first of all. Five milligrams five times daily obviously would be 25 mg. Yes?
A Yes.

Q Your prescription for diamorphine, was it predicated on the basis that he might require the whole of that Oramorph dose?
A Yes.

Q And he would require it because of the degree of pain that he would be in?
A Yes.

Q Presumably it would also be predicated on the basis that he was in such pain that he required subcutaneous drugs to relieve it, or he was unable to swallow?
A Yes.

Q And that by the time the syringe driver would be used, he would require a substantial increase from 25 mg orally?
A Yes.

Q And that such an increase would be at a minimum level of at least four times what he had been receiving?
A Yes. And that was on clinical assessment of the patient.

Q Yes.
A And the severity of the bed sores, and the degree of rigidity and immobility of the patient, and the mental anguish of his ongoing depression and withdrawal.

Q Where, please, have you ever red that it is acceptable to start a patient on a subcutaneous dose which is four times the previous dose that they had received?
A It is not written in guidelines, but you do it on the assessment of the patient, not what you read in the text book.

Q Let us not worry about the guidelines for a moment. Have you read any report, any proper piece of research anywhere, that would justify that approach?
A I think it would be very difficult to perform research on patients at the end of their life, as this man was. I think it would be very difficult to do double-blind trials and cross-over trials. This man was dying.

Q At the time that you wrote this prescription you had never read anything that could conceivably support it, had you?
A No.

Q And if in fact the nurses had gone up to 80 mg, that would have been an eightfold increase, would it not?
A Certainly.

Q Why to that did you feel the necessity to add midazolam?
A Because of its anxiolytic properties, because of its preventing terminal restlessness, because he was on antipsychotic drugs before he went on to the syringe driver and I wanted those symptoms controlled by the midazolam.

Q You would appreciate, would you not, as you have already told us, I think, that to add midazolam to diamorphine would substantially increase the level of sedation?
A I would.

Q Can we look at what actually happened to this patient? He was given Oramorph on the day that you prescribed it, on 10 January, and he was given, I think, 5 mg at night. Yes?
A Yes.

Q Let us go over the page to page 14. During the day, from 6 o'clock in the morning of 11 January, he was given first of all a dose of 5 mg, and then three further doses of 5 mg – that is 20 mg – and then 10 mg administered at 20.00 hours. Yes?
A Yes.

Q So he is getting 30 mg a day?
A Yes. The equivalent of eight co-proxamol tablets on the second layer of the ladder.

Q On that second day, before he had even started his first syringe driver of a minimum dose of 40 to 80, you doubled the minimum dose.
A Yes.

Q In evidence you told the Panel that you did so, as I understand it, because of the intensity and depth of his pain, his rigidity and discomfort.
A And mental distress.

Q Do you now remember that?
A I have told you that I do not actually remember the case, but that is what I would have done faced with that situation with that man dying.

Q What you actually said in your police statement at paragraph 23 was this:

"I would have been concerned, although it was not necessary to administer the medication at that stage, Mr Pittock's pain, anxiety and distress might develop significantly".

A Yes.

Q "And that appropriate medication should be available to relieve this if necessary". Yes?
A Yes.

Q There is no indication there that his pain, anxiety and distress had in fact increased; it was simply a feeling by you that it might.
A It was.

Q That is not the same as saying that you did that because of the intensity and depth of his pain, his rigidity and discomfort is it?
A It is anticipating these symptoms.

Q So you were anticipating the depth of his pain, his rigidity and discomfort?
A Yes.

Q You thought those things might happen, but actually they had not?
A They had not at that moment in time, no.

Q What had changed between 10 January and 11 January which caused you to double the minimum dose?
A I had made a further medical assessment of him.

Q Had you?
A On the Friday morning.

Q Why do you say that?

A A Because I went in every morning and I would be looking at him and how his condition had changed since my previous examination of him.

Q If, in fact, he was not displaying pain rigidity and discomfort, why would you feel the need to double the dose? Nothing had happened.
A Yet.

B Q You felt it appropriate to give him a minimum starting point of 80 mg of diamorphine and let us not forget midazolam which you also doubled.
A Yes.

Q This is a man who was then on 30 mg of Oramorph.
A Yes, and I relied on the nursing staff reporting to me that at that moment in time he did not need any more than that 30mg of Oramorph.

C Q An exact equivalent dose subcutaneously would have been 10mg, a slight increase would have been ~~50~~ 15 mg of diamorphine.
A Yes.

Q This now before he started the syringe driver at all is an eight-fold increase is it not?
A Yes.

D Q Have you read anywhere that that sort of increase is in fact appropriate and justified?
A No.

Q You said that with a sense of astonishment.
A No, I say it with a sense of perfect honesty. I have never seen it written down how somebody not standing at the patient's bedside can make an assessment of what level of
E analgesia and anxiolytic treatment they are going to need as they approach death. Guidelines are fine.

Q You have relied on this, Dr Barton, on a number of occasions.
A I have.

Q As have your representatives, that it is crucial to stand by the bedside. Yes?
F A It is.

Q Do you think that the editors of the BNF and those who wrote the Wessex Guidelines had never stood at a patient's bedside?
A I sometimes wondered.

Q The guidelines would have been based on the treatment of patients suffering pain
G would they not?
A Yes.

Q Doctors standing by the bedside watching patients in pain and prescribing to them.
A Yes.

Q To deal with pain.
H A Yes.

A

Q
A

Q uidelines - because you apparently wrote
som for the Wessex Guidelines - you knew that
the
B A vays appropriate when dealing with an
indiv

Q
A [Palliation] is the relief of symptoms that you know are possibly not going to be curative but are going to make the patient comfortable. This is at the far end of the process. This is all systems shutting down, the patient in front of you dying.

C

Q Doctor, at this stage this patient was not, unless you failed to note it, displaying great symptoms of pain was he?
A I was minded that it quite possibly would be necessary and not very long in the future judging by his condition.

Q Can we take it that if you had the palliative care hand book in your pocket at the time
D that you wrote out this prescription you did not look at it?
A No.

Q Because if you had, you would not have written out this prescription.
A I would have written exactly the same prescription whether or not I had consulted the little green book.

E

Q Was there any point in keeping the little green book in your pocket?
A It was very useful for doses of other drugs that I was not particularly familiar with, rather than the drugs that I used most regularly.

Q The section on palliative care using opiates and the section in the BNF on the use of opiates you might as well just have ripped out and thrown away because you were not looking at those were you?
F A Not on this particular occasion, no.

Q Let us look at what happened to the patient. On page 15, we are now on 15 January, his catheter had been bypassing and the patient is described as being in distress. A catheter bypassing can be very unpleasant, I expect, for a patient.
A I imagine that the distress she was referring to was not just caused by the fact that his catheter was leaking. He was in general distress and I actually saw him that morning.

G

Q On 15 January, you instituted a syringe driver.
A I did.

Q Up until this point, he had been on 30mg orally a day.
A He had.

H

Q No doctor wants to see his patient in pain.
A No.

Q You must have known that the Wessex Guidelines - because you apparently wrote something, I cannot now remember what you did for the Wessex Guidelines - you knew that the Wessex Guidelines ---
A Very appropriate in palliative care, not always appropriate when dealing with an individual patient requiring terminal care, dying.

Q Help us with that, palliation ---
A [Palliation] is the relief of symptoms that you know are possibly not going to be curative but are going to make the patient comfortable. This is at the far end of the process. This is all systems shutting down, the patient in front of you dying.

Q Doctor, at this stage this patient was not, unless you failed to note it, displaying great symptoms of pain was he?
A I was minded that it quite possibly would be necessary and not very long in the future judging by his condition.

Q Can we take it that if you had the palliative care hand book in your pocket at the time that you wrote out this prescription you did not look at it?
A No.

Q Because if you had, you would not have written out this prescription.
A I would have written exactly the same prescription whether or not I had consulted the little green book.

Q Was there any point in keeping the little green book in your pocket?
A It was very useful for doses of other drugs that I was not particularly familiar with, rather than the drugs that I used most regularly.

Q The section on palliative care using opiates and the section in the BNF on the use of opiates you might as well just have ripped out and thrown away because you were not looking at those were you?
A Not on this particular occasion, no.

Q Let us look at what happened to the patient. On page 15, we are now on 15 January, his catheter had been bypassing and the patient is described as being in distress. A catheter bypassing can be very unpleasant, I expect, for a patient.
A I imagine that the distress she was referring to was not just caused by the fact that his catheter was leaking. He was in general distress and I actually saw him that morning.

Q On 15 January, you instituted a syringe driver.
A I did.

Q Up until this point, he had been on 30mg orally a day.
A He had.

A Q From 11 January?
A And he had not been assessed over the weekend.

Q When you say he had not been assessed over the weekend?
A The 15 January was a Monday morning, so I would have come back from the weekend and been appalled at the condition that he was in.

B Q You then instituted a syringe driver.
A Yes.

Q You now had the opportunity not just of following your own prescription but you could have written out a completely new prescription, could you not, to deal with a patient's symptoms then?
A I could.

C Q We know that you did not do so because there is no further prescription; we are still relying on the prescription that you wrote out on 11 January. Yes?
A Yes.

Q Let us imagine for a moment that we are going to use the guidelines. The patient is on 15mg equivalent, but you want to increase it because the patient is in pain and distress. Yes?
D A Yes.

Q If you want to increase it, because a measure of flexibility is allowed within the palliative care guidelines and the BNF, instead of reducing it by a third, you could reduce the oral dose by half when converting it. Yes?
A Yes.

E Q That would give you 15mg with an increase in pain relief.
A Yes.

Q Can you just tell us your thinking when you decided to give this patient five times more than that?
A Because that was the dose that he needed.

F Q How did you assess that?
A By assessing his clinical state that morning.

Q It is extremely unfortunate, I expect you would agree, that you made no note whatever about it.
A Yes.

G Q If the patient had deteriorated to that extent, that is something, undoubtedly, you should have made a note about is it not?
A Yes.

Q Did you use the concept of titration at all for this patient?
A No.

H

A Q The nursing staff, who you have roundly praised and told us that you relied on, had in their patient notes a prescription from you over that weekend for a syringe driver to instituted.
A Yes.

Q There was absolutely no reason why, either on the Saturday or the Sunday, if the patient's distress was such that it was felt to be needed, they could not institute that syringe driver was there?
B A None at all.

Q Do you know why they did not?
A I have no idea.

Q It rather makes your anticipatory prescribing slightly pointless in this case does it not? The patient is apparently reduced to great pain and distress, such that by the Monday morning
C you have to give him what I am going to describe, frankly, as a huge dose of diamorphine and midazolam and the nurses have not done anything about it.
A I cannot comment on what happened over the weekend. I can only tell you what I saw at 7.30 that Monday morning.

Q The dose was started at 8.25 in the morning and by the afternoon/evening he was unresponsive. Yes?
D A Yes. You would expect that as the initial level began to build up that there would be a period possibly of reduced consciousness. By the next day some agitation noticed when being attended to.

Q What does that actually mean.
A He did not like being turned, nursed or washed or his dressings changed on his sacral ulcers, although if he was left alone he was probably reasonably comfortable on that level of
E analgesia.

Q When he was being moved, you say he exhibited some distress, presumably through pain?
A Yes.

Q Why did you choose haloperidol to add to the mixture?
F A Because it is an antipsychotic and I thought that the agitation that he was showing might have been part of his depression and dementia and that that would be a better approach to controlling his symptoms than increasing the diamorphine at that point in time.

Q If patient is unconscious ---
A Well he was not.

G Q Why do you say that?
A Some agitation was noticed when being attended to; he was not unconscious.

Q Are you saying that some agitation means that he was responsive in speaking?
A He was responsive. I do not say he was speaking.

H

A Q I do not think we have put haloperidol into the section in our file from the BNF. May I pass a copy of it please to you and also to the Panel. (Same handed) There are two pages that need to go in and I will ask your Panel assistant to pass them out.

THE CHAIRMAN: These are to go into Panel volume 1 behind tab 3. Would you like to indicate a page positioning for them, Mr Kark?

B MR KARK: We might as well put them at the back after co-codamol. I have not paginated these. It would be 52 and 53. We added co-codamol a couple of weeks ago and that is page 51.

THE CHAIRMAN: We did add a co-dydramol reference and we put that in at page 51. We will mark these pages 52 and 53.

C MR KARK: Do you have that, Dr Barton?
A I do.

Q I am putting it because I think it is appropriate that we have this available to us. We can see that it is for schizophrenia and other psychoses, mania, short-term adjunctive management of psychomotor agitation, excitement and violent/or dangerously impulsive ---
A These are all indications by mouth; I was not using it orally. You do not have the
D subcutaneous indication in there. It will be in the palliative care hand book.

Q I have copied the wrong bit. You can put that aside. I will find the right bit and we will come back to it. Let us go back to the chronology. At page 16, Mr Pittock is now on a syringe driver with 80mg of diamorphine, 60mg of midazolam and 5mg of haloperidol. Would you expect his level of consciousness to be much reduced?
A No.
E

Q Why not?
A Not with haloperidol. It was not very sedating.

Q Diamorphine and midazolam at those levels would reduce his conscious level considerably, would it not?
A It would.
F

Q Can we go to the following day, the 17th first of all, the diamorphine has now been increased by 50 per cent. Yes?
A Yes

Q The midazolam has been increased by slightly less than 50 per cent. The haloperidol has been quadrupled.
G A Yes.

Q Can we take it that you cannot now remember your thinking behind that prescription?
A I was aiming for a balance of the different drugs I was using to keep him as comfortable as possible.

Q If we go on through page 20, I think that remains as it was before, and page 21 we can
H see that on 20 January he was on 120 mg of diamorphine, 80 mg of midazolam. The

haloperidol was discontinued, but he was now on Nozinan. The Nozinan you had added, I think, on the 18th.
A Yes, on the Friday.

Q The Nozinan was to do what?
A That is a much more sedating, anxyolitic anti-psychotic.

Q That would have what?
A Stopped the restlessness and agitation.

Q It would have considerably increased his level of sedation, would it not?
A It would.

Q When Dr Briggs reviewed this patient, he would have been reviewing an unconscious, but apparently agitated patient.
A Yes.

Q You would not have expected him to review this patient's treatment overall, would you? You would not have expected him to go right back to the beginning of your prescriptions and review the entire programme, as it were.
A No, but I would have expected, if he felt there was anything inappropriate about any of the prescriptions, he was at liberty to change them.

Q Of course, all of the prescriptions that you wrote out and administered, you say were based upon your observation of the patient or on the nurse's observation of the patient.
A During that week, yes.

Q Can we just have a look at the charges together, please? Do you have those available to you?
A Yes.

Q Head of charge 2 is dealing with this patient. We can see what you have admitted and all of the administration of the drugs, of course, is admitted. Can we go down to (b)(i)? The suggestion is that,

> "the lowest doses prescribed of Diamorphine and Midazolam [on 11 and 15 January] were too high".

You do not accept that.
A Too high for what?

Q For the patient's condition at the time.
A The patient's condition required those levels of both those drugs as you can see from the fact that he continued to need increased dosages for several days afterwards.

Q Do you nevertheless accept that they were dramatically over any form of guideline that you could have been relying on?
A I do, but I still say that they are appropriate for that man in that condition on that day.

A Q On reflection, just thinking about the dose ranges, do you accept that an eight-fold increase, which would have been the top of your range, must have been too high?
A No.

Q You do admit that the prescription created a situation whereby drugs could be administered to Patient A which were excessive to his needs.
A Yes.

B

Q On what basis do you admit that?
A That if one of my nurses had decided to institute the syringe driver at the dose of 200 mg of Diamorphine, that could have been excessive to his needs.

Q I think they could not, on these prescriptions, have started at 200, could they? But they could have started at 180 or 120 with Midazolam.
C A That is not considered to be appropriate for nurses to be able to prescribe that level of medication, although it was appropriate for me to prescribe that level, because I thought it was appropriate.

Q I just want to pause on the thinking behind that. You accept that prescriptions created a situation whereby drugs could be administered by the nurses which were excessive to his needs. Yes?
D A Yes.

Q Does that not mean that the dose range was too wide?
A Yes.

Q Can we look at (b)(ii) again? In relation to 2(a)(ii) and 2(a)(iii), it is alleged that the dose range was too wide. Do you now admit that that is so?
E A Yes.

Q Right. You do not accept that the doses of diamorphine administered to the patient on 15 and 17 were excessive to his needs.
A No.

Q Do you accept that your prescription described at paragraph 2(a)(vi), which was the
F addition of the Nozinan which you have just described, I think, as a strong sedative, effectively, in combination with the other drugs already prescribed, were excessive to the patient's needs?
A No. It did not work, but it was not excessive to his needs.

Q Then (e) charges you as follows,

G "Your actions in prescribing the drugs as described n paragraphs 2(a)(ii), (iii), (iv) and (v)" –

Just to remind ourselves, that is Oramorph and diamorphine 40 to 80 on 5 to 10 January, and then the prescription on 11 January, the diamorphine and midazolam, and then the prescription on 15 January, then on 17th and then on 18th, were inappropriate. That is the charge. That is the allegation. You accept that in relation to 2(a)(iii) at least, it was
H potentially hazardous. Yes?

A A Yes.

Q Again I just want to understand your thinking. If a prescription by you is potentially hazardous, and now you have admitted too wide, how can it be appropriate?
A It is not the same question. The starting dose that I gave him from the range I had written out, I felt was appropriate to that patient at that time.

B MR KARK: The stem of the charge reads,

> "Your actions in prescribing the drugs as described".

MR LANGDALE: Sir, I feel I must interrupt because the question is being put on a basis which may possibly be confusing and may indeed run contrary to the evidence that has been heard by the Panel.

C

Going back to Charge 2(b)(ii), the dose range was too wide, that is something about which Professor Ford gave evidence. He said in relation to the dose range,
"If the starting dose was correct" -- in relation to Mr Pittock, we are not talking about the 20 to 200 case – he said,

> "If the starting dose was correct, then the dose range was not too wide".

D

In other words, if one goes, by way of illustration, to the prescription shown on the history at page 13, the dose range on that prescription, 40 to 80, was not too wide; in other words, if you prescribed a dose range at a level and the highest was simply double that level, that was not in itself too wide. Questions are being put to Dr Barton on the basis that the dose range was too wide in those circumstances, which Dr Barton's indication at the start of the case was that that was not correct. Similarly, when one looked at the diamorphine on 11th, the range
E was 80 to 120. If 80 was the correct starting dose, then 120 was not too wide a range, because it allowed for an increase.

So the evidence adduced by my learned friend from his own witness is not that the dose range was too wide. The criticism made by Professor Ford was that the starting point is too high.

So I think, sir, that these questions are running the risk of actually creating a confusion and
F possibly resulting in unclear answers, because it is very important – I say this by way of illustration in relation to 2(b)(iii),

> "the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs".

That is the case if, for example, a nurse, given a range, wrongly started at the top of the range,
G when the patient's needs did not require it. That is the whole point about the "could be", in relation to these charges. We are running into the same problem in regard to the question of "potentially hazardous". I would like my friend to frame his questions, if he would, very carefully in terms of the evidence that we have heard and what the charge items actually say.

MR KARK: I am grateful for that reminder of Professor Ford's evidence, but this is now Dr Barton's evidence, and she may well admit charges, and she is entitled to admit charges if, on
H

reflection, in her view, her doses – we have heard she was standing by the patient at times – were in fact too wide. She is perfectly entitled to admit that.

MR LANGDALE: What I am objecting to is my learned friend putting forward as part of his case something that his expert witness does not state. It is not Professor Ford's evidence, and therefore unless my learned friend is seeking to say that we ignore Professor Ford's evidence for these purposes, my learned friend should not be putting a case different to the one he has called through his own witness.

MR KARK: I am sorry, but Professor Ford's whole premise on this was that the starting dose was wrong in the first place. Dr Barton should not have been writing these prescriptions at all. If Dr Barton is going to give the evidence that her starting point is acceptable, she is still entitled to be asked, or I am still entitled to ask her, well, even on that premise, that the starting point is alright, if that is your evidence, Dr Barton, "Do you accept the range is too wide?" I will pursue that unless stopped. I think it is a perfectly legitimate point to put to her, but I will move on on a ruling.

THE CHAIRMAN: Before I turn to the Legal Assessor and ask for his view, I think what Mr Langdale was saying was that the evidence that Professor Ford had given was that "if", and he did not accept it, that starting dose had been correct, then it would follow from the doubling up principle that the range in this case would not necessarily have been too wide. He was concerned that the witness might inadvertently have been confused by these two different elements.

MR KARK: I do understand that. This is rather circular. I keep coming back to Professor Ford's starting point which is that we should not be starting from here anyway. Dr Barton is saying we should be starting from here and I want to ask her whether her view is that, if she is starting at that range, nevertheless in her view the dose is too wide. She has accepted that it was. Maybe a correction is now going to be forthcoming, but I do not think it is inadmissible to ask her, because the whole premise of Professor Ford's evidence was that this was wrong in the first place.

MR LANGDALE: May I make a suggestion to avoid what sometimes is quite properly put, but sometimes a little cumbersome when the Panel has to take advice from the Legal Assessor? This is not cloud cuckoo land. The witness has been sitting there and has heard what has been said. If my learned friend wants to put his questions in the circumstances, I think he can, but I made it clear that he must make it clear on what basis he is suggesting the range is too wide if it is contrary to his own main witness on the subject. I think we are going to be wasting time unless, my friend having considered what has been said, he rephrases his questions or proceeds in a way that he thinks is appropriate.

THE CHAIRMAN: I am grateful for that. I think the real point, Mr Kark, is that we need to avoid confusion at all costs. Even if the witness is not confused, the Panel may well be.

MR KARK: Certainly sir. Dr Barton, having heard that short interchange, do you want to go back to 2(b)(ii)?

A I was very confused about what you were trying to ask me. I do not agree that the lowest dose that I prescribed was too high, and I do not agree that the dose range that I prescribed on that chart was too wide.

A Q But you do accept that the prescription did create a situation whereby drugs could be administered which were in fact excessive to the patient's needs.
A Yes.

Q So far as that is concerned, you still stick by your guns, do you, that you say that these prescriptions were, nevertheless, in Patient A's – Mr Pittock's – best interests?
A They were.

B

MR KARK: That is all I seek to ask you about Patient A. You have been giving evidence for an hour and a quarter and I expect a break would be good for both of us.

THE CHAIRMAN: Perhaps the business of the incorrect photocopying could be dealt with before we move on to the next patient.

C MR KARK: I will certainly try, sir.

THE CHAIRMAN: We will break now and return at five minutes past 11.

(Adjourned for a short time)

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

MR KARK: We have been looking at haloperidol. Perhaps we could just flag this up in the Palliative Care Handbook which you referred to. Perhaps we should go to Tab 4 to see what it says about it. We can turn to page 15 of the file numbering and page 26 of the internal documents. The heading is, "Drugs used in the syringe driver". About half-way down the left hand column we see haloperidol. So this is obviously to be used by subcutaneous injection;

E

"2.5 – 10 mg over 24 hours. Antidopaminergic".

A "Antidopaminergic antiemetic".

Q Which is what?
A Antiemetic is anti-sickness.

F

Q That bit I understand.
A It is anti-the sorts of things you get in Parkinson's Disease, rigidity and stiffness.

Q "Higher doses occasionally used for sedation".
A Yes.

G Q "Extrapyramidal side effects occur with high doses".

What does that mean?
A Dystonic, odd movements. That is what the nurse at that weekend was concerned about with Mr Pittock, hence calling Dr Bates in.

Q Then if we go to page 21, under the general heading of "Confusion", on the right hand side, under "Management", we see "6. Drug Therapy",

H

A

"If paranoid, deluded, agitated or hallucinating, haloperidol 1.5 – 3mg up to three times a day orally".

A Yes.

Q Then we see underneath that,

B "Review early as symptoms may be exacerbated by sedative effects".

A "Watch for extrapyramidal side effects", which is what they thought he had that weekend, and the next two drugs are much more appropriate for the condition that we were in, in the next paragraph, the midazolam, between 10 – 100 mg over 24 hours or the Nozinan 25 – 100 mg over 24 hours.

C Q And,

"Review early as symptoms may be exacerbated by earlier sedative effects."

That means what? That it can ---?

A We were not particularly concerned about the sedative effects in this patient, in the terminal care of his condition. They are talking here about using it orally for schizophrenic D and psychotic patients.

Q Right.

A Which was not really relevant for using it in a syringe driver.

Q All right. Finally we have part of the BNF, which we need to punch. This is from the 1998 BNF. We have a heading "Prescribing in Palliative Care". I am going to see if we may E already have this, in fact. We do. We do not need that, because we can go back. I am afraid I just had not seen it earlier – I beg your pardon. Let us go back to tab 3. We did not look at this earlier, Dr Barton, and you may want to do so. At page 3 of tab 3 – page 13 of the BNF but page 3 of our file – "Restlessness and Confusion":

"Restlessness and confusion may require treatment with haloperidol…"

F and that is dealing with 1 – 3 mg by mouth every eight hours. Then, on the right hand side of page 4, under the same heading "Restlessness and Confusion" under "Syringe Drivers":

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

A Yes.

G

Q That deals, I think, with that. You can put it away. Can you turn, please, to Elsie Lavender and Patient B. You may want to get the chronology out for Patient B. This lady, we know, in February had a fall and she was X-rayed apparently at the Royal Haslar. She was treated over a fairly lengthy period of time and then came to you on 22 February, as we see form page 7 of the chronology. I think you agree with Professor Ford in essence when he said it was too early to say that this patient's chances of recovery were small. Do you accept H that she had a reasonable chance of recovery?

A I accept that she had a chance of recovery, but that she had a number of comorbidities and she had only just been managing at home before she came into hospital, so that her outlook was probably residential or nursing home, certainly not home.

Q Right. You said, I think, in evidence to Mr Langdale, "I felt that she deserved the opportunity to try to remobilise".
A Yes.

B

Q This patient, up until her transfer to Daedalus Ward had been on co-proxamol and dihydrocodeine, I think.
A Yes.

Q If we need to, we can go back in the chronology. Would you go to page 2. At the bottom you will see:

C

"Prescribing co-proxamol and dihydrocodeine. Administered until transfer to GWMH."

A Yes.

Q So she does not appear to have been on anything stronger than that?
D A Which, in the palliative care guidelines, is an equivalent of 30 mg of oral morphine.

Q Quite. You told the Panel that the problem with her wrists may have been pre-existing. Is that right?
A There was mention somewhere in her notes of her having had a carpal tunnel syndrome problem previously, and she also may have had a neuropathy, a nerve damage, in the arms due to her diabetes.

E

Q Did that not require an evaluation by you?
A It would have been assessed in the general examination of the patient on arrival, but not recorded.

Q Was not recorded. On 23 February she is reviewed by you. On 24 February she is reviewed by you again. On 24 February there is a note by Nurse Joines that her pain was not
F controlled properly by DF118 – that is dihydrocodeine?
A Yes.

Q Did you consider at this stage, as Professor Ford said you should have done, that there should be an evaluation because the pain should not have been worse at that stage?
A I did not feel at that stage that transfer back to the unit that had discharged her to us would have been productive in any way for this lady. Had she been put through the MRI
G scanner and had a fracture of the cervical spine being found, there was no specific treatment for it. Her treatment was not palliation of her symptoms.

Q Does that mean in effect that she would have been on a terminal pathway?
A Yes.

Q So your view was, from 24 February when this patient is continuing to complain of
H pain, that she is on a terminal pathway?

A A Yes.

Q Did you consider asking to see the X-ray or the X-ray report which had been done on 5 February?
A No.

B Q Before you decided to institute opiate medication to deal with her pain, did you not consider that an assessment of the cause of her pain would be a good idea?
A Any assessment of the cause of her pain would not have been germane to her management. It would not have altered our management in any way.

Q You started this patient, as we see, on 24 February on 20 mg a day of MST. Yes?
A Yes. Which was in effect a step-down from the equivalent dosage of step two analgesia that she had been having previously, but it was a good starting dose for MST.

C Q At the bottom of page 9, we see that when moved she was screaming "My back", but she was uncomplaining when left alone?
A Yes.

Q On 26 February, if we look at the top of page 11, I just want to examine with you by this stage what she had actually been on. Up until this point, this patient had been on 20 mg
D MST a day?
A Yes.

Q Yes?
A Yes.

Q You then wrote out a prescription for diamorphine of between 80 and 160 mg per
E day?
A Yes.

Q Together with 40 to 80 mg of midazolam. Yes?
A Yes.

Q From what she had been on to that point, that would as a starting point, have been an
F eightfold increase, if administered immediately. Yes?
A Yes.

Q You agree with that?
A Yes.

Q And she had never had midazolam before?
G A No.

MR LANGDALE: I am sorry. It may save me re-examining and taking more time. Is this on the basis that she is receiving MST 30 mg per day, because I think the right figure is 40. I may have misunderstood what was being put. If you look on page 10, you can see it is 20 twice a day.

H

B.

A MR KARK: I am sorry. What I was putting to the
interruption at all – was that up until that day she ha
back to page 9 of the chronology, you can see 25 Fe
administered? Take your time because it is importa
A That is the weekend again. That is a Sunday,
morning and reviewed her, I increased the MST and
the syringe driver.

B Q I understand that, but up until the Monday sh
A Yes.

Q Right. At the point that you wrote out that application for diamorphine and midazolam. If administered immediately that would have been an eightfold increase?
A Yes.

C Q Let us go back to what happened about the MST. You then increased her MST to 20 mg twice daily. Yes?
A Yes.

Q And that was started at 10 o'clock that evening. Yes?
A Yes.

D Q So on that day she receives 30 mg and on the following day the prescription takes effect and she receives 40 mg a day?
A Yes.

Q Again, on the basis of a prescription that you wrote out, the nurses could at any stage have instituted those prescriptions which you had directed subcutaneously?
E A Yes.

Q And they could have done so either by reference to you or they could have done that of their own volition and normally, but not always, they would have let you know afterwards?
A Yes.

F Q Would you agree that that, in effect, would have been a massive increase in the amount of morphine that this patient was receiving?
A Yes.

Q Can we take it that when you wrote out that prescription on the 26th you would not have been referring, or at least taking any account, of the Palliative Care Handbook or the BNF?
G A Yes.

Q That prescription of yours continued to the 4 March, if we go to page 12, where we can see that the MST dose – I think this is a Monday again – was increased again and she was put up to 30 mg twice daily, 60 mg a day?
A Yes.

H

MR KARK: I am sorry. What I was putting to the witness – and I do not mind the interruption at all – was that up until that day she had been, I think, 20 mg per day. If you go back to page 9 of the chronology, you can see 25 February, do you see 10 mg twice daily administered? Take your time because it is important.

A That is the weekend again. That is a Sunday, so that when I came in on the Monday morning and reviewed her, I increased the MST and wrote up the anticipatory prescription for the syringe driver.

Q I understand that, but up until the Monday she had been on 20 mg a day?

A Yes.

Q Right. At the point that you wrote out that application for diamorphine and midazolam. If administered immediately that would have been an eightfold increase?

A Yes.

Q Let us go back to what happened about the MST. You then increased her MST to 20 mg twice daily. Yes?

A Yes.

Q And that was started at 10 o'clock that evening. Yes?

A Yes.

Q So on that day she receives 30 mg and on the following day the prescription takes effect and she receives 40 mg a day?

A Yes.

Q Again, on the basis of a prescription that you wrote out, the nurses could at any stage have instituted those prescriptions which you had directed subcutaneously?

A Yes.

Q And they could have done so either by reference to you or they could have done that of their own volition and normally, but not always, they would have let you know afterwards?

A Yes.

Q Would you agree that that, in effect, would have been a massive increase in the amount of morphine that this patient was receiving?

A Yes.

Q Can we take it that when you wrote out that prescription on the 26th you would not have been referring, or at least taking any account, of the Palliative Care Handbook or the BNF?

A Yes.

Q That prescription of yours continued to the 4 March, if we go to page 12, where we can see that the MST dose – I think this is a Monday again – was increased again and she was put up to 30 mg twice daily, 60 mg a day?

A Yes.

Q We look at what happened on 5 March, page 13 of the chronology. You describe in your notes how this patient has deteriorated over the last few days?
A Yes.

Q You know that Professor Ford criticises you for a lack of evaluation, or re-evaluation of the patient?
A Yes.

Q But you accept, I expect, that there is no note of any proper evaluation here?
A No.

Q And there should be?
A Yes.

Q If one took place.
A Yes.

Q Are you saying that you would nevertheless have re-assessed the patient and performed a proper examination of her?
A I would.

Q But made no note ---
A Made no note of it.

Q --- of it. Nor indeed has any nurse made any note of any such examination. Yes?
A Yes – or no. Yes.

Q On 5 March there is a note in the nursing care plan, at the bottom of page 13:

"Pain uncontrolled - patient distressed. Syringe driver commenced…."

Apparently the patient had had a very poor night?
A Yes.

Q This patient had previously been on 60 mg of morphine. The equivalent would be 20 mg. If you wanted to give her an increase in the dose and stay within the BNF guidelines, you would have halved it and given her 30 of diamorphine. Yes?
A Yes. On the palliative care guidelines, yes.

Q On any guidelines you care to mention. Yes?
A Yes.

Q What you in fact decided to administer to this patient was 100 mg, which is three times the dose recommended, which would have included an increase?
A Yes.

Q In fact, just more than three times, is it not?
A Yes.

Q To that you have added midazolam?

A A Yes.

Q Again, this is the last question: nowhere in any literature are we going to find any sort of teaching or guidance that justifies such a dose, are we?
A No. But I was the patient's carer. I was standing at the bedside. I was assessing the level of pain and discomfort and terminal distress she was suffering, and I considered that was an appropriate dose to give her in the syringe driver.

B

Q You told the Panel that when you wrote out this prescription, you had over-sedation in mind. Yes?
A Yes.

Q And so you were well aware, were you, that this patient could become over-sedated?
A Yes.

C

Q With potentially fatal consequences?
A Yes.

Q In fact the syringe driver, I think, was commenced on 5 March by Margaret Couchman, and what she told the Panel was that the pain was uncontrolled, the patient distressed, the syringe driver commenced. She said, "I think I remember from my interview
D that I was told by the night staff how distressed she was, so the note was based on what I was told by someone else."
A At the handover at eight o'clock that morning she would have been told that the patient had had a terrible night, which is an example now of the same night staff working on that ward, communicating with the day staff and agreeing that terminal care should not be given.

E Q Yes. She said, "If I had spoken to the patient and she had complained herself about pain, I probably would have noted it." Yes?
A When?

Q So she is relying before she starts this patient on what is effectively her terminal pathway, as we have chosen to describe it, she is relying on a report by the night staff?
A Yes.

F

Q Yes?
A Yes.

Q Not upon anything she has seen?
A Because she is still having the handover in the office at eight o'clock in the morning, or quarter to eight.

G

Q And not upon anything that you have seen?
A Not until I went in then to see the patient when I arrived on the ward.

Q She said, "Dr Barton would have come in, and I would have told her how distressed the patient was and how much pain she was in."

H

A A Yes. And instead of relying on a snapshot view taken by myself that morning, those are the observations of the night staff who had been caring for and turning her and seeing to her throughout the night, which were entirely valid.

Q And it was on that basis that you started this patient on, would you accept, a massively increased dose of diamorphine together with midazolam?
A I accept that it was an appropriate dose of opiate and anxiolytic to give her that
B morning.

Q Do you accept it is a very large increase indeed?
A It was a large increase over what she had been receiving orally, yes.

Q You cannot now claim that you performed any re-assessment can you?
A I am sorry?
C

Q Do you claim that you performed any re-assessment?
A I went in to see her that morning.

Q And made no note about it.
A And made no note about it.

D Q It can have been no surprise to you that this patient died the following evening can it?
A No --

Q She died at 9.28 pm. Alan Lavender's evidence was this:

> "I attended daily, I met with Dr Barton after two to three days. She said to me, 'You can get rid of the cat. You do know that your mother has come here to die'".

E

Do you accept that that was the sort of conversation, if you were being blunt and brusque about it, that you may have had with him?
A I certainly would have suggested that if we were considering a rest home or a nursing home that an alternative home would have to be found for the cat, but I deny that I would have used as quite as blunt language as that when talking to the son of the patient.

F Q He said,

> "It was as if her death had been pre-determined soon after she was on a syringe driver. I assumed it was for pain. She deteriorated quite quickly. She appeared unconscious and smelling terrible and leaking faeces".

Can I ask you this, and we will come to this with another patient, is the loss of control of
G bowels and bladder sometimes a consequence of sedation with diamorphine?
A It is sometimes a consequence of being on the pathway to dying.

Q Is it also sometimes a consequence?
A If you are giving people large doses of opiates you are much more likely to make them totally constipated than make them loose control of their bowels and, again, you have the problem of retention of urine if you are giving high dose of opiates. A lot of these people
H were catheterised so that that situation did not arise. Mrs Lavender put herself on the

A terminal care pathway when she fell top to bottom of her flight of stairs at home before she ever came into hospital. I did not put her on the terminal care pathway.

Q You say she put herself on the terminal care pathway; what you are saying is by the time she reached your hospital she was on the terminal care pathway. Is that right?
A Yes.

B Q Her son described her as,

"Appeared to be making a full recovery, she was alert, lucid and other than a little pain in her shoulder not complaining of pain. It was obvious that it was a little tender and she did not like people touching it".

A I suggest that is a tribute to the dose of MST that she was having prior to the last day
C of her life, it was giving her that degree of pain relief without any sedation.

Q From the time that she arrived at your hospital, did you consider or suggest any alternative treatment other than palliative care?
A No.

Q Can we turn to the heads of charge briefly, please. We take it looking at 3(b)(i) that
D you do not accept that the lowest commencing dose prescribed on 26 February - which was 80mg of diamorphine and 40mg of midazolam, and on 5 March, which was 100mg and 40 mg respectively - that those were too high?
A No.

Q Over the page you do not accept, presumably, that although the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to her
E needs, that it was inappropriate to prescribe those drugs?
A No.

Q Or that it was not in her best interests?
A No.

Q In relation to your management of Patient B it is alleged you did not perform an
F appropriate examination and assessment of Patient B on admission.
A I do not agree.

Q You did not conduct an adequate assessment as Patient B's condition deteriorated.
A I do not agree.

Q Let us just pause here for a moment; you did not provide a plan of treatment.
G A There was no plan of treatment. She was being given palliative care and end of life care.

Q So the plan of treatment was palliation?
A Yes, make comfortable.

Q When we look at your notes and we consider your answers about performing
H assessments but not noting them, how is that meant to work with the partners in your GP

practice on a day when you are not working, on a course, or you are chairing a discussion somewhere and one of your GP partners is called to come in to assist a patient, what are they meant to be basing their care upon?

A They are basing their care on the expert guidance they are given by the nursing staff in charge of that patient. It is exactly the same situation if you are asked to do a house call on a patient in their own home or a patient in a nursing home or rest home, you do not have in front of you a full set of comprehensive case notes, but you rely on the person looking that patient to give you the information you need.

Q But you accept, do you not, that their task would have been made very much easier if you had been making proper notes?

A In none of these cases would comprehensive notes have made any difference to the care of the patients given by Dr X, Dr Briggs or Dr Brook.

Q Do you not accept that by failing to make a proper note of your assessments which you say you were conducting, you were leaving any doctor who came after you in a worse position in order to deal with that patient than they should otherwise have been?

A Yes.

Q Can we move on please to Patient C. Patient C was quite ill when she arrived at Queen Alexandra Hospital - his is Eva Page.

A Yes.

Q In the clinical notes of 12 February when she was still at the Queen Alexandra Hospital there is a note that the aim in the management of this patient should be palliative care.

A Yes.

Q She was recorded as not for CPR.

A Yes.

Q So one has to be realistic about the prospect of this patient.

Can we turn to the chronology at page 4. She was reviewed by Dr Lord On 25 February. Perhaps we ought to look brief at the entry of 19 February, the page before. Plainly at that stage she is described as being tired and thirsty. There is a plan that oral fluids should be encouraged, but she was still eating relatively solid food. Yes?

A Yes.

Q She was given a little midazolam, 2.5mg to help her to go to sleep. Can we go to page 4, please.

> "Reviewed by Dr Lord. Confused and some agitation says she's frightened. Not sure why. Tends to scream at night. Not in pain. Try Thioridazine. Transfer to GWMH" –

and in fact it should reveal for continuing care. That is what she was coming to you for. Yes?

A Palliative care, continuing care.

practice on a day when you are not working, on a course, or you are chairing a discussion somewhere and one of your GP partners is called to come in to assist a patient, what are they meant to be basing their care upon?
A They are basing their care on the expert guidance they are given by the nursing staff in charge of that patient. It is exactly the same situation if you are asked to do a house call on a patient in their own home or a patient in a nursing home or rest home, you do not have in front of you a full set of comprehensive case notes, but you rely on the person looking after that patient to give you the information you need.

Q But you accept, do you not, that their task would have been made very much easier if you had been making proper notes?
A In none of these cases would comprehensive notes have made any difference to the care of the patients given by Dr X, Dr Briggs or Dr Brook.

Q Do you not accept that by failing to make a proper note of your assessments which you say you were conducting, you were leaving any doctor who came after you in a worse position in order to deal with that patient than they should otherwise have been?
A Yes.

Q Can we move on please to Patient C. Patient C was quite ill when she arrived at Queen Alexandra Hospital - his is Eva Page.
A Yes.

Q In the clinical notes of 12 February when she was still at the Queen Alexandra Hospital there is a note that the aim in the management of this patient should be palliative care.
A Yes.

Q She was recorded as not for CPR.
A Yes.

Q So one has to be realistic about the prospect of this patient.
Can we turn to the chronology at page 4. She was reviewed by Dr Lord On 25 February. Perhaps we ought to look brief at the entry of 19 February, the page before. Plainly at that stage she is described as being tired and thirsty. There is a plan that oral fluids should be encouraged, but she was still eating relatively solid food. Yes?
A Yes.

Q She was given a little midazolam, 2.5mg to help her to go to sleep. Can we go to page 4, please.

"Reviewed by Dr Lord. Confused and some agitation says she's frightened. Not sure why. Tends to scream at night. Not in pain. Try Thioridazine. Transfer to GWMH" –

and in fact it should reveal for continuing care. That is what she was coming to you for. Yes?
A Palliative care, continuing care.

A Q On 27 February she was transferred to you. You did make a note and Professor Ford is not critical of this particular note of yours that we see at the bottom of page 4. She was able, as we see from the top of page 5, to hold a beaker and pick up small amounts of food, but she needed a lot of encouragement. Your prescription when she arrived was a relatively small dose of Oramorph given the patient's condition.
A Yes.

B Q Which Professor Ford I think described as being reasonable.
On 28 February we can see that she was very distressed and calling for help and she was given Thioridazine with no relief. She remained distressed and Oramorph was given and then Dr Laing apparently prescribed regular Thioridazine and heminevrin.
A Yes.

Q What would heminevrin do?
C A It is a sedative.

Q Then we see (page 6)

"Can make her wishes known quite well. Does as she is asked. Pain: Yes on movement. Pegasus mattress. Independent turning in bed. Two members of staff for bath/shower. Encourage fluid intake".

D

It then goes on to say that she should be encouraged to do for herself what she can in terms of personal hygiene.

We can see through the notes that she is then regularly receiving though Thioridazine and heminevrin. Can we then go to what happened on 2 March. This is a Monday. Your note reads,

E

"No improvement on major tranquilliser".

The major tranquilliser would have been Thioridazine would it?
A Yes.

Q Then,

F

"I suggest adequate opiates to control fear and pain. Son to be seen by Dr Lord today". She was then reviewed by Dr Lord and said to be,

"Spitting out Thioridazine, quieter on prm, SC diamorphine. Fentanyl patch started today. Agitated and calling out ..."

G That review by Dr Lord appears to have been after she was started on the Fentanyl patch. Do you agree?
A After she had the first dose of subcutaneous diamorphine and the Fentanyl patch had been put on. She then had a subsequent dose during the ward round.

Q If we go over the page, we will have to come back to page 8, we can see what happened about the patch. You prescribed it. It was a 25mcg patch and it was administered
H at 8 o'clock in the morning. Yes?

A A Yes.

Q A Fentanyl patch is rather slower to kick in is it not than an immediate injection?
A Yes, it takes approximately 24 hours to reach its steady state level.

Q You also knew that it would remain in the system for longer and the effects of it would build up over time.
B A To the 24 hours and then remain at steady state until it was taken off on the third day.

Q You also told us that if a syringe driver was started you would see to it that the patch was removed immediately.
A I would not remove the patch myself by hand, but I would ensure that the nursing staff knew to remove the patch.

C Q Why would that be so important?
A Because otherwise the Fentanyl level would remain at that steady state while you were adding in the diamorphine in the syringe driver.

Q Which could lead to?
A It would give a higher dose than you in fact wanted from the syringe drive.

D Q And could lead to an overdose and over sedation; yes?
A It could do, yes.

Q Even when you remove the Fentanyl patch, you know that that does not remove the Fentanyl from the system.
A The Fentanyl level slowly degrades back down again over the subsequent 24 hours.

E Q It takes that long to get rid of it does it not?
A Yes.

Q You also agree that you would not want to run both together; you would never want to run a syringe driver and a Fentanyl patch at the same time would you?
A No.

F Q That is in fact precisely what happened here is it not?
A We do not know what happened because none of the nurses have actually signed for taking off the patch, but I would assume that having our normal protocol was that when a syringe driver was started, the patch was removed.

Q We have seen in a later case that it is specifically recorded.
A Sister Hamblin recorded that she had taken the patch off. I can only assume that
G whoever took this one off did not record it on the drug chart.

Q That is a significant failing is it not if that happened?
A It is.

Q A Fentanyl patch may be put on the body where you would not normally see it. If the patient is lying in bed where would you expect the Fentanyl patch to have been put? It can be
H put on any hairless part of the body can it not?

A A She did not have a very hairy body.

Q Can you remember where it was?
A I have no idea where they put it.

Q If the Fentanyl patch was administered, as it appears to have been at 8 o'clock on 2 March, we can take it that there would be no reason to remove that until the syringe driver started.
A Yes.

Q So on 3 March when the syringe driver did start, it would be pretty much at its peak would it not?
A Yes.

C Q By that I mean at its most potent.
A Yes.

Q We see that following the administration of the syringe driver at the bottom of page 9, it is recorded that there is a rapid condition this morning - I may be putting this wrong, so just pause for a moment before answering - the syringe driver was started at 10.50 in the morning and in fact this note must post date that because it is a note by Nurse Hamblin:

D "Rapid deterioration in condition this morning. Neck and left side of body rigid - right side flaccid. Syringe drive"

it should be commenced "at 10.50".
A Yes.

E Q The time at which that note had been made it would appear that the syringe driver had already been commenced. Yes?
A Yes, but it does not tell you at what time that morning the rapid deterioration in condition occurred. It was certainly before she recommenced at 10.50.

Q On 2March when that Fentanyl patch was started, and the day before the syringe driver was started, this patient was effectively opiate naive.
F A Yes.

Q What do you say is the purpose of the Fentanyl?
A I am sorry, she was not opiate naive; she had Oramorph. The purpose of the Fentanyl was to give her palliation of her symptoms of pain and distress and in a terminal cancer patient it appears that it was quite appropriate to use that kind of opiate administration in this lady.

G Q Can we just go back to the issue of whether or not she was opiate naïve? She transferred to your hospital on 27 February.
A Yes.

Q Up until then she had received no opiates at all, right?
A Yes.

H

Q On 28 February she receives one dose of Oramorph 5mg at 4.20.
A So she is quite opiate naïve, not totally.

Q Just a moment, let us finish this. She gets no opiates on 1 March, yes?
A Yes.

Q By 2 March you would not expect the Oramorph to be having any effect whatever, would you?
A No, it would be out of the system.

Q That is why I put to you that she was effectively opiate naïve.
A Yes.

Q Thank you. Can we look at the charges in relation to Patient C, please? You have admitted that the prescription that you wrote out on 3 March was too wide, yes?
A Yes.

Q You have admitted that the prescription created a situation whereby drugs could be administered to the patient which were excessive to the patient's needs.
A Yes.

Q What is alleged against you is that,

"Your actions in prescribing the drugs as described in paragraph 4(a)(ii)" –

that is the diamorphine and the midazolam in that wide range, "were inappropriate". Can I just ask you to think about this? How can that prescription be appropriate?
A You are talking about the subcutaneous prescription in a patient already receiving and about not to be receiving a fentanyl patch. Because I wished to deal with the terminal distress. We thought that she had probably had a stroke, a cerebral metastases. I was concerned that she might well suffer from terminal restlessness and agitation and I wished to add midazolam so in order to use midazolam, I wanted to use the diamorphine with it and cease using the fentanyl patch.

Q I just want to make sure that we all follow this. Even though you accept that the dose range was too wide; even though you accept that you created a situation whereby drugs could be administered to this patient which were excessive to the patient's needs, nevertheless you stand by your case that such prescription was appropriate.
A It was appropriate.

MR KARK: Thank you. We can move on to Patient D. I am not sure how long we have been going.

THE CHAIRMAN: We have been going over an hour already so we will break for 15 minutes.

(Adjourned for a short time)

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

MR KARK: Dr Barton, we were just about to deal with the case of Patient D, Alice Wilkie. She had been admitted to the Queen Alexandra Hospital at the end of July 1998. She is described as having dementia. She had then an unresolved urinary tract infection. She was 81 years old. She had been prescribed and administered a small amount of haloperidol whilst she was at that hospital on 1 August, and then she comes to you on 6 August. This was the clerking in that you spoke about earlier, although I think we heard from the doctor that he did not regard this as an assessment. He regarded it simply as notifying that the patient was arriving at the hospital. In any event, certainly up to the point of her arrival at your hospital, we should regard this patient, should we not, as being opiate naïve?

A Yes.

Q She was transferred to your hospital, I think my record is, for four to six weeks' observation and then to decide on placement.

A Yes.

Q There is a note on 10 August by Dr Lord that her place at Addenbrooke's was to be given up. What is RV?

A Review in one month.

Q If no specialist medical or nursing problems, patient to a nursing home. Then on 17 August there is a record of deterioration. The 17 August was a Monday.

A Yes.

Q Up until this point, I do not think we have any note from you at all, do we?

A No.

Q How often would you have seen this patient?

A During that preceding week I would have been on the ward, but as I explained in my evidence-in-chief, the ward was in a certain amount of chaos.

Q Because of Mrs Richards.

A Because of Mrs Richards, and I neglected to make any note of any change in Mrs Wilkie's condition during that preceding week, or she may have remained quite stable during that week.

Q But also with other patients when Mrs Richards was not on the ward, I think you have accepted that there was a singular failure to make notes of any of your assessments, was there not?

A Yes.

Q Then on 17 August there is a contact record. That would be made by a nurse, would it?

A Yes, that was made by Philip Beed.

Q Her condition generally deteriorated. There is no mention of pain, is there?

A No.

Q In fact the last mention of any pain was back on 6 August. I will just find it for you. It is on transfer when there is a note, "Does have pain at times but unable to ascertain where".

A There is another one on page 6,

A

"Does have pain occasionally but cannot advise us where".

Q That is right, but that is on the same date, is it not?
A Yes.

Q Then can we look at your prescription? On this occasion I am going to ask that we
B actually look at the copy of the original. That is in Bundle D and it is page 145. I am trying to avoid doing this too often, but it may be appropriate in this case.
Our chronology reveals, or has put this prescription on to 17 August. I just want to ask for your assistance. If we look at page 145, is this a prescription written up by you?
A Yes.

Q How much of this is written out by you?
C A All the left hand side, the drug doses were written up by myself, and the right hand side, the administration was written by Philip Beed.

Q Would this be your normal practice, to write a daily review prescription in this way without putting a date on it?
A My assumption would be that with this lady I wrote that on the morning of 20 August, the day it was started, and that I would have expected Philip Beed to write in the date it was
D administered at the top of that column on the 20th, which is why I did not date it, because he was going to date it that day.

Q That is why I am asking about the date and where we have it on the chronology. Looking at this now you cannot say, can you, when you wrote it?
A No.

E Q We have not looked at this aspect and I have not got the relevant statute in front of me, but when you are writing out a prescription for a controlled drug, is it not a requirement that it is dated?
A I do not know.

Q In any event, whenever you wrote it, whether it was on 17th or later, you have made no record in any note of why you wrote it out.
F A No.

Q Apparently you thought it was appropriate to start this patient at 20 mg of diamorphine. We have become rather inured, perhaps, to seeing these prescriptions, but 20 mg of diamorphine to an opiate naïve patient is not a small amount, is it?
A No. It is the equivalent of, by your calculations, 60 mg of morphine orally during the 24 hours. By my calculations in those days it was 40, which is 5 mg of Oramorph five times
G a day and a double dose at night, so it is a reasonable starting dose even for an opiate naïve patient if you are considering that they are at the point of terminal care.

Q Can I just pick you up on that? Whether or not a patient is at the point of terminal care does not justify you putting them on a syringe drug with opiates in it, does it?
A Yes. This lady, at that point in time, on the morning of 20 August, the Monday morning, required terminal care and she required subcutaneous analgesia, so I wrote the chart
H up that morning and it was administered by Philip Beed.

Q Just pause for a moment, Dr Barton, and think about that answer. Because a patient is on a route to terminal care, that is cause enough, is it, to prescribe opiates by way of syringe driver.
A Because the daughter had reported to Philip that her mother was in pain and distress and because we had noted over the previous few days that her general condition had deteriorated. I wrote down, "Marked deterioration over the last few days". Not an excuse to write up every person reaching the point of terminal care for a syringe driver with opiates, but appropriate for this lady that Monday morning.

Q That is precisely why I asked you to clarify that.
A I am sorry, I did not mean to give you a carte blanche to give everybody – I do apologise.

Q What you are saying is that for this patient it was appropriate.
A That Monday morning it was appropriate.

Q If it was written up on the Monday morning.
A Yes.

Q Let us look at what happened on the Monday morning, and that is 20 August. Marilyn Jackson gave evidence about this. She said this:

> "I went in one lunch time and mum was really very sleepy. She was flinching in her face. I asked her if she had a pain. She said yes. I told a nurse. Beed eventually came and said, 'We did not know your mother was in any pain and we will give her something to relieve her. You may find when you come in this evening that your mum is sleepy'".

Let us just pause there for a moment before I read on in that lady's evidence. A relative reports that her mother is in pain. Would that of itself have justified you writing up a syringe driver prescription of between 20 and 200 mg of diamorphine?
A Not under normal circumstances, if the ward was being run with its normal level of efficiency, but I think at that particular time I think the situation, the circumstances were not normal. I think Philip paid great heed to what the very sensible daughter, who had been spending quite a lot of time with her mother, said, in the absence of having been able to have the time to make the observations himself.

Q I want to come back to your prescription. When do you say you wrote this?
A I started the syringe driver at 13.50 on 20 August.

Q Sorry, when do you say you wrote up this prescription?
A I anticipate that I wrote it that morning. I have no recollection at this distance of time of when I wrote the prescription.

Q We see this word of yours, "anticipate", all the way through the police statements. What it means is that you are guessing on the basis of the notes.
A It is an educated guess, but I am guessing, yes.

Q Yes, on the basis of the notes. So you anticipate that you wrote that up when?

A A On the Monday.

Q When on the Monday?
A There are two alternatives.

Q That would be the 17 then, not the 20th.
A Yes, all right.

B

Q It is your words.
A "Condition generally deteriorated over the weekend", but I did not write anything up until,

"Marked deterioration over the last few days".

C I made an entry on 21st, "subcutaneous analgesia commenced yesterday".

Q That is not, with respect, what I am asking you about. Can you help us as to when you wrote up this prescription?
A The answer is I cannot.

Q If Marilyn Jackson saw her mother at lunch time and went to find Philip Beed, you
D certainly normally would not have been there at lunch time to write up any prescription, would you?
A Unless I was either clerking in a patient or about to attend a ward round.

Q If you had been there on that day and decided that that is what the patient needed that day.
A After examining her.

E

Q Of course after examining her, would you not have written in the date, 20 August?
A You will notice that I wrote it up on a daily review prescription page, which is the back page of the chart. There is not a space for me to write the date that I prescribed the prescription.

Q There is a date.
F A There is the date when it was administered.

Q There is a date when you are saying, not when it is administered, but when you are saying it should start. Is that not what a regular prescription is all about?
A No. On a daily review prescription, there is not a start date box for me to fill in. The box is filled in by the prescriber prescribing the drugs.

G Q If you had been there on 20 August would you, do you think, have written up when that syringe driver commenced?
A Sorry?

Q If you had been there on 20 August, you had become aware of this conversation between Philip Beed and Marilyn Jackson, would you have put in the date?
A Not on that page of the drug chart because there was not a space for me to put it.

H

Q Philip Beed then apparently reacted to that comment by Marilyn Jackson?
A Yes.

Q And he instituted this patient on 30 mg of diamorphine?
A Yes.

Q The equivalent of a 90 mg by my or the BNF's or the Palliative Care Handbook's calculation?
A Yes.

Q Of oral morphine. Yes?
A Yes.

Q Would you agree that would be a very high dose in these circumstances?
A It was a dose that he felt at that time was appropriate.

Q Do you agree it is a very high dose to start a patient on the equivalent of 90 mg oral morphine? That is a large dose, is it not?
A It is a large dose.

Q And higher than the minimum that you had prescribed?
A Yes.

Q Marilyn Jackson said this: "I went back at about eight o'clock and she was unconscious. I tried to rouse her but she never regained consciousness. She died the following evening. Why did they use a high dose of diamorphine in a syringe driver? The syringe driver was never mentioned to me." First of all, in relation to communication with Marilyn Jackson, do you agree that if that is right, that is an extremely unsatisfactory state of affairs?
A Had it occurred like that, it would have been extremely unsatisfactory.

Q And you would not be surprised, would you, with this patient who was opiate naïve if she was started, as we know she was, on a dose of 30 mg of diamorphine and 20 mg of diamorphine, if she quickly became unconscious? That would not surprise you?
A She became comfortable and pain free, is the entry.

Q Your description is "comfortable and pain free"?
A Yes.

Q She is unconscious, is she not?
A I have no idea whether she was unconscious or not. She was certainly comfortable and pain free, which is what ---

Q The evidence of her daughter ---
A --- Philip was aiming to achieve with the dosage in the syringe driver.

Q I will not go back to it, but that should not necessarily be the aim of palliative care, should it?
A This is terminal care, we are talking here. This lady was dying.

A Q Are you say that doses can therefore be higher, and that a state of unconsciousness is the goal?
A I am saying the doses may well have to be higher. A state of unconsciousness is not the goal but relief of symptoms is the goal.

Q The goal, surely, is the relief of symptoms but if possible keeping the patient alert and conscious?
B A But it is a constant balance between the two, and it is very difficult with the severity of the symptoms always to maintain alertness and consciousness at the cost of pain relief.

Q If this patient was complaining of pain to her daughter – she was flinching in her face – is there any reason why she could not be given a 5 mg or 10 mg dose of oral morphine that you can think of?
A If she was not by then able to swallow, or she was unwilling to take fluids, I
C have no idea.

Q Presuming for a moment that she was conscious enough to speak to her daughter, if she was able to eat and drink – at least to drink – there would be no reason, would there, not to give her oral morphine?
A Unless you were minded to give the midazolam in order to deal with any restlessness.

D Q If she could not eat or drink and she needed immediate relief from pain a syringe driver, as you told us yesterday, was not the appropriate method, was it?
A Go through that statement again.

Q If she could not eat or drink, but she needed immediate relief from pain, then the institution of a syringe driver was not the appropriate method to give her ---
A It depends whether the pain was an acute situation or whether the pain was a chronic
E situation which had been building up, in which case the subcutaneous route would have been absolutely ideal for her.

Q But not necessarily of this high dose?
A Quite necessarily in his opinion at this high dose.

Q What Philip Beed told us was that he could not remember the patient at all.
F A No.

Q "30 mg would have been based on the level of pain the patient was experiencing. I had no other reason for giving diamorphine," and then he spoke about hydration.
A Yes.

Q Here is a nurse, albeit a senior one, on the basis of your prescription setting a higher
G than minimum level of diamorphine.
A Yes.

Q Adding midazolam to it?
A Yes. And had he consulted me either before or after putting up that syringe driver, I would have agreed with his clinical judgment.

H Q How do you know? How do you agree with ---

A A Because I had worked with Philip Beed for five years. I knew that he was a very competent senior nurse and his assessment would have been accurate at the bedside of that patient on that day.

Q His comment to Marilyn Jackson apparently was that he had not realised that the mother was in pain.
A But this is what he did once he realised that she was in pain, as was a perfectly
B appropriate line of treatment to take once he realised that she was in pain.

Q He also, however, appears to have made no note of that?
A No.

Q That is an extremely satisfactory position, is it not?
A The whole situation at that time was extremely unsatisfactory.
C

Q And the first note that you have made about this patient was on 21 August?
A Yes.

Q At the top of page 9:

"Marked deterioration over last few days. SC [subcutaneous] analgesia commenced
D yesterday."
A Yes.

Q Sorry, I should finish that.

"Family aware and happy."

E A Yes.

Q And she died that day, that evening at 6.30?
A Yes.

Q Do you accept that with this patient the opiates that she was given are very likely to be a prime cause of her death?
F A No.

Q I was going to refer to the charges which are the charges on page 6. Perhaps I should do so in any event. I expect your answer is going to be the same. You have admitted that the dose range was too wide. You have admitted that they created a situation whereby drugs could be administered and which were excessive. You have admitted that the prescriptions were potentially hazardous but you say, do you, that such a prescription was appropriate?
G A I do.

Q And in the patient's best interest?
A I do.

Q I would like to move on please, to Patient E. I am sorry; there is something else I ought to ask you, and it is this. There are two matters, actually. We do not need the notes
H

for that. You told us that it was to your regret that your attention was focused on Gladys Richards. Yes?
A Yes.

Q Are you saying that as a result of that, your care of this patient, Alice Wilkie, suffered?
A I think in retrospect had both Philip and I been aware a few days earlier of the deterioration in Alice Wilkie, that we would have instituted the more normal pathway of giving her a small dose of Oramorph and then moving on to the syringe driver when her pain and distress merited it, rather than going straight for subcutaneous analgesia on that 20 August.

Q Does it follow that because it was left to the relative to point out to Philip Beed that her mother was in pain, that if you were going to institute opiate analgesia there is an even higher level of responsibility to review whether that level of analgesia was correct?
A Yes.

Q Because there is a great danger here if people's minds are elsewhere, that the patient could in fact be over-sedated?
A Yes. But she was not.

Q Let me turn to Patient E, please, about whom we have just been speaking. We spent quite a lot of time in this case, of course, looking at the case of Gladys Richards know that she was taken to the Royal Hospital Haslar. She had fallen at her nursing h She had fractured the right neck of her femur on 29 July. She underwent an operation had some morphine, I think, on the day of her operation and also two days later, on 2 August. There is a note on 3 August that she had a little discomfort on passive movement, but she was sitting out in a chair and she should be given the opportunity to try to remobilise. She is going to be transferred to you. On the 8th there is a note that she was a bit distressed but had some haloperidol and had a bit of breakfast and ate a good lunch. Then, on 10 August, we have this referral, that she is now fully weight bearing, walking with the aid of two nurses, which I think you doubt.
A It was not what I saw when I admitted her to the ward on 11 August.

Q Why did you not reveal in your note any concern at this significant change in the patient's state of health?
A Because I was making an assessment on admission of the patient, and our plan for the future was going to be based on my assessment and that of my nurses. What was found – allegedly found – at the previous hospital was not relevant to that assessment. We would give her our own assessment and it was perfectly possible that the act of transferring her had in fact set her back and her mobility quite a lot. She might then improve.

Q We heard from, I think, more than one witness that although patients can deteriorate on transfer, it is quite often a temporary situation?
A Certainly.

Q And so can you just help us? Why do you say that the earlier assessment was effectively irrelevant to your considerations?
A Because I had now a baseline assessment with a Barthel of 2 and usually continent and needing help with ADL on which my nursing staff were then going to work. It was not

for that. You told us that it was to your regret that your attention was focused on Gladys Richards. Yes?
A Yes.

Q Are you saying that as a result of that, your care of this patient, Alice Wilkie, suffered?
A I think in retrospect had both Philip and I been aware a few days earlier of the deterioration in Alice Wilkie, that we would have instituted the more normal pathway of giving her a small dose of Oramorph and then moving on to the syringe driver when her pain and distress merited it, rather than going straight for subcutaneous analgesia on that 20 August.

Q Does it follow that because it was left to the relative to point out to Philip Beed that her mother was in pain, that if you were going to institute opiate analgesia there is an even higher level of responsibility to review whether that level of analgesia was correct?
A Yes.

Q Because there is a great danger here if people's minds are elsewhere, that the patient could in fact be over-sedated?
A Yes. But she was not.

Q Let me turn to Patient E, please, about whom we have just been speaking. We have spent quite a lot of time in this case, of course, looking at the case of Gladys Richards and we know that she was taken to the Royal Hospital Haslar. She had fallen at her nursing home. She had fractured the right neck of her femur on 29 July. She underwent an operation. She had some morphine, I think, on the day of her operation and also two days later, on 2 August. There is a note on 3 August that she had a little discomfort on passive movement, but she was sitting out in a chair and she should be given the opportunity to try to remobilise. She is going to be transferred to you. On the 8th there is a note that she was a bit distressed but had some haloperidol and had a bit of breakfast and ate a good lunch. Then, on 10 August, we have this referral, that she is now fully weight bearing, walking with the aid of two nurses, which I think you doubt.
A It was not what I saw when I admitted her to the ward on 11 August.

Q Why did you not reveal in your note any concern at this significant change in the patient's state of health?
A Because I was making an assessment on admission of the patient, and our plan for the future was going to be based on my assessment and that of my nurses. What was found – allegedly found – at the previous hospital was not relevant to that assessment. We would give her our own assessment and it was perfectly possible that the act of transferring her had in fact set her back and her mobility quite a lot. She might then improve.

Q We heard from, I think, more than one witness that although patients can deteriorate on transfer, it is quite often a temporary situation?
A Certainly.

Q And so can you just help us? Why do you say that the earlier assessment was effectively irrelevant to your considerations?
A Because I had now a baseline assessment with a Barthel of 2 and usually continent and needing help with ADL on which my nursing staff were then going to work. It was not

relevant whether Haslar said or did not say that she could walk with two people and a zimmer.

Q What about the fact that when she became fidgety and agitated, it meant she wanted the toilet?
A I am sure that my nursing staff were very experienced and adept at recognising non-verbal clues in demented patients when they wanted to use the toilet.

Q Apart from the morphine that she had received at the time of her operation and very shortly after it, this is a patient whom we should regard as opiate naive?
A Yes.

Q A patient who needed to mobilise if she was to recover. Yes?
A If possible, yes.

Q Can we just have a look, please, at what you prescribed. You prescribed 5 to 10 mg of Oramorph.
A Yes.

Q This was presumably on admission?
A Yes.

Q At the time that you assessed her?
A Yes.

Q So the first prescription that you wrote out for this lady who, up until this point was opiate naïve, was 5 to 10 mg Oramorph is required. I presume that in fact should be four times daily?
A Yes. Four hourly, I would think it was.

Q Four hourly. All right, yes. Then you also wrote out your usual – if I may all it – very wide dose of diamorphine?
A Yes.

Q And midazolam?
A Yes.

Q And haloperidol?
A Yes. And hyoscine.

Q And hyoscine. Did you regard this patient as being on a terminal pathway?
A No.

Q Did you regard this patient as being in your hospital purely for palliative care?
A No.

Q Can you explain, please, why you thought it appropriate to give the nurses the power immediately to institute a syringe driver with this patient?
A Because I anticipated with the severity of the dementia in this patient and the insult to her that the fractured neck of femur had caused she could, at some stage in the future, become

A palliative and then terminal. I was not anticipating it happening that day or that week even, or even that month, but I wanted the drugs written up in anticipation so that they could be used. Had I done that for Alice Wilkie, Alice Wilkie would have had a more comfortable few days taking Oramorph before she needed subcutaneous analgesia.

Q So you wrote this prescription up not on the basis of anything that was actually happening?
B A No.

Q But because, as you put it, you anticipated ---
A I did.

Q --- that they might one day need palliative care?
A I did.
C

Q And might one day become terminal?
A I did.

Q I suppose it could be said of anybody in this room.
A No. Not today.

D Q Let us see what happened to her. She was given Oramorph pretty much immediately?
A The nurses felt that after that journey, and probably my assessment of her, that she was quite uncomfortable, so she was given a dose that afternoon and late that night to settle.

Q And the following day, 12 August, she is given Oramorph again. yes?
A At 6.15 in the morning.

E Q And haloperidol was given?
A Yes. Just before midnight.

Q And the reason why the Oramorph was not given again that evening is because the patient was drowsy. Can I just ask you to turn up a particular note. It is bundle E, of course, page 64. I am afraid it is a very poor quality copy. It may be that we can do better.
A Page 64 is "Exceptions to Prescribed Orders".
F

Q Yes.
A Is that what you want?

Q That is right.
A All right.

G THE CHAIRMAN: It may be that this is a replacement copy, but it is usually fine.

MR KARK: Oh yes – I have stupidly left the old one in as well. (To the witness) Page 64, 12 August, 18.00 hours. "All medications – Patient drowsy".
A Yes.

Q Is that an indication that she was not given any medications because she was drowsy?
H A Yes.

Q So on the evening of the day after her admission ---
A Yes.

Q --- when she had been prescribed Oramorph and given Oramorph, and also haloperidol, she was so drowsy that the nurses did not think it appropriate to give her any more?
A Yes.

Q Is that a fair way of describing that?
A Yes. She had had a dose of haloperidol that morning and she had had her lactulose that morning, and that evening she was too drowsy to take the lactulose or the haloperidol, and they quite appropriately did not give any Oramorph because it did not seem to be indicated. She was not in pain and she was not uncomfortable.

Q And she was drowsy?
A I do not think you can blame the Oramorph for the drowsiness that evening.

Q Would the haloperidol cause her to be drowsy at all?
A Possibly.

Q On 13 August as we know, this patient was found on the floor by Philip Bead. Apparently he checked her and put her into a chair and Dr Brigg contacted and advised an X-ray and analgesia. She was given Oramorph and haloperidol. It is plain from what follows that she would have been actually in some considerable pain because she dislocated her hip.
A Certainly.

Q Is that something which normal would be fairly visible?
A I never saw the X-ray; I do not know which way the hip dislocated.

Q On 14 August, she was reviewed by you.
A Yes.

Q She was screaming. It was not controlled by haloperidol, but she is said to be very sensitive to Oramorph.

"Right hip shortened. X-ray query is this lady well enough for another surgical procedure".

She was in fact taken back to hospital and operated upon.
A Yes, she had a closed reduction of the right hip, not an open operation, no cutting.

Q It was manipulated?
A It was pulled and manipulated under intravenous sedation.

Q Lesley O'Brien told us this:

"It turned out she had a fall. She dislocated her new hip. It took them 24 hours to transfer her back to the Haslar. She was admitted there and operated on successfully. She recovered consciousness the next day, took fluids and she was eaten and drinking.

A She only had minor discomfort. Within 24 hours she was up standing and weight bearing again, back to how she was before".

Is that evidence with which you are prepared to accept?
A I cannot accept or deny it. I was not there. I did not see her at the Haslar Hospital. I did not know what state she was in after being 24 hours unrousable after the midazolam.

B Q This was the lady who was previously a nurse.
A Yes.

Q The patient comes back to you on Daedalus ward and you knew on her transfer that this patient had been affected more than most by the midazolam that she had received.
A I knew that.

C Q So you knew that she was sensitive to morphine and you knew that see was sensitive to midazolam.
A No, I did not know that she was sensitive to midazolam. This was midazolam being used in a entirely different way. It was being given as a bolus intravenously to cause anaesthesia.

Q As a pre-med?
D A She was very slow to recover from that which I felt was the significant point to make a note of, in that she had been very slow to recover from another anaesthetic insult.

Q Perhaps it is misunderstanding, but if you say that somebody is sensitive to a drug does it not mean that they are going to react more than the normal person to it?
A Her brain reacted more than the normal way to a bolus of intravenous midazolam, not the midazolam itself but the way that her brain reacted to it.

E Q Do you still have your notes available to you? Could you turn up page 31 to look at the readmission. You describe her in this note as, "Now appears peaceful".
A At that moment in time when I examined her she appeared peaceful.

Q What time do you say this was?
A I am sorry, I have no idea. I would imagine that it was lunch time, but I did not put a
F time on the admission note.

Q Because she is coming back from the main hospital, is she not, so she is not going to be arriving at 8.30 in the morning; the normal time of arrival would be lunch time.
A Yes.

Q Can we keep a finger there please and go to page 47. Do you see at the top
G "17 August 1998 13:05"?
A Yes.

Q This is a nurse note by Miss Couchman.
A Yes.

Q "In pain and distress. Agreed with daughter to give her mother Oramorph 2.5mgs.
H Daughter reports surgeon to say she must ---

A A "Mother must not be left in pain".

Q "Mother must not be left in pain if dislocation occurs again".
A Yes.

Q "Dr Barton contacted and has ordered an X-ray".
A I imagine that at 13:0 5 I had been and gone and that when I saw her and readmitted
B her, she was comfortable, but she became subsequently uncomfortable at 13:05.

Q If she had been transferred in the way that has been described ---
A I have no explanation as to why when at the moment in time that I saw her she seemed comfortable, but that is the note I made.

Q I understand that. You are telling us that you believe that that was prior to the note
C made by Margaret Couchman. Is that right?
A Yes.

Q A further X-ray was to be taken.
A Yes.

Q Did you order it by telephone?
D A And viewed by one of the partners.

Q When you came in on the 18th, had that X-ray been taken?
A Apparently it had and it had been viewed by one of the partners and Philip Bead's report that there was no dislocation seen. I understand that it showed a large haematoma at the site of where the dislocation had occurred.

E Q Would you have asked to see that X-ray?
A No.

Q Why not?
A Because I am not an orthopaedic surgeon. I would accept what my partner and the radiologist said about the X-ray.

F Q What about the radiologist's report?
A That would come back to me in due course.

Q Let us look at what happens to this patient hereafter. You make a note,

"Still in great pain, nursing a problem. I suggest subcutaneous diamorphine, haloperidol and midazolam. Will sees daughter today. Please make comfortable".

G

If we turn over the page, we can see your prescription at the top of page 13, Oramorph, diamorphine to start at 40mg and midazolam. As you know, Professor Ford has said about your prescription for diamorphine that that was high but not unreasonably so.
A Yes.

Q In relation to the midazolam, his view is that that was simply unjustified. What do
H you say was the purpose of giving this patient midazolam?

A A It was to provide her with relief of any restlessness and mental distress and to act in conjunction with the haloperidol which I swapped over because she had been having it orally and therefore continued to give it. Midazolam would also provide some sedation for her.

Q The diamorphine should take away her pain should it not?
A It should take away her pain.

B Q Which is what she was immediately complaining of.
A Yes.

Q You knew that so far as the midazolam was concerned when she had it in a different setting that she had taken rather longer than normal to recover from it.
A It was still an appropriate drug to use under those circumstances in that patient.

C Q Can we take it that you would have appreciated reading the hospital note, as apparently you had, that with this particular patient it was likely to have an extra sedatory effect?
A Possibly.

Q There was no need at all, I suggest, to add midazolam to this mix.
A In my clinical judgment there at the patient's bedside, it was an appropriate drug to
D add to the diamorphine and the haloperidol.

Q Lesley O'Brien told us,

"On 18 August Dr Barton came in the doorway and folded her arms, lent on the wall and said, 'The next thing will be a chest infection'".

E So far as this patient is concerned, that is in fact exactly what happened is it not; she did get a chest infection?
A She did.

Q Do you accept that is something you may have said to Lesley O'Brien?
A I cannot imagine that I actually couched it in those terms, but I certainly would have been minded to tell the daughters that in view of the prolonged immobility and her general
F state that she was going to develop a chest infection.

Q This lady's problem was a haematoma.
A It was a huge haematoma around the site of the operation, the prosthesis.

Q What active steps could be taken to relieve a haematoma?
A Nothing.
G

Q Does it depend on the type of haematoma?
A Nothing could have been done for that haematoma.

Q Why do you say that?
A Had she survived, the body would eventually have resolved it and it would have hopefully drained away, but there was nothing surgical or acute or immediate that you could
H do to relieve it. You certainly would not stick a needle into it or something like that.

Q Dr Barton, you had not seen it.
A I knew it was on the X-ray.

Q But you had not seen the X-ray.
A I knew what the X-ray showed and I was not minded to stick a large bore needle into the thigh of a lady who had recently had surgery to that hip to remove a collection of blood which in itself was not doing the patient any harm.

Q Why are you describing this as a massive haematoma?
A Because I think that is what was said on the X-ray report.

Q You are saying that there were no active steps that you could have taken?
A Nothing.

Q What can happen with a haematoma, as you have said, is that it can resolve itself.
A Yes.

Q But that takes time.
A Yes.

Q Did you think that provided you palliated her symptoms of pain carefully that this haematoma might resolve?
A Yes.

Q Would it be important to avoid bronchopneumonia to keep the patient in at least semi-conscious state, so that they could clear their own secretions. Would that help?
A Yes, but she had to have adequate analgesia and she had to have haloperidol for her terminal dementia and she had to have midazolam for her restlessness otherwise she would make the haematoma worse I imagine.

Q Lesley O'Brien said this:

"The amount they gave her caused her never to wake up again. She was not conscious; she was not screaming or moving or doing anything".

A She was not in pain and she was peaceful and she was comfortable which was the aim of the prescriptions, nothing else.

Q For peaceful we should read unconscious and unrousable.
A For peaceful you should read comfortable and free of pain.

Q Do you agree with Dr Lord when she says that sometimes what one has predicted does not happen?
A Are we talking about this?

Q No, she made a general comment.
A Yes.

Q One of the dangers of putting a patient on a terminal pathway, ignoring this patient for the moment, is that you might get it wrong. Do you agree?
A Yes.

Q Was this patient on a terminal pathway?
A When she came back having been unrousable for 24 hours approximately after her intravenous midazolam, she was on a terminal pathway.

MR KARK: Sir, perhaps that is a convenient moment.

THE CHAIRMAN: We will rise and return at 2 o'clock.

(Luncheon adjournment)

THE CHAIRMAN: Mr Kark?

MR KARK: Can we turn to the case of Mrs Ruby Lake, Patient F. This lady had been living alone. She is described on page 2 of our chronology as mobile, independent and self caring. and then she had the misfortune to fall and fracture the left neck of her femur. Post-operatively she suffered a degree of left ventricular failure.
A Yes.

Q She remained fairly unwell and she had bouts of breathlessness. On 12 August, i go to page 8, we can see at the entry one above the bottom, that being 11 August, that sh a wash, her a bottom and sacral area were very red and breaking down. She was incontinent of faeces. She complained of stomach pain and remained very sleepy. Then on 12 August she is described as "Much improved. Has sat up today. Developing sacral bed sore". Would you agree that the picture of this lady is somewhat up and down; she has her good days and she has her bad days?
A Yes, and very slow to recuperate from the surgery.

Q Then on 13 August, page 9 of hour chronology, she was assessed by Dr Lord for her future management.

> "Post-op recovery was said to be slow with periods of confusion and pulmonary oedema. Over last two days she has been alert and well, now our intention to work in her mobilisation".

The physio has visited her for the past six weeks. That was a referral to Dr Lord and then the review by Dr Lord takes place over the page at the top at page 10. She is said to be catheterised.

> "Appetite poor. Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease, LVF [left ventricular failure] have been problems recently. Still dehydrated, hypokalaemic and has normochromic anaemia. Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement".

The lady was obviously fairly poorly.

Q One of the dangers of putting a patient on a terminal pathway, ignoring this patient for the moment, is that you might get it wrong. Do you agree?
A Yes.

Q Was this patient on a terminal pathway?
A When she came back having been unrousable for 24 hours approximately after her intravenous midazolam, she was on a terminal pathway.

MR KARK: Sir, perhaps that is a convenient moment.

THE CHAIRMAN: We will rise and return at 2 o'clock.

(Luncheon adjournment)

THE CHAIRMAN: Mr Kark?

MR KARK: Can we turn to the case of Mrs Ruby Lake, Patient F. This lady had been living alone. She is described on page 2 of our chronology as mobile, independent and self caring. and then she had the misfortune to fall and fracture the left neck of her femur. Post-operatively she suffered a degree of left ventricular failure.
A Yes.

Q She remained fairly unwell and she had bouts of breathlessness. On 12 August, if we go to page 8, we can see at the entry one above the bottom, that being 11 August, that she had a wash, her a bottom and sacral area were very red and breaking down. She was incontinent of faeces. She complained of stomach pain and remained very sleepy. Then on 12 August she is described as "Much improved. Has sat up today. Developing sacral bed sore". Would you agree that the picture of this lady is somewhat up and down; she has her good days and she has her bad days?
A Yes, and very slow to recuperate from the surgery.

Q Then on 13 August, page 9 of hour chronology, she was assessed by Dr Lord for her future management.

> "Post-op recovery was said to be slow with periods of confusion and pulmonary oedema. Over last two days she has been alert and well, now our intention to work in her mobilisation".

The physio has visited her for the past six weeks. That was a referral to Dr Lord and then the review by Dr Lord takes place over the page at the top at page 10. She is said to be catheterised.

> "Appetite poor. Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease, LVF [left ventricular failure] have been problems recently. Still dehydrated, hypokalaemic and has normochromic anaemia. Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement".

The lady was obviously fairly poorly.

A A Yes.

Q In the following entry on 14 August she is described by the physio as, "Brighter today. Sitting out. Walked short distances with a frame + 1 - managed very well" and then the plan is to gradually increase her distance of walking as her energy increases. Again, it is the same picture, up and down days; she can be brighter and better and moving with a frame. Do you agree?

B A Yes.

Q On 15 August, page 12, she is given codeine phosphate, no doubt that would be for pain would it not?

A Yes.

Q "L [left] sided chest pain in ribs through to back - since being manhandled". I do not

C want to be critical of anybody outside this room, but the day before she had been reviewed by a physio who had plainly walked her for a distance with a frame.

A Yes.

Q I suppose it is not inconceivable that that manhandling by the physio might in fact the next day have been causing her problems. Yes?

A It is possible, yes.

D

Q If that is right, if it is the manhandling that had caused her some pain, it is the sort of pain, hopefully, that would resolve itself.

A Yes.

Q It is not a chronic sort of pain; it is the pain as a result of the exertions of the day before.

E A Yes.

Q I should go on, she is also said to have pain in her left shoulder from arthritis, but she has paracetamol to good effect, which would mean that the paracetamol appears to have controlled the pain.

A Yes.

F Q Go to page 13, over the page, please. On 17 August she is described as being "well. Mobilising slowly. Awaiting transfer to GWMH". She is described by the physio as,

> "bright. Sitting out in a chair. Independent to sit and stand. Mobile with Zimmer frame and supervision. Managed well".

So again I am not going to try and make out that this woman is going to be dancing down the

G steps the next day, but again it is a picture of this lady being capable of movement and having her good days.

A Slow improvement.

Q Then we can see at the end of that day's entries that at 20.15 she seemed confused in the afternoon. She had had a spike in temperature, 38.8. That is not a very high temperature, is it?

H A No.

Q She had been given some paracetamol. The next day,

"Reviewed by SHO at the Royal Hospital, Haslar. Well, comfortable and happy. Last pm spike temp, now 37.3",

So that is relatively normal, is it?
A Yes.

Q "Mobilising well. To go to GWMH today".

There is then an entry at 02.00,

"Increased shortness of breath. Recommenced on oxygen therapy".

I suppose that must have taken place before the entry I have just read. They are the wrong way round.
A I cannot tell you whether it happened the morning she was transferred or the morning before the day she was transferred.

Q I am presuming this note is made on 18 August at 2 o'clock in the morning.
A In which case it is the day before.

Q Why cannot it have happened on 18 August when she is transferred?
A I do not know. It could be either. It is not clear from the chronology.

Q If we need to we can have a look at the note, which is page 614. That would appear to be a note made at the Royal Haslar, would it not?
A Yes.

Q It is 2 o'clock in the morning, as we can see, on 18 August.
A So it is the day she was transferred and she had an episode of shortness of breath in the night.

Q Did you have the ability to give oxygen therapy at Gosport?
A Yes.

Q So these entries are, I think, the wrong way round. The next entry is,

"Reviewed by SHO at Royal Hospital Haslar. Well, comfortable and happy. Last pm spike temp, now 37.3. Mobilising well, go to GWMH today".

She is then transferred to your hospital, Dryad Ward.
A Yes.

Q We see there is a fairly lengthy transfer letter:

"Has had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload, now resolved, it appears. Presently she is slowly mobile with Zimmer frame and supervision. Able to wash top half

A independently but requires help to wash back and bottom. Bilateral leg ulcers redressed every 4-5 days. Has broken area on left buttock and in cleft of buttocks – improving. Has small appetite, oral fluids need encouraging. Urinary catheter in situ. Diarrhoea resolved. Usually lucid, only very occasionally seems confused at night. Hearing aid appears to have gone missing".

That is not a particularly gloomy outlook, is it?

B A No.

Q Then she is reviewed by you on the same day as the entries we have just looked at.

"Transfer to Dryad Ward continuing care".

Then you set out her history. Past medical history angina, CCF. I cannot again remember

C what that is.

A Congestive cardiac failure.

Q I am grateful.

"Catheterised. Transfers with 2. Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death".

D

What you told us about this lady, as I understood it, is that this is a lady who is at the end of her life and is likely to be on a terminal care route before too long. You said your comment about gentle rehabilitation was slightly tongue in cheek. Can you help us with that?

A No. She was entitled to come to the ward. She was entitled to be considered for gentle rehabilitation, but with her co-morbidities and risk factors, I was not enthusiastic as to whether rehabilitation would work for her. It follows on from Dr Lord's note that she had

E cardiac problems and might not make a full recovery.

Q I understand that, but did you regard her, I think you said – I should have checked the transcript – as a lady who was at the end of her life?

A She was certainly towards the end of her life, but whether it was days, weeks or months I was unable to say on that first assessment of her on the ward.

F Q Likely to be on a terminal care route before too long. Why?

A With her past history of angina and congestive cardiac failure, with her dependence. Her Barthel 6 does not really give a good assessment of medical co-morbidities. It only refers to the activities of daily life. This was a potentially very ill elderly lady.

Q Potentially very ill.

A Yes. I saw them week in, week out, year in, year out. I looked after hundreds and

G hundreds of these ladies. The fact that you fall and fracture your neck of femur is often a very strong pointer to the fact that you are nearing the end of your life.

Q It can be, can it not?

A It can be.

Q It is certainly an unfortunate event for any elderly person.

H A It is a very major life event for some of these people with major health problems.

A
Q
A

Q we have looked at, up until this stage, her pain .
A

B
Q she had to have her operation, totally opia
A

Q Can we look at your prescription, please, page 16 of the chronology? You prescribed Oramorph, 5 – 10 mg as required. Temazepam, 10-20 mg as required. Was that to help her
C sleep?
A Yes.

Q Diamorphine by syringe driver, 20 – 200 mg. Hyoscine and midazolam, 20 – 80 mg. Yes?
A Yes.

D Q This was one of your anticipatory prescriptions, was it?
A It was.

Q It allowed the nurses at any stage thereafter to initiate effectively what would have been the end of this patient's life, the beginning of the syringe driver.
A Yes.

E Q You thought that was appropriate, did you?
A I did.

Q Her Barthel was 6, rather better than many that we have seen.
A But as I said, the Barthel only refers to a measurement of the activities of daily living. It does not give you a score as to frailty of the cardiovascular system, or severe dementia, which she did not have. It is only a measure of one of the strengths of the patient. It does not
F measure all of them.

Q But can we take it, from the fact that you were prescribing as a minimum dose, 20 mg of diamorphine and 20 mg of midazolam to a lady who I think it would be right to describe as elderly and frail, would it?
A Yes.

G Q That you were once again ignoring the Palliative Care Handbook.
A Yes.

Q And the BNF of course.
A Of course.

H Q On the day of her admission – let us look at what happened if we go back to page 15 – it looks like she was given 5 mg of Oramorph as soon as she arrived. Is that right?

A

Q Many recover, do they not?
A Many recover.

Q This lady again, as with many others that we have looked at, up until this stage, her pain had, I think, been controlled by paracetamol.
A It had.

B

Q Apart from the early days, no doubt when she had to have her operation, totally opiate naïve, yes?
A Yes.

Q Can we look at your prescription, please, page 16 of the chronology? You prescribed Oramorph, 5 – 10 mg as required. Temazepam, 10-20 mg as required. Was that to help her
C sleep?
A Yes.

Q Diamorphine by syringe driver, 20 – 200 mg. Hyoscine and midazolam, 20 – 80 mg. Yes?
A Yes.

D Q This was one of your anticipatory prescriptions, was it?
A It was.

Q It allowed the nurses at any stage thereafter to initiate effectively what would have been the end of this patient's life, the beginning of the syringe driver.
A Yes.

E Q You thought that was appropriate, did you?
A I did.

Q Her Barthel was 6, rather better than many that we have seen.
A But as I said, the Barthel only refers to a measurement of the activities of daily living. It does not give you a score as to frailty of the cardiovascular system, or severe dementia, which she did not have. It is only a measure of one of the strengths of the patient. It does not
F measure all of them.

Q But can we take it, from the fact that you were prescribing as a minimum dose, 20 mg of diamorphine and 20 mg of midazolam to a lady who I think it would be right to describe as elderly and frail, would it?
A Yes.

G Q That you were once again ignoring the Palliative Care Handbook.
A Yes.

Q And the BNF of course.
A Of course.

H Q On the day of her admission – let us look at what happened if we go back to page 15 – it looks like she was given 5 mg of Oramorph as soon as she arrived. Is that right?

A A At 14.15, fairly shortly after she arrived, I imagine.

Q She had not been given any Oramorph at the previous hospital, had she?
A She had not, but she had undergone the trauma of a transfer across, being unloaded into a bed, being assessed by myself and the nurses. She probably deserved a small dose of adequate analgesia at that point.

B Q This is a comment that you have made previously, "She deserved Oramorph". Can you just explain to the Panel what you mean by that?
A My patients did not have to suffer pain unnecessarily.

Q There is no suggestion that this patient was in pain, is there?
A The nurses would not have given that dose of Oramorph if they had not felt that she required it for pain.

C MR LANGDALE: You say no sign of pain. Perhaps you should look at page 15, Barrett.

MR KARK: Thank you.
A She had leg ulcers. She had a sacral pressure sore. She had undergone a journey and she had had a fractured neck of femur repaired. It is quite possible she was in quite a lot of pain.

D Q You concluded that she, as you put it, deserved Oramorph.
A Yes.

Q Let us look at what happens to her in the evening.

"Settled and slept well 22.00 until midnight. Woke very distressed and anxious, says
E she needs someone with her. Oramorph 10 mg given 00.15 with little effect. Very anxious during the night. Confused at times".

Yes?
A Yes.

Q If a patient is confused, Oramorph is not something that is likely to assist them, is it?
F A No, but if she is beginning to go into a little bit of congestive cardiac failure, lying flat in the bed at night, it is a very appropriate drug for the night staff to give at that time.

Q How would you diagnose congestive heart failure?
A It is something the nurses would assess when they saw her. They knew her history from the notes. They knew that it was possible that it was going to happen to her and they would act appropriately.

G Q How do you diagnose it?
A You have got to listen to the chest and see if they have got any creps at the basis of the lungs. Night staff do not normally carry stethoscopes. They would be making a clinical judgment that this lady needed Oramorph.

Q Would they be looking at this patient without a stethoscope and saying to themselves,
H "I reckon this lady has got congestive heart failure"?

A A Yes. They knew she had congestive heart failure. They knew that she had been breathless the night before her transfer.

Q That is something the night staff would be doing, is it, diagnosing congestive heart failure?
A It is quite appropriate for them to deal with it in that way at that time of night.

B Q What she actually wanted, this lady, was for someone to sit with her.
A That is what she said, yes.

Q Yes. That is what she said. Of course we do not know what the staffing levels were like on that particular night, but it would not be an appropriate response to this patient if somebody could just sit with her, to give her morphine, would it?
A If that is what she said, is what she meant and was the only problem she had that
C night, it would have been very nice if there was someone available to sit with her. But she remained confused and very anxious. I would think it was the confusion that made her say she wanted someone with her. I was not there. I cannot tell you what the situation was clinically, but I feel it was appropriate that the night nurses gave her a dose of Oramorph at that time of night to settle her and make her more comfortable.

Q But which might, do you agree, have increased her confusion?
D A Not a dose of 10 mg orally, no.

Q You do not think so?
A No.

Q An elderly frail patient just moved to new surroundings.
A I do not think so. She had no problems with the first dose after her arrival in the
E afternoon.

Q How do we know that?
A Because they would have mentioned it in the nursing report had they had any major problems.

Q Do elderly patients sometimes hallucinate with small amounts of morphine?
F A Occasionally.

Q Page 16 again please. Just looking at your syringe driver prescription, I mean if the nurses had given that prescription, administered that prescription, even half-way up the scale, at 100 mg diamorphine and 40 mg of midazolam, might that have killed the patient?
A Certainly.

G Q Shall we go over to see what happened to the page, over to page 17? Nurse Hallman has made an entry at 11.50,

"Complaining of chest pain, not radiating down arm – no worse on exertion".

Is that an indication that it may not be a heart problem?
A She felt that it might not be a heart problem.
H

Q "Grey around mouth" would indicate what?
A That it might be a heart problem. It was more serious than a musculoskeletal strain that she had suffered before her transfer to us.

Q What should be the normal immediate reaction if this lady is suffering a degree of heart failure?
A Give her a dose of morphine.

Q How would you do that?
A She had Oramorph written up on the drug chart, so she very properly gave it.

Q I think you said, so far as the syringe driver is concerned, that you may have been in hospital and you would have sanctioned this.
A I would.

Q This lady, at 4 o'clock in the afternoon, the day after she arrived at your hospital, has a needle inserted into her and a syringe driver started.
A Yes.

Q That, so far as this lady is concerned, as you put it, she is now in her terminal stage.
A Yes.

Q You think you were chairing a meeting at the time.
A Yes.

Q But you would have agreed to the syringe driver being started once it had happened.
A They did not put the syringe driver up until 1600 so it is quite possible I would have seen her and assessed her before they put the driver up, after they had given the Oramorph.

Q And the dosage that she was given – I think previously – the day before, she had had 10 mg, had she not?
A Yes.

Q And then on that day she had had 20 mg. I am sorry – no. The day before she had had 5 mg. Then she gets 10 mg at quarter past twelve, so we are now into 19 August, and a further 10 mg at 11.15. Yes?
A Yes.

Q So the day before she was on 5 mg. At this stage she has 20?
A Yes.

Q And she started at a dose of 20 mg. The equivalent dose would be 60 mg of Oramorph. Yes?
A Yes.

Q To which you added midazolam?
A Yes.

Q What note is there to reflect that this lady is now in the terminal stage of her life?
A There is no note to record that.

A

Q Either by a nurse or by you?
A No.

Q No note at all?
A No note at all.

B Q Do you think that is acceptable?
A No.

Q Was there a culture on this ward of just not bothering to make a note about these sort of significant events?
A No.

C Q You were not making notes, were you?
A I was not good at making notes, but my nurses were certainly usually considerably more conscientious about making notes than that particular day.

Q And you did not pick up that your nurses had not made a note?
A I did not, no.

D Q Some 17 hours later, if we go over the page… We should, perhaps, with the bottom of page 17.

"Condition appears to have deteriorated overnight. Driver recharged 10.10."

A Yes.

E Q

"Family informed…

Night: General condition continues to deteriorate. Very bubbly."

That would be an almost inevitably consequence of the syringe driver causing this patient to lose consciousness, would it not?

F A That would be the inevitable consequence of her congestive cardiac failure causing her to retain secretions both in the lungs and in the upper respiratory tract.

Q

"Ruby rousable and distressed when moved. Syringe driver recharged at 07.35 (on 21st)."

G A So she was not unconscious and she was not over-sedated.

Q She is rousable when moved?
A Yes.

Q The following day, at the top of page 18 – in fact it is 20 August – the diamorphine is doubled?

H A Yes.

Q The midazolam is doubled?
A At 16.50.

Q At 16.50.
A Yes. The initial doses are discarded and the hyoscine is also increased at 16.50 because she was increasingly bubbly.

Q Some 15 hours later, I think it is, the diamorphine is put up again. The midazolam is put up again. Yes?
A Yes.

Q And all of this is occurring, we need to remind ourselves perhaps, within three days of her being described as well, comfortable and happy?
A Yes.

Q She is now at the very end of her life, is she not?
A Yes is.

Q Let me remind you of what Diane Mussell had said about this patient. She was moved to the GWMH on 17 August. I think she is a day out in her dates, is she not? Yes. "She seemed clean and well cared for. She was able to talk until late on 19 August when she was quite agitated and depressed. I felt there was a good chance she would be coming home. By the 20th there was a notable deterioration. She was unable to respond, either through hand gestures or oral communication. I think she was on a syringe driver by that time." She went on to say, "There was nothing that struck us out of the ordinary regarding her care." Anita Tubbritt gave evidence about this patient on Day 14. She said the decision to increase the dose – and this is on 21 August – from 40 to 60 would have been "a joint decision between me and Nurse Turnbull. I cannot remember the basis for it. On 19 August, the patient was deteriorating. That would mean the patient's breathing. Perhaps there was discomfort or distress, physical pain, pain, agitation, probably all those things." But again, with a lack of notes, she was not able to say?
A Yes.

Q You recorded her cause of death as broncho-pneumonia. You would accept, would you not, that the sort of drugs that this patient was being given could in fact effectively initiate broncho-pneumonia?
A I think that the condition she was suffering from could well end up as broncho-pneumonia. Broncho-pneumonia is a common terminal event in congestive cardiac failure.

Q Did you at any stage, if a patient had become unrousable, as I suggest this patient had according to the evidence of Diane Mussell on the 20th; she was unable to respond either through hand gestures or oral communication – did you consider reducing the dose?
A I did not.

Q How often, can you help us, did you ever reduce the dose of a syringe driver?
A I would be unable to tell you at this remove of time.

Q It is not something that happened very frequently, is it?
A I would think probably not.

Q You also said about Professor Ford's evidence that the criticisms by Professor Ford "do not give me cause to question my judgment"?
A I did.

Q You said that on other occasions as well?
A I did.

Q Do you mean that? That they do not even give you pause for thought about your judgment?
A I do.

Q The effect of that answer is to demonstrate, is it not, that if allowed to do so, you would behave in exactly the same way again?
A I have not been practising palliative care in any form since 2002.

Q I understand that,
A And the whole ethos of palliative care and possibly, I suspect, terminal care, has change din the intervening ten years since I last did it. I think that staffing levels and protocols nowadays would mean that you would not practise anticipatory prescribing and syringe drivers would not be put up in the same way that we had to do them all those years ago.

Q But, Dr Barton, having listened to the evidence, apart from your failure to keep notes?
A Yes.

Q You simply to not accept the criticisms of Professor Ford, do you?
A I do not.

Q I do not think there is any purpose, in light of those answers, in taking you to the charges. You do not accept your prescriptions were either inappropriate or not in the best interests of Patient F?
A No.

Q That is in spite of you agreeing that they were potentially hazardous. Yes?
A Yes.

Q Let us move on, please, to Patient G. Arthur Cunningham we know had been looked after for a while by Dr Lord at the Dolphin Day Hospital. He had been a fairly frequent visitor to the Dolphin Day Hospital and then, on 21 September, if we go to page 8 of the chronology, which is where I am going to start, he was again reviewed by Dr Lord at the Dolphin Day Hospital in relation to his sacral ulcer. He was admitted to your hospital. The purpose of his admission to your hospital was for aggressive treatment of his sacral ulcer. Do you agree?
A It was.

Q Obviously you were, or should have been, better equipped to deal with his sacral ulcer than either a nursing home would have been or the Dolphin Day Hospital would have been?
A Yes.

A Q If we go over the page, to the top of page 9, this was the patient who had not been swallowing his tablets and we can see the plan set out by Dr Lord. His laxatives and antibiotics were stopped.

"(2) Dryad today, Aserbine for sacral ulcer, nurse on ---"

Is it "site" or "side"?

B A Side.

Q

"... on side, high protein diet, Oramorph ... if pain
(3) N/Home [Nursing home] to keep bed open for next 3/52 [3 weeks] at least
(4) Patient informed of admission – agrees
(5) Inform N/Home, Dr Banks + social worker. Prognosis poor."

C Yes?

A Yes.

Q We can see that the plan was to admit him to Dryad Ward for treatment of his pressure sores and then you reviewed him, as we see at the top of page 10 of the Dolphin Day Hospital. Yes?

D A Yes. It says reviewed by Dr Barton on Mulberry Ward. That is not correct.

Q I have crossed that through on mine.

A I saw him with her at the day hospital and then was invited to look at the sore on Dryad Ward.

Q You agreed for him to be admitted. Yes?

E A I did.

Q Your note, would you agree, is rather more pessimistic than those that had preceded yours?

A Yes.

Q "Make comfortable" – and that is code, is it not, for palliative care?

F A Yes.

Q

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

Yes.

A Yes.

G Q All of that note reveals, does it not, that this patient was in fact so far as you were concerned on a terminal pathway?

A Yes.

Q Did you tell him that?

H A No.

Q Did you tell him that the likelihood was that as soon as he got to your hospital, he would be on a syringe driver?
A No.

Q Did you have any intention, in fact, of trying to cure his sacral sore?
A I was happy to follow the plan given to me by Dr Lord with the nursing procedure, to try and get to the black eschar of the surface of his sacral wound and to try and improve his nutrition, which had obviously been very poor for several weeks in the nursing home, and to make him comfortable. I was entirely following what Dr Lord had laid down for me but it was the second worst sacral sore I have ever seen in my medical career, and I did not feel when I saw it that afternoon that we had a snowflake's chance of healing it. It was right down to the bone.

Q And your view was that it was not going to be practical to try and give him a high protein diet?
A I was happy to get the nursing staff to order the high protein diet from the kitchens, but I was much more preoccupied about making him comfortable than worrying about what the nurses were going to give him to eat.

Q Day 11, page 78 in the coroner's inquest, you said this:

"I agreed with Dr Lord that his prognosis was poor. It was not going to be practical to try and give him high protein diet."

A This is a nursing procedure, not a medical procedure. The nurses order from the kitchens what they consider to be a high protein diet and, had it been appropriate, of course we would have given it to him.

Q Why was it inappropriate?
A Sorry?

Q Why was it not appropriate to give him a high protein diet?
A Because he became seriously ill that evening and it was not appropriate then to try and give him a high protein diet.

Q What did you expect the nurses to follow?
A The guidance that they had been given by Dr Lord. It was not at variance with anything I said or did. It just became impractical to give a man a high protein diet when he needs a syringe driver.

Q So when you, their resident doctor, assessed him and simply revealed than in your view he was to be made comfortable ---
A Yes.

Q --- and had to be given adequate analgesia?
A Yes.

Q You nevertheless expected the nurses, did you, to follow a route which you considered to be impractical?

A A I probably did not even discuss whether it was impractical or not. They had the instructions from Dr Lord, and they would have set in motion the Aserbine and the high protein diet.

Q But, Dr Barton, these things do not happen in a vacuum, do they? You were not simply making a note, and then leaving the hospital. You would have been speaking to the nurses, would you not?

B A I would. And I would have said that in my opinion he was to be made comfortable.

Q Yes. You would have reflected quite clearly to the nurses your pessimistic outlook, would you not?

A Yes. I would. I do not think it was pessimistic. I think it was a realistic outlook, faced with the sight and smell of the sore.

C Q And the reality of this patient was that before he had ever even got into Dryad Ward so far as you were concerned he was on a terminal pathway?

A Yes.

Q Let us have a look at the prescription, please, that you wrote out at page 12. You wrote him up for Oramorph. You wrote him up for diamorphine. I am not going to go through each of these any more, and you will appreciate why, and you wrote him up for

D midazolam?

A Yes.

Q In the evening of his admission, he was given Oramorph. In fact he was given Oramorph in the afternoon and then again in the evening?

A Yes.

E Q We have to look, I think, at the note on page 13 before we come back to see what happened to him that night. Page 13, at the top of the chronology, is a note made by Nurse Hallman on 22 September. It talks about an episode the evening before. Yes?

A Yes.

Q When this patient, on any view, if the note is right, had behaved very badly indeed.

A For a very good reason – probably that he was in a lot of pain and distress at that time,

F to cause him to behave like that.

Q He was certainly very confused, was he not?

A He was.

Q Whether it was pain causing his confusion or anything else, there is no reason for this man to have behaved in that way unless there was something wrong?

G A Unless he was toxic and in a lot of pain and confused.

Q You said "toxic and in a lot of pain and confused". Undoubtedly he must have been very confused, must he not. Yes?

A Remember, I had seen the sore that afternoon. I knew how toxic he was likely to be, having just stopped the antibiotics at the day hospital because they had been ineffective. He was likely to be toxic as well.

H

Q When you talk about a patient being toxic, do you mean that they have toxins in the blood?
A Yes.

Q Is that something that is relatively easy to check?
A To ---?

Q Check.
A If you had the facilities to do blood cultures you could check for toxins in the blood. We did not have facilities at the hospital to do blood cultures very often.

Q You could take bloods though, could you not?
A Not at that time of night, no. We had a blood lady who came on week-day mornings and took blood, and then it was taken to the main hospital at lunch times.

Q If this was an urgent - you are a doctor you could take blood could you not?
A I would not be taking blood under these circumstances.

Q Let us see what happened. He remained agitated until approximately 8.30 in the evening. We know that he had been given Oramorph 10 minutes or so before becoming calmer. If we look at page 11, it is quite complex. You see right at the end of the entry on page 11, "Oramorph 10mg at 20:20". Yes?
A Yes.

Q That seems to have been effective because he remains agitated until 20:30, no doubt when the Oramorph kicks in?
A I think that is very quick. Yes, I suppose it was beginning to kick in and then at the same time they put up the syringe driver.

Q The syringe driver was not started until 11.
A I beg your pardon, I am looking at the following night. That night it was 23:10.

Q The syringe driver was put up shortly after 11 o'clock at night.
A Yes.

Q As requested. Have you been able to glean from listening to the evidence or reading the notes who requested it?
A No.

Q The syringe driver being set up at that time of night would be done without your verbal authority would it not?
A I would not be in the hospital. It is quite possible that they rang me earlier in the evening and I suggested the Oramorph to proceed to the syringe driver if they felt that they were not going to be to control his symptoms overnight, or they may have gone ahead on their own say so knowing that I would be the following morning.

Q The scenario is this: either they telephone you at the time, but you certainly do not re-examine the patient?
A No.

Q Or they set it up of their own volition, and obviously you certainly do not re-examine the patient.
A No.

Q The time that you would have next seen the patient at best guess would be the following morning.
A Yes.

Q Unless the patient was in significant pain, setting up a syringe driver would have been quite unjustified would it not?
A No.

Q Can you tell us why not?
A I have suggested that he was in pain; I have suggested that he was very confused, agitated, restless, frightened, all of the reasons for which I would want to put up a syringe driver to give him both diamorphine and midazolam to control his symptoms.

Q You would be content, would you, that this patient who was transferred to your hospital on that day for treatment of his sacral ulcer is started on an end of life progress by way of syringe driver?
A I would if it was appropriate and he needed it.
Q You would not say to your nursing staff "Hold on, that is going to mean the end of this patients life. Let us just wait until the morning, give him Oramorph."
A If they felt that that was the appropriate course of treatment to take that night, I would have agreed to it. I had seen him that afternoon. I knew what clinical state he was in that afternoon.

On the 21, that day, he had told Mr Farthing that his behind was a bit sore and asked for some chocolate. Yes?
A I can make no comment about that conversation, I was not there.

Q It certainly appears that he was able at times to eat and certainly drink because he had two glasses of milk that night.
A Yes.

Q There was absolutely no reason not to give him Oramorph until the morning was there?
A Certainly, except the clinical impression of the night staff was that he needed subcutaneous analgesia and they put it up.

Q Let us have a look at page 13. The syringe driver has been started and the driver is said to be running as per chart. Over the page, we can see the syringe driver was continued at 20:20 in the evening. On 23 September, he is described as becoming in the evening a little agitated, "syringe driver boosted with effect". Can you help us, this was your hospital and your nurses, what would you take that reference to be?
A I was aware that there was a button on the side of the Graseby syringe driver that it says on it "start, boost" but I was not aware that you got a very large dose of anything that was in the driver if you pressed the button. I always felt that it was probably more satisfactory for the nursing staff to feel they had done something to help relieve the pain than that he had got an increased dose of opiate or midazolam, otherwise the driver would have

A run out much more quickly if you had been able to increase the rate. It would have run through more quickly which, as far as I know, it did not do.

Q Can we look later at what happened later on the 23rd, if you go to page 15. This is the morning, diamorphine continued at the same rate but midazolam tripled. Yes?
A Yes. You have missed out a day; you have missed out the point at which because he was toxic he became chesty overnight and I added hyoscine into the driver to control his
B chestiness. That is the 23rd.

Q I beg your pardon. I am going to come back to page 14 in any event, but I am just looking at the prescription and what was administered to him. I want you to deal with the tripling of the midazolam. In normal circumstances - we have looked a lot at diamorphine - midazolam would also have a very sedatory effect would it not?
A It would be very effective for terminal restlessness and agitation.
C

Q Professor Ford described this as a very high dose for this patient which would produce very marked sedation. Would you agree with that?
A It was an appropriate dose in the minds of the nursing staff and myself to give him at this point in his terminal illness.

Q Let me try it again. Do you agree with Professor Ford that this was a very high dose
D which would produce very marked sedation?
A It would produce different individual effects in individual patients and in this particular patient it did not produce an excessive amount of sedation, either at the dose of 20 or at 60mg.

Q On the 24th, we can see first of all at what happened to him and then we will look through the notes, at the bottom of page 16, diamorphine is doubled at 10.55 and then it is
E increased to 69, so in one day in fact it has tripled has it not?
A Yes.

Q The midazolam goes up to 80mg.
A Yes.

Q Let us have a look at the notes going back to page 15. You note that he remains
F unwell

> "Son has visited again today and is aware of how unwell he is. Sc analgesia is controlling pain just. Happy for nursing staff to confirm death".

That I think is actually the first explicit reference to pain except from his old back injury.
A And his knees.
G

Q Did you at any stage re-examine this patient to see what was happening with his sacral sore?
A The sore? No.

Q Did you re-examine this patient?
A I re-examined the patient, but I did not turn him over and look at his sacral sore.
H

A Q At the top of page 16, this is a note from Nurse 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 40mg, midazolam 80mg and hyoscine 800mcgm. Dressing renewed this afternoon. Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition. ... Nursed on alternate sides during night, is aware of being moved".

B

Then he is said to have a peaceful nights sleep.
He was already on an increased dose of diamorphine of 60mg and 80mg. Can we look just in the middle box at page 17. "Peaceful night, position changed". Yes?
A Yes.

Q Over the page to page 18,

C

"Condition appears to be deteriorating slowly. All care given ... mouth care given".

The driver is now recharged with another increase. Yes?
A Yes.

Q On the basis of the notes, can you see any justification for that?
D A Whoever was responsible for changing the syringe driver must have decided in consultation with me or whoever was on duty that day that the increase was appropriate to control his condition.

Q On the basis of the notes, can you see any justification for that increase?
A There was nothing in the notes in justification or otherwise.

E Q When we looked at the nursing notes earlier, we saw a similar failure did we not? This is not just a one off failure is it?
A No.

Q I am going to suggest to you again there was a culture here of simply not bothering to make notes. Do you accept that now or not?
A I do not. There was a culture of both myself and my nursing staff doing our very best
F to give the most appropriate treatment and care to our patients and neglecting the paperwork.

Q Giving this patient on 26 September 1998 diamorphine at a rate of 80mg and the midazolam at 100mg of which Professor Ford was very critical and described it as a very high dose indeed, those doses ran a clear risk that the drugs would bring about the end of his life.
A He was dying. He was reviewed on that day, 26 September, by my partner,
G Dr Brooke, who also obviously felt that the medication was appropriate for his condition at that time.

Q Let me remind you of the words of Mr Farthing. He spoke about telephoning the ward and was told that his stepfather had become aggressive to the staff and they had given something to calm him down. "I said I would be in the next day to have strong words with him". This now is 23 September.

H

"I went to the ward. He was unconscious, unrousable, he was totally different. He had gone from a normal person to someone who was totally comatose".

If that reflects this patients position, that is not acceptable is it?
A What you are seeing from the clinical notes that we did make, that was not the position. This was a man who was obviously toxic when he arrived at the day hospital on the Monday afternoon. He became increasingly confused and toxic during the evening and on the following morning he required an appropriate dose of sedative and analgesics which would have made him much more comfortable. He was not unconscious or unrousable.

Q By the 24th, if we go back to page 16, he was on 40mg which was increased to 60mg of diamorphine and midazolam at 80mg. Yes?
A Yes.

Q Mr Farthing said this:

"Dr Barton not come in until the next day of the 24th at around 5 pm. He had not become conscious all day. Dr Barton told me bluntly that he was dying from the poison emanating from his bed sores".

Yes?
A Yes.

Q That is your evidence now.

"She refused to remove the syringe driver due to the pain he would experience".

Let me pause there for a moment. You have referred to him in your notes as his son. Yes?
A In the statement I wrote for the police I referred ---

Q In your clinical notes, page 15 of the chronology,

"Remains unwell, son has visited him again today".

Yes?
A Yes.

Q Did you know whether he was a stepson or a son?
A I cannot remember.

Q He was clearly a very caring and loving relative was he not?
A Clearly.

Q Why could you not reduce the dose so that he could speak to his father?
A Because his father/stepfather was in the terminal phrase of his life. My duty was totally to his father and it would have been inhumane to stop the infusion of the opiates and the anxiolytic.

Q Inhumane to this man who two days earlier said that his butt was a bit sore and he was requesting some chocolate.

A Inhumane to that man in the condition that he was in on the ward that day.

Q You told the Panel, "If I had felt he was over sedated, there would be no problem in reducing his opiates". Is that still your evidence?
A Quite right.

Q Whether Mr Farthing was a next of kin or a loving relative, would you have taken account of his sentiments?
A No.

Q No?
A No, my duty lay to Mr Cunningham.

Q So it does not matter if he is the next of kin or anybody else does it?
A No.

Q Going back to the initiation of the syringe driver, can I just remind you of what Ingrid Lloyd said to us on day 14 and then I am going to ask you to comment on it. She talks about 21 September. Let us go back in the chronology and remind ourselves where we are. This is on the day of his admission. She says that Nurse Hallmans entry is a retrospective one and that was in relation to the events of the night before.
A Yes.

Q In that the events she described had already been happened.

"They were mentioned in handover. It was with this knowledge that she and I agreed that a syringe driver should commence. This was done so that Mr Cunningham remained in a pain free and peaceful state. Although I have stated in the notes Mr Cunningham was peaceful at 2030 hours, it was not certain he would remain in this state. The syringe driver was not commenced until 2310 hours as it required two nurses and Fiona Walker wasn't available until this time as she had other duties to attend to as the night nurse in charge".

I will continue so that you have the full picture.

"The purpose of the syringe driver was to enable a pain free and peaceful state for Mr Cunningham. With regard to who authorised the syringe driver this was a decision made by three trained nurses including myself, Shirley and Fiona. The drugs were being prescribed to be given at our discretion".

Let me just take you back.

"Although I have stated in the notes that Mr Cunningham was peaceful at 20.30, it was not certain that he would remain in this state, and it was started at 10 past 11 because it required two nurses".

If a syringe driver was being administered in an anticipatory manner, on the basis of your anticipatory prescribing, that would not be a very satisfactory state of affairs, would it?
A I think in this particular circumstance it was perfectly appropriate for them to use that method of administering the opiate and the anxiolytic to a patient who had previously shown,

A through the latter part of the day, that his behaviour became very disturbed and difficult both for himself and other patients, as well as the staff, if he was not given adequate analgesia and sedation.

Q That rather reflects the comment I think you made yesterday. "I take this stand by what I did".
A I do.

B

Q If this patient had become conscious at Mr Farthing's request; you had reduced the dose and he had become conscious and had the ability to ask you to remove the syringe driver, would you have done so?
A It is a hypothetical question. I cannot answer it.

Q Mr Farthing was asking you to reduce the dose so that he could speak to his father. If
C his father had then said, "I am sorry, I do not want to die in this way".
A I could not have been put in that position of being asked to do that, because I would not have agreed to reducing the amount of analgesia he was being given for very good clinical reason.

Q Let me put it another way. If a patient says to you, "I don't want that thing in me. I would rather die as conscious as possible", you would not be able to put a syringe driver
D into that patient, would you?
A That is the situation that Dr Lord was talking about, not initiating analgesia at the request, in her case, of the next of kin or, in your hypothetical case, the patient themselves. The patient has a perfect right to say, "I do not want any analgesia. I wish to die in agony".

Q The patient has the perfect right to say, "Take that thing out of me".
A Certainly.

E

MR KARK: Would that be a convenient, moment, sir.

THE CHAIRMAN: Yes, I think it would. We will return at half past three.

(Adjourned for a short time)

F THE CHAIRMAN: Welcome back everybody. Mr Kark, before you begin, I just want to say, Dr Barton, I have been reminded that this is not an endurance competition and this Panel well understand the stresses that extended cross-examination places on any witness. You have heard me say this before and Mr Kark invited you at the beginning of his cross-examination, if at any time during the course of the day you feel you have reached that point when you have had enough, then please say so and we will not subject you to further questions at that point. If you are happy to go on now we shall proceed.

G

MR KARK: Dr Barton, I was proposing to try and deal with two more patients this afternoon and then stop, but again, if you do not feel awake enough or capable, then just indicate and we will stop. I did mean, however, to ask you just one more question about the last patient, Arthur Cunningham.

H You are charged with not obtaining the advice of a colleague when his condition deteriorated, and you have admitted that you did not. I just want to have your evidence. Do you accept

A that you either could or should have sought advice, either as his condition deteriorated or when Mr Farthing asked you to stop the medication, as it were?
A I have been considering your question during the break. I have never, in 35 years of practising medicine, been asked by anybody to withdraw, or withhold analgesia so that they could die in pain. I have never been asked by a relative to withhold or withdraw analgesia. I was just completely knocked sideways by the question you asked me. I felt perfectly competent to deal with Mr Cunningham's problems and his terminal illness. It was just that
B your idea of withholding analgesia from somebody who was dying was just abhorrent to me.

Q Right. Did you think about obtaining the advice of one of your consultants when you had the son or stepson there saying, "Please, do not necessarily stop but perhaps reduce the dose so I can speak to him"? Did you think it would be appropriate to take the advice of a consultant?
A No.
C

Q This is a situation which you have just told the Panel was totally novel to you.
A Abhorrent. I did not say it was novel. I said I just could not consider anybody wanting to put a loved relative through that sort of pain that would have ensued had the analgesia been reduced.

Q Dr Barton, with respect, that is your take on it. Mr Farthing did not want his father to
D be in pain. He wanted to be able to speak to him. You understand that, do you not?
A Yes.

Q He was not doing it so that his father could relive any pain. That was not the purpose of his request, or did you think it was?
A No, I did not think that for one moment, but that would have been the effect.

E Q The reason I said it was novel was because you have just said that in 35 years it had never happened to you, so it was, with respect, for you a novel experience.
A A first, yes.

Q Let us move on. Patient H, please. This is Mr Robert Wilson. This is the gentleman who was or had been an alcoholic, effectively.
A Yes.
F

Q He had alcoholic liver disease.
A Yes.

Q He had fractured his left humerus in a fall on 21 September and it seems that he did not want it to be repaired. He did not want to undergo an operation.
A Yes.
G

Q His wife did not return from her holiday. His sons only found out what had happened to him about a week after the event. You, I think we can safely say, have no independent recollection of him.
A No.

Q In relation to this patient, you have accepted, I think, that you knew that this man had
H been or was an alcoholic and had alcoholic liver disease.

A A Yes.

Q He had, during the course of his stay at the Queen Alexandra, on a number of occasions, had paracetamol. He had also had, I think, codeine. On 3 October he had had 2.5 mg of morphine because his arm was hurting him.
A Yes.

B Q That was by way of injection.
A Yes.

Q Again this is a patient who, when he got to you, we should properly regard as opiate naïve.
A Yes.

C Q Codeine is not going to affect his future resistance to morphine realistically, is it?
A No.

Q You knew, and I understand what you say about it, that those with liver problems such as this, needed to be treated particularly carefully.
A I knew that and I also knew that opiates were not contra-indicated if they were necessary for the patient.

D Q I have understated the morphine position so let me correct it. I think he was given 2.5 mg on 3, 4 and 5 October, which were described as being, "of good effect" for his painful arm. Then if we go to page 17 of the chronology,

> "No problems. Eating well. Elbow and cuff in situ arm remaining swollen".

E He is described as "chatty and funny".

> "Hand remains very red and oedematous. Sacral cleft quite red with penile discharge. Ankles very oedematous and tender. Appetite variable. Paracetamol given as prescribed.
> PM Sat out for most of afternoon, but was very tired and needed to rest in bed by the end of the afternoon. Communicating quite well although varies according to mood.
> F Asked doctor to consider stronger analgesia, now prescribed codeine phosphate".

So the doctors were not ignoring any requests for analgesia, and they were prepared to prescribe him codeine and paracetamol, even though he had liver problems.
A Yes.

G Q If we can go, please, to page 22 of the chronology, 13 October. He is reviewed y the medical team. He has oedematous limbs at high risk of breakdown. His right foot already about to break down. This is due to oedema secondary to cardiac failure and low protein. His weight is up to 114.4 kg. For those who like old-fashioned language I think that is about 17.5 stone. He is described as being in a good mood this morning, "no complaints of any pain". He was passing urine independently using a bottle. Peaceful night. Slept well again. No complaints of pain. Then we have the referral letter, again revealing to you that he had alcohol problems. He was being transferred for continuing nursing care needs.
H A Yes.

Q His Barthel was 7, which again in your terms at your hospital would be relatively high. Somebody needing a lot of help but very much better than many of your patients.
A But not giving you a measure of the co-morbidities present in this patient.

Q I entirely understand that. It is simply the assistance that he needed with his activities of daily living.
A Yes.

Q He is still in a lot of pain with his arm and difficulty on moving. On a high protein diet, legs very oedematous and at high risk of breakdown secondary to cardiac failure and low protein. He needs 24 hour nursing care. Medication paracetamol four times a day. Over the page, refused to mobilise. Remains oedematous. Transfer summary,

"Ensure left arm supported. Sit to stand practise with two. Transfer practise with 2...Plan: Continue with active movements mobility and transfer practice".

Would you agree that just as with the patients who have had to have these hip operations, getting a patient like this moving, is pretty critical to their rehabilitation.
A And, by the same token without adequate analgesia it would be impossible to get him mobilising, hence the entry, "refused to mobilise", because it hurt.

Q I understand that. But shall we deal with one issue at a time. Do you agree that with a patient like this, and those who have had those hip operations, if they are going to have any chance of recovery, you have got to try to get them moving.
A Yes.

Q He is given codeine, paracetamol that day, and then he is transferred to you, and you make a note yourself of his past medical history, his alcohol problems, recurring oedema, congestive cardiac failure. You note that his Barthel is 7, "Plan: gentle mobilisation". On the same day we can see there is a nursing entry, if we go to page 24, he is described as, "fully comprehending".
A Yes.

Q "Restless at times. Used urinal with assistance as he wanted to stand".

So it is a reflection that he is able, at least, to stand and move about, albeit with assistance.
A Yes.

Q The last time that this patient had had morphine, I think, had been about nine days before on 5 October after he had knocked his arm.
A Yes.

Q Let us see what you prescribed for him, please. If we go over the page to page 25, Oramorph, up to 10 mg four-hourly.
A Yes.

Q That was actually given to him on the day of his arrival on the ward, and you prescribed diamorphine – again I will not go through it – and midazolam and the lowest dose

A equivalent to diamorphine would be 60 mg orally. The most he had had until that time was 5 mg.
A Yes.

Q After he knocked his arm.
A Yes.

B Q A massive increase, would you agree?
A Yes.

Q Do you accept that your prescription appears, at least on the face of it, to be flying in the face of his management by other doctors up to that date?
A I think that my management reflected my feeling that although he had come to me for gentle rehabilitation, that his overall prognosis was poor. He was in incipient cardiac failure C when he arrived with me and that his condition could well deteriorate at any time.

Q Yes. I will put the question again. Do you accept that the prescriptions that you wrote out on the day of his admission appeared, on the face of it, to be flying in the face of his management by other doctors at that stage?
A They appeared to be flying in the face because they are more realistic than the previous prescriptions that were written.
D

Q So none of the other doctors, in your view, who had been dealing with this patient up until this stage at the Alexandra Hospital had been realistic.
A About the long-term future for this man, no.

Q In your view, was this patient for terminal care?
A No. He was for palliative care because none of the conditions from which he suffered E were curable. He had irreversible liver disease. He had congestive cardiac failure. He probably had a degree of renal impairment. None of these were curable, so any treatment that we gave him was palliative.

Q Are you saying that your view that he was never going to leave your hospital?
A I thought that it was unlikely that he would ever leave the hospital.

F Q But he came to you for rehabilitation, did he not?
A Yes.

Q And rehabilitation was not an impossibility?
A No.

Q Or was it?
G A No.

Q No. When you wrote out what I hope you will forgive me describing as your usual prescription of diamorphine 20 to 200 and midazolam 20 to 80, what account, if any, did you take of his alcohol liver-related disease?
A I did not reduce the doses because I knew that he had previous acute alcoholism and had liver damage. I kept the doses exactly the same.
H

A Q You took no account of it, did you?
A No.

Q It would have been important, would it not, for the nurses to be aware that he had had alcoholic liver disease and the effect that that would have on the administration of any opiates?
A Yes.

B Q Why did you not reduce your usually wide range to take account of that fact?
A Because I still felt that, should the need arise, that it was appropriate that he had an effective amount of diamorphine and midazolam should he need it.

Q The potency of the drugs that the nurses would administer would be made more potent by reason or stronger by reason of his liver disease, would they not?
C A Yes.

Q Did you give the nurses any special warnings about that?
A The nurses were well aware of the special conditions, as evinced by Shirley Hallmann's long history of heavy drinking. The nursing staff would have been aware that he had a chronic alcohol problem.

D Q Yes. Shall we look at what happened to him from the day of his admission when he was able to use a urinal with assistance because he wanted to stand. He was given, on the day of his admission, I think it is, 20 mg of oral morphine. Yes?
A The ---

Q I am looking at page 25 – 10 mg administered at 14.45 and 23.45?
A Yes.

E Q Did you consider whether codeine might do it – whether codeine might control his pain?
A I knew that codeine had not controlled his pain because he had been prescribed it on the acute ward in addition to paracetamol.

Q But did you consider an intramuscular dose into his arm? If his arm was particularly
F painful, it might help control his pain?
A Intramuscular injection of what?

Q Of morphine?
A No. It was very swollen and oedematous. It would have been quite inappropriate to inject morphine into the arm.

G Q On the following day, 15 October, the day after his admission, he was commenced on Oramorph four times daily, 10 mg, and a double dose at night.
A Yes.

Q And so if we look at the bottom entry on page 26 we can see that Oramorph was administered, 10 mg at 10 o'clock, 2 o'clock and 6 o'clock in the evening, and then the 20 mg dose was given on that one occasion, giving him 50 mg on his second day at your hospital?
H A Yes.

A

Q Yes?
A Yes.

Q Did you consider at any stage that this man's deterioration appears to have broadly followed the potency of the opiate medication you were giving him?
A No. I felt that his deterioration mirrored the increase in chestiness and emergence of
B his cardiac failure, following the move to my hospital and the first night.

Q You see, if we look at the entry in the middle of page 26 when he has been started on these doses of Oramorph, he is given 20 mg at midnight with good effect, then 10 mg at 6 o'clock in the morning.

"Condition deteriorated overnight. Very chesty +. "

C

I think that means very, very chesty.

"difficulty swallowing medication. Incontinent urine ++"

Now the day before he had been able to stand at a urinal?
A I think that the "very chesty ++" and the "difficulty swallowing medication" and the
D incontinence mirrored the appearance of his cardiac failure, which would have been ameliorated, if anything, by doses of Oramorph during the night, not made worse.

Q Page 27, please. He is reviewed by Dr Knapman. There is a note that he had declined overnight with shortness of breath.

"... bubbling. Weak pulse. Unresponsive to spoken orders."

E

Did you consider that what happened to this man, who three days earlier had been described as being in a good mood with no complaints of any pain, may have been the result of your opiate medication that was causing that man to be like that?
A Dr Knapman obviously did not consider that it was a result of the opiate administration. He felt that he was in cardiac failure and he gave an increased dose of diuretic to try and reverse the increasing cardiac failure that he was demonstrating.

F

Q When you gave evidence, you seemed to suggest – and I just want to have this clear from you – that it was Dr Knapman who had instituted or directed the institution of the syringe driver. Is that your evidence?
A It is difficult to say because obviously I did not make a note, but I was not in the hospital that Friday morning, 16 October. It is quite possible that I was not available at the hospital for the rest of the day, in which case Dr Knapman, as the duty doctor, would have
G been asked to agree to the syringe driver.

Q Except that he would not need to, would he?
A They would have asked him if it had been appropriate, but no, it was written up anticipatorily for them to use should it become necessary.

H

A Q I am going to ask you, I am afraid, to look at some nursing notes. Could you take up the file for Patient H, could you go to page 266B. That is 16 October 1998. That is the day we are looking at, is it not?

"Seen by Dr Knapman am as deteriorated over night. Increased Frusemide to 80 mgs daily. For A.N.C"

B A All Nursing Care.

Q

"Wife informed will visit this morning."

And that note is signed off – I am not sure who that is, I am afraid.
A No, I am not sure who that is.

C Q The next entry is p.m., is it not?
A Yes.

Q 16 October 1998, p.m.

"Patient very bubbly chest this pm. Syringe driver commenced 20 mg diamorphine
D 40-0 mcgs Hyoscine. Explained to family reason for driver. Wife informed of patients continued deterioration. Has been to visit."

And that is signed by Nurse Hallmann.
A Yes.

Q There is no indication from that that Dr Knapman authorised that syringe driver, is
E there?
A And there is no information as to whether I authorised the syringe driver either there.

Q I understand that.
A No.

Q On any basis, the syringe driver was available to be authorised because you had
F written it up?
A Yes.

Q If we go to page 28, we can see at the top that Oramorph had been given to this patient that day, 30 mg, and then diamorphine was started through the syringe driver at 20 mg at ten past four in the afternoon. I am not going to go back again through the conversion rates but, again, do you accept that that is a fairly significant increase?
G A Yes.

Q It is from 30 mg up to the equivalent of 60 mg orally, is it not?
A Yes.

MR LANGDALE: I am sorry – I would just like to clear this point up. I think in fact in the previous 24 hours, he had been on a total of 50 mg of Oramorph. If I have got that wrong,
H

A I apologise, but I think in the previous 24 hours, the administration of diamorphine has been 50.

MR KARK: I think Mr Langdale is right. If we go back to page 26 – I am grateful. I have certainly made a note – 50 mg for 24 hour period. Then, on the 16th... Yes, Mr Langdale is right. He is given Oramorph in the morning, and then he is started on the syringe driver. It is still an increase but it is certainly not such a significant increase. Yes?

B A Yes.

Q All right. Then at page 28 we can see that he was reviewed. Professor Ford described this patient. "By this stage he has deteriorated and is very ill." It is described as a rapid deterioration. Professor Ford said this, and I want to ask you to comment on it: "No one appears to have considered the effects of the opiates and the response" – and this is looking at the entry at the bottom of page 28 – "is to add another sedative in. There was a failure to

C monitor carefully the effects of the opiates." First of all, are you saying that you were considering the effects of these opiates?

A Yes, and if he was suffering from congestive cardiac failure the opiates were entirely appropriate to manage his symptoms.

Q When he came to your hospital ---

A He had already put on 11 kg in weight, which was made up of fluid. His arms, his

D legs were oedematous. He was already on the point of developing congestive cardiac failure. It would have been that journey in the minibus and the transfer that would have tipped him into congestive cardiac failure.

Q That is your view?

A Yes.

E Q And I understand. You appreciate that on the day after his arrival on 15 October he was given, as Mr Langdale has just properly pointed out, 50 mg of morphine orally, which is more morphine than he had received in his entire stay in the Queen Alexandra Hospital.

A And it was entirely appropriate to give him that for the condition that he was in.

Q You spoke about his transfer. Let us look at what Gillian Kimbley said about it, because she actually travelled with him. She told us: "I travelled with him on his transfer to

F the Gosport War Memorial Hospital. He was not too bad. He was in a wheelchair. It took about an hour and a half. I could hold a conversation with him. He was exhausted. We spoke to Dr Barton and she said to him, 'Get straight into bed and I will give you something to calm you down'." You appeared to be rather appalled at that. I have to say, of all the criticisms in the case, that is not one that I would level at you. You were simply telling, on her account, the patient to get into bed because he had had a long journey.

A Yes.

G

Q All right.

A That is normally a nursing procedure, however, not for the medical staff to undertake.

Q But if he had had a long journey, there would be no problem about saying to a patient, "Hop into bed", would there?

A He was probably not capable of hopping by that time. He would have been helped

H into bed, yes.

Q She said this: "He had his sedation. He seemed okay. He had his lunch. He was fine. I visited him the next day. In less than 24 hours there was a big difference. He had food hanging out of his mouth. He was mumbling, not making sense. He was semi-conscious. I spoke to a sister and she said, 'Your husband is dying. He will be dead within a week.' I could not believe it. By 16 October he could not even speak. I had no further conversation with him from that time." From the drugs that he was given you would have no reason to disagree with that report of his condition, would you?
A I would ---

Q That is quite likely to be the effect of the drugs.
A From the condition that he was suffering from, I could understand that she had noticed a very marked deterioration in his overall ability to hold a conversation and hold his food in his mouth. I would be blaming it on the effect on his brain function, caused by the congestive cardiac failure rather than the opiates necessarily.

Q Again in relation to the transfer, she said, "He was buffeted a little bit on transfer, but it was not too bad. He was a bit tired afterwards. It did not take four hours. The plan was for him gently to get mobilised. The sister discussed with me his cardiac failure and the fluid on his body. From the 16th he was unconscious." Now, this is a patient who undoubtedly had a long journey, but it was a long journey from which he might have recovered. Do you agree with that?
A He might have recovered, but the treatment that he was given was perfectly appropriate on his arrival at the ward and the next day when his congestive cardiac failure became apparent.

Q Mr Ian Wilson gave evidence about this patient as well. I just remind you. He said: "I saw him the evening before his transfer to GWMH. He had eaten. He had been drinking. Sat up alongside his bed. Someone had the *Daily Sport* and there was a jovial atmosphere. On the 15th" – so this is the day after his admission and the day after he has been started not on the syringe driver but on his Oramorph – "he was in a comatose state. He did not appear able to move himself. I leant over. He spoke his last words, 'Help me, son, they are killing me,' and I thought he was dying. He was comatose." Does your answer apply to that as well, that it would have been his illness that was causing him to be in that state?
A Yes.

Q Mr Wilson went on: "I could not rouse him," and he never saw you. You have no recollection of this patient, have you?
A I have not.

Q So far as this patient is concerned, going to the heads of charge if you would please, in particular to head of charge 9(b), which I think you find on page 9 if you have the green copy.

> "b. In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. ..."

- which we have looked at already. The prescription was 14 October –

> "... was,

Q She said this: "He had his sedation. He seemed okay. He had his lunch. He was fine. I visited him the next day. In less than 24 hours there was a big difference. He had food hanging out of his mouth. He was mumbling, not making sense. He was semi-conscious. I spoke to a sister and she said, 'Your husband is dying. He will be dead within a week.' I could not believe it. By 16 October he could not even speak. I had no further conversation with him from that time." From the drugs that he was given you would have no reason to disagree with that report of his condition, would you?
A I would ---

Q That is quite likely to be the effect of the drugs.
A From the condition that he was suffering from, I could understand that she had noticed a very marked deterioration in his overall ability to hold a conversation and hold his food in his mouth. I would be blaming it on the effect on his brain function, caused by the congestive cardiac failure rather than the opiates necessarily.

Q Again in relation to the transfer, she said, "He was buffeted a little bit on transfer, but it was not too bad. He was a bit tired afterwards. It did not take four hours. The plan was for him gently to get mobilised. The sister discussed with me his cardiac failure and the fluid on his body. From the 16th he was unconscious." Now, this is a patient who undoubtedly had a long journey, but it was a long journey from which he might have recovered. Do you agree with that?
A He might have recovered, but the treatment that he was given was perfectly appropriate on his arrival at the ward and the next day when his congestive cardiac failure became apparent.

Q Mr Ian Wilson gave evidence about this patient as well. I just remind you. He said: "I saw him the evening before his transfer to GWMH. He had eaten. He had been drinking. Sat up alongside his bed. Someone had the *Daily Sport* and there was a jovial atmosphere. On the 15th" – so this is the day after his admission and the day after he has been started not on the syringe driver but on his Oramorph – "he was in a comatose state. He did not appear able to move himself. I leant over. He spoke his last words, 'Help me, son, they are killing me,' and I thought he was dying. He was comatose." Does your answer apply to that as well, that it would have been his illness that was causing him to be in that state?
A Yes.

Q Mr Wilson went on: "I could not rouse him," and he never saw you. You have no recollection of this patient, have you?
A I have not.

Q So far as this patient is concerned, going to the heads of charge if you would please, in particular to head of charge 9(b), which I think you find on page 9 if you have the green copy.

> "b. In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. ..."

- which we have looked at already. The prescription was 14 October –

> "... was,

i inappropriate,

ii. potentially hazardous,

iii. likely to lead to serious and harmful consequences for Patient H,

iv. not in the best interests of Patient H."

Do you agree that in light of his alcoholism and liver disease your prescriptions should have been lower?
A No.

Q I will not take up time going through the rest of those charges, and I was going to turn to Patient I. Dr Barton, are you alert enough to deal with another patient, or would you like to break now?
A Could I have a brief break, please.

MR KARK: I am sure you can.

THE CHAIRMAN: I do not think it was the doctor's alertness that we were concerned about, but merely the fact that it is a very gruelling experience. You can certainly have that break, Doctor.

THE WITNESS: Thank you. Shall I just go and come back?

THE CHAIRMAN: Please do, and anybody else who would like a short break, now is the time.

(After a short pause)

Q Dr Barton, Patient I, was the 92-year old patient who on 19 March 1999 was pulled over by her dog causing her to break her right hip. She was operated on on 20 March [illegible] you may or may not remember that morphine caused her to have hallucinations.
A Yes.

Q Nevertheless, she did in fact continue to receive some opiates during her stay at the hospital. Unfortunately, she continued to have pain in her hip for quite a while after her operation. If we go to 24 March, the day before, at the bottom of page 6, there is reference to her skin being very thin and fragile lower legs. "Has proved difficult to get mobilised and her post-op rehabilitation may prove some what difficult". Her main problem is described by Dr Reid as,

"Pain in her right hip and swelling of her right thigh. Even a limited range of passive movement in right hip still very painful".

Yes?
A Yes.

i inappropriate,

ii. potentially hazardous,

iii. likely to lead to serious and harmful consequences for Patient H,

iv. not in the best interests of Patient H."

Do you agree that in light of his alcoholism and liver disease your prescriptions should have been lower?
A No.

Q I will not take up time going through the rest of those charges, and I was going to turn to Patient I. Dr Barton, are you alert enough to deal with another patient, or would you like to break now?
A Could I have a brief break, please.

MR KARK: I am sure you can.

THE CHAIRMAN: I do not think it was the doctor's alertness that we were concerned about, but merely the fact that it is a very gruelling experience. You can certainly have that break, Doctor.

THE WITNESS: Thank you. Shall I just go and come back?

THE CHAIRMAN: Please do, and anybody else who would like a short break, now is the time.

(After a short pause)

Q Dr Barton, Patient I, was the 92-year old patient who on 19 March 1999 was pulled over by her dog causing her to break her right hip. She was operated on on 20 March and you may or may not remember that morphine caused her to have hallucinations.
A Yes.

Q Nevertheless, she did in fact continue to receive some opiates during her stay at the hospital. Unfortunately, she continued to have pain in her hip for quite a while after her operation. If we go to 24 March, the day before, at the bottom of page 6, there is reference to her skin being very thin and fragile lower legs. "Has proved difficult to get mobilised and her post-op rehabilitation may prove some what difficult". Her main problem is described by Dr Reid as,

"Pain in her right hip and swelling of her right thigh. Even a limited range of passive movement in right hip still very painful".

Yes?
A Yes.

A Q At the top of page 8,

"Still in a lot of pain which is the main barrier to mobilisation at present - could her analgesia be reviewed?" She is still been given paracetamol. At the bottom of page 8 we see that the swelling on her right leg has increased; that her skin is paper thin and very fragile. Haematoma is said to have developed and broken down. "Dress with gelonet. Elevate. Ready for GWMH when bed available. Needs great care of skin + B warn GWMH of skin state".

At the bottom of page 9, we can see that she transfers to Dryad ward. That is on 26 March. Her last dose of morphine, by my reckoning, had been some five days earlier, 5mg on 21 March. Again this is a patient who we must regard as opiate naive.
A Yes.

C Q On the first day of her arrival at your hospital upon your prescription, she was given I think 25 mg of Oramorph if you go to page 11. Yes?
A Yes.

Q Again, can we take it that the palliative care hand book has figuratively gone out of the window, as has the BNF? You are starting this lady on 25mg of opiates.
A She had had major surgery. She had a very early transfer to us. She had a journey. D She had a lot of pain in that hip. This is not the palliative care pathway I am throwing out of the window. This is a lady in need of realistic levels of analgesia while we get to know her and assess her rehab potential. "Plan, sort out analgesia". It would not have been appropriate to continue giving her paracetamol and that level of dosage of Oramorph was equivalent in strength to one daily and considerably more pleasant for most patients to take than the codeine-based analgesics.

E Q She had not been on eight dihydrocodeine had she?
A No, and that would have been the alternative. I was going to move up from the first rung of the analgesic ladder. I was not going to continue to give her paracetamol. I went to the bottom of level three rather than the top end of level two.

Q Let us examine that for a moment. She had on 23 March, if you go back to page 6, a gram of paracetamol.
F A Yes.

Q That is not the maximum is it?
A Yes.

Q It is the maximum?
A No, 1 gram four times a day would have been the maximum. We would accept that G her analgesia was not adequate during her time at Haslar.

Q I understand that. Let us look at what she had been on. Page 6, on 23 March 1 gram of paracetamol. The next day another gram, page 8.
A Yes.

Q The next day another gram of paracetamol. Did you think about increasing her H paracetamol?

A A No, I did not think that that would be appropriate analgesia.

Q Did you think about going to level two on the analgesic scale?
A Yes, and I have explained that the equivalent to a reasonable dose of level two analgesia would have been a small dose of Oramorph which is what I gave her.

Q Why could you not start on the next level up from paracetamol?
B A I could have.

Q You could have done?
A I could have done.

Q If we go on to page 11, this patient, as we see at the top, is said to be experiencing a lot of pain on movement. Yes?
C A Yes.

Q We heard from both Professor Ford and Mr Redfern about this patient. Yes?
A Yes.

Q Mr Redfern considered it very unusual to continue requiring morphine so late on.
A Yes.
D

Q Professor Ford said you would not have expected such pain so long after the operation. Yes?
A Yes.

Q Did you ask yourself "What on earth is going on with this hip?"
A Yes, but I did accept that there are enormous variations in the rate at which people get
E over major surgery. I was also aware that she had had a haematoma develop and break down before she was transferred over to us and that might have indicated that the prosthesis was still very uncomfortable.

Q What was your continuing plan, therefore, for this patient?
A To sort out her analgesia to make her comfortable?

F Q Did that plan change at any stage?
A No.

Q I suggest you never went back to the root course of this patient's pain did you?
A No.

Q Mr Redfern told us that in orthopaedics they had a very low threshold for re-
G operating. You smile, so we had better record it. Why are you smiling about that?
A Because orthopaedic surgeons are well known to have a very threshold for re-operating. If it moves, operate on it. This lady had barely survived her first major surgery. She would certainly not have survived another operation.

Q That is your view apparently of Mr Redfern.
A Yes.
H

Q Let me just remind you of some of his evidence. This is Day 16/21.

"Q What would have happened if this lady had been sent back to the Haslar Hospital? Would it have required a re-exploration of her hip?
A On the assumption that there was a failure of fixation, then there would have been an evaluation of her general fitness to [under]go revision surgery".

A Yes.

"A And had she passed that assessment, which is usually done by the anaesthetist who is scheduled to do the surgery, then she would have undergone revision surgery.

Q That evaluation is very important?
A Yes.

Q Because decisions have to be made about what is in the patient's best interest?
A That is correct".

Q Then he was asked this:

"Q If a patient is elderly, in poor physical shape, it may well be thought this is not in the patient's best interests to undertake surgery under general anaesthetic?
A Yes. There would have to be considerable co-morbidity though. We have a very low threshold for operating on people with fractured neck of femur, because they commonly carry considerable co-morbidity. The bar is set fairly low".

A Yes.

Q Is that your understanding as well?
A Yes.

Q Then,

"Q And one would want to evaluate whether it is generally in the patient's interests and that they will survive the insult that general anaesthetic involves?
A Death under anaesthesia is extraordinarily uncommon, even in very frail patients".

Is Mr Redfern one of those surgeons who you would ---
A I think that is a very balanced account of the risks, but the risks of re-operating on an elderly frail lady at her age, even without a large number of co-morbidities, are exponentially higher. She has been through it once and you are asking her to go back to theatre and have it re-explored. I did not feel at that time it would be appropriate for her.

Q What is the realistic alternative for this patient?
A Sort out her analgesia.

Q And then?
A Keep her comfortable.

Q Does that mean this patient is on a terminal pathway again?
A She is on a palliative care pathway because it is perfectly possible that without having further surgery, particularly if there had been an infection there which we were beginning to suspect, that she would regain a certain amount of function, an adequate amount of function.

Q Would you have discussed the possibility of surgery or going back to the hospital with the patient?
A Not at that stage. It was too soon at that stage.

Q On 28 March she was given two doses of Oramorph which apparently she vomits up, if we can go to page 13. You advised to stop Oramorph. Yes?
A Yes, go back down to level two.

Q She is now on to co-dydramol.
A Yes.

Q On Monday 29 March, she is given two tablets four times days list. Is that the maximum?
A Yes.

Q There is no mention of any pain in the nursing notes is there?
A There is not.

Q Over the page at page 14, on 30 March, again the same dose of co-dydramol, "Both wounds redressed with paranet". What is that?
A A dressing.

Q Then,

"Steri-strips from surgery removed. One small area near top oozing slightly - mepore dressing in situ. Check in a couple days. Sat out in chair for assisted wash/dressed. Zinc and castor oil applied to bottom, liquid paraffin ...applied to legs".

A On that day it appeared as if her condition was possibly beginning to improve apart from this slightly worrying thing about the oozing on the top of her dressing beginning.

Q On the Wednesday, we come back to Oramorph. Yes?
A Yes.

Q Which Professor Ford described as being appropriate if the co-dydramol had not worked.
A Yes.

Q If we go to the top of page 15, she is described as walking with a physiotherapist this morning but in a lot of pain.
A Yes.

Q This is now five days after admission.
A So it is two weeks after surgery.

Q By this stage, surely you must have been beginning to worry about what was causing this patient's pain.
A I was beginning to wonder why she was still in a lot of pain. The physio I feel would have noted had the prosthesis been dislocated or had collapsed at that point because it would have been apparent when she walked.

Q The physio might have done.
A No, would have done.

Q But this was your patient.
A Yes, but they are very expert professionals when assessing post-operative hip surgery patients.

Q Dr Barton, this is your patient; she is several weeks after surgery; you would have been seeing her according to your evidence daily would you?
A During the weekdays, yes.

Q Would it not have concerned you, whatever the physiotherapist was doing, because he might be making it worse, would it not have concerned you to re-examine the leg and the hip?
A What by X-raying it you mean?

Q No, first of all re-examine it.
A There was nothing to see. It had a dressing on it which was just oozing.

Q It was oozing; why could you not swab that?
A We then did swab it.

Q I know you did then swab it.
A When there was enough to swab, when it became apparent that it was likely to be an infection, then we took a swab and instituted antibiotics.

Q Can we just pause, please, page 15, 1 April, Thursday so you would have been on duty.
A Yes.

Q The wound is described in the following way:

"Wound in right hip oozing large amounts of serous fluid and some blood. Hole noted in wound".

Does that give fairly obvious indicators of a possible infection?
A It is a possible infection. It is also possible that that haematoma that she had at the time shortly after the surgery was now resolving and discharging through the suture line. That would give you serous fluid and a bit of blood. It was not necessarily infected at that point.

Q Would you not want to swab it to find out?
A I was going to swab it the following week.

A Q I am not sure where you have gone; I am still on Thursday 1 April when this patient's wound is oozing a lot of serous fluid and blood. Would you not have wanted to swab it?
A It would have been possible to swab it, yes.

Q Would you not have wanted to find out what was going on?
A Yes.

B Q Over the weekend, she is then on the Thursday to deal with her pain started on slow release morphine. Yes?
A Yes.

Q On the Sunday, her wound is still losing serous fluid and blood.
A Yes.

C Q So that is not getting any better?
A No.

Q We see that you actually get to her, at least you are noted as seeing her on Tuesday 6 April.
A Yes.

D Q "Seen by Dr Barton. MST increased to 20mg. Nephew has visited, if necessary once Enid is discharged home (she is adamant about not going to a nursing home) he will employ someone to live in. Enid has been incontinent of urine a few times over the weekend. I have spoken to her about a catheter".

Then a swab is taken, and that was at your direction, was it?
A Yes.

E Q So it took from Thursday to Tuesday to take a swab from this oozing wound.
A Yes.

Q Can you explain why?
A No. I cannot explain why we waited from Thursday to Tuesday to do the swab. I have no intelligent explanation of it.

F Q In terms of a wound infection, that is actually quite a significant period of time potentially, is it not?
A Yes.

Q You want to get antibiotics started if you need to, as quickly as possible.
A Yes.

G Q Can we go please to page 18? You apparently see the patient in the morning and it looks as if, at that time, the fracture site is described as, "red and inflamed". That would be the wound site, would it?
A Yes.

Q "Seen by Dr Barton", and you start her off on antibiotics.
H A Yes.

Q Those are general antibiotics. You do not know what is going on in there, but you understandably --
A I am awaiting the results of the swab but I am going blind to suitable broad spectrum antibiotics to treat infection.

Q This patient is then seen by Dr Reid, and he obviously performs a full examination, does he not?
A Yes.

Q "Still in a lot of pain and very apprehensive. MST up to 40 mg a day. Try adding flupenthixol".
A An anxiolytic.

Q "For x-ray right hip as movement still quite painful – also, about 2" shortening right leg".

Can you explain why that is something that you had not noticed?
A Because it had not been apparent until that day. I had not seen any shortening the last time I had examined the hip, which would have been the previous Thursday when I did not take the swab.

Q Did you review her on that day with Dr Reid?
A I do not think I was there.

Q You see your note that we have just looked at, "Seen by Dr Barton", would have been made in the morning, would it not?
A But I would have looked at the patient in the bed and looked at the wound – they would have shown me the wound oozing, but I would not have attempted to walk her or examine the hip.

Q No, but you plainly did not undertake the same sort of examination that Dr Reid conducted.
A No, I did not, not that morning.

Q Because we can take it, I think, that the leg probably did not shorten itself two inches --
A During the morning.

Q During the morning.
A No.

Q And Dr Reid on the Wednesday has asked for an x-ray.
A Yes.

Q This presumably is something that would have been relayed to you, "Dr Reid examined one of your patients and found that one leg was two inches shorter than the other leg and asked for an x-ray".
A Yes.

Q That would be relayed to you, or you would see it in the notes.
A Yes.

Q The following day, you would want to know what had happened about that x-ray or what was happening about the x-ray, would you not?
A I knew that it had been booked. I did not pursue the x-ray any further than that. I knew that Dr Reid was going to review it when he saw her on the next ward round.

Q Which would be when?
A The following Monday, by which time she would have finished her course of antibiotics.

Q But her antibiotics, of course, are not going to deal with her shortened leg.
A It is going to deal with her wound infection.

Q If she has got a shortened leg, certainly as a lay person it is very much like the repair has collapsed in some way, is it not?
A Something has happened to the repair, but that is not as urgent a problem as dealing with the wound infection.

Q So your comment, that I have recorded, is that nothing about the x-ray would have altered your management.
A That is correct.

Q You also said, "I would not have looked at the x-ray".
A No.

Q Why not?
A Because looking at the x-ray would not have altered my management of her patent wound infection, leaving aside whether the prosthesis had or had not collapsed, or the head had dislocated. That would not alter my management of the wound infection and you could not transfer her back to the orthopaedic unit with a raging wound infection.

Q Did you think of consulting the orthopaedic department to see what they would do?
A No.

Q Can we go over please to page 21 of the chronology? Sorry, I have missed something important. Can we go back to page 20? On the Saturday there is a nursing note that she had a very poor night and the patient appeared to be leaning to the left.

"Does not appear to be as well and experiencing difficulty in swallowing".

A Yes.

Q You say, I think, "I would take this to be a stroke".
A Yes, or a transient ischemic episode.

Q Did you have any other possible diagnosis for that?
A No.

A Q Bearing in mind that her right hip is painful and inflamed, apparently, that something has gone wrong with her operation. Did you think it could be connected to that?
A If she had a wound infection and she had become septicaemic, I suppose a bolus of infection to the brain. That is a possibility.

Q Come Sunday, page 21, she is described as,

B "Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way",

and there is pain on movement.
A Yes.

Q If we look at the review by yourself, and you think this is on the next day I think, 12 April.
C A I do.

Q "Enid's condition has deteriorated during this afternoon. She is very drowsy, unrousable at times. Refusing food and drink. She denies pain when left alone but complaining when moved at all".

"Unrousable at times", would you need to reflect upon that when you administer any
D morphine to her?
A No. I would be keen to give her adequate analgesia. I would be aware that she was unrousable at times because she had entered the terminal phase of her life on the Saturday.

Q So at this stage all hope is lost for this patient. Is that right?
A Yes.

E Q No point in looking at any x-ray.
A This is Saturday we are talking about?

Q No, Monday 12 April. Just pause for a moment.
A Yes, they come in on Monday morning. I am not expecting to look at the x-ray one way or the other. I come in to find that Enid has deteriorated markedly over the weekend and has entered the terminal phase of her life.
F

Q That is your view.
A That is my view.

Q At the bottom of page 21 we can see that on the Sunday she is given Oramorph at 7.15 in the morning, 5 mg and then 20 mg of MST.
A Twice.
G

Q So a total of 45 mg.
A Yes.

Q Which would be, MST is oral, so 45 mg, an equivalent dose would be around 20mg.
A Yes.

H

A Q Of diamorphine. Over the page please to page
prescription for diamorphine and midazolam, did you
A Yes.

Q You decided that this patient should start on 80
A Yes.

B Q Which would be the equivalent oral dose of 24
A Yes.

Q Now reflecting upon that, do you accept that th
A I prescribed what I considered to be an appropr
symptoms on that Monday morning when I saw her on the ward. I did not consult with the Palliative Care Guidelines. I gave Enid what I thought was appropriate for her condition.

C Q She was, the day before, described as "very drowsy and unrousable".
A Yes.

Q You then give her a dose which was four times as high as the one she had been on.
A Yes.

D Q Even now you do not think there was anything wrong with that, do you?
A I gave her what I felt on that morning, seeing her, was the appropriate dose.

Q So the answer, Dr Burton, with respect, is no.
A No.

Q You do not think there was anything wrong with that.
E A No.

Q You must have been surprised when Dr Reid reduced it by a half.
A If he felt it was appropriate to reduce it, that is absolutely fine.

Q It is absolutely fine, all things might have been fine, but did you not say to Dr Reid, "What are you doing with this patient?"?
F A I was not there.

Q No, but did you become aware that that is what had happened, that he had reduced the dose that you thought was necessary by a half?
A Yes.

Q Did you take it up with him?
G A No.

Q Why not?
A Because I did not think it was necessary to take it up. I had had my opinion of how she should be treated that morning. He had a different opinion that afternoon. He had changed the dose of the analgesia. That was absolutely fine.

H Q But did you say to yourself, "Well, one of us must be wrong"?

A Q Of diamorphine. Over the page please to page 22 and 23. You wrote out your usual prescription for diamorphine and midazolam, did you not?
A Yes.

Q You decided that this patient should start on 80 mg of diamorphine.
A Yes.

B Q Which would be the equivalent oral dose of 240 mg orally.
A Yes.

Q Now reflecting upon that, do you accept that that was far too high?
A I prescribed what I considered to be an appropriate dose to control her pain and her symptoms on that Monday morning when I saw her on the ward. I did not consult with the Palliative Care Guidelines. I gave Enid what I thought was appropriate for her condition.

C Q She was, the day before, described as "very drowsy and unrousable".
A Yes.

Q You then give her a dose which was four times as high as the one she had been on.
A Yes.

D Q Even now you do not think there was anything wrong with that, do you?
A I gave her what I felt on that morning, seeing her, was the appropriate dose.

Q So the answer, Dr Burton, with respect, is no.
A No.

Q You do not think there was anything wrong with that.
E A No.

Q You must have been surprised when Dr Reid reduced it by a half.
A If he felt it was appropriate to reduce it, that is absolutely fine.

Q It is absolutely fine, all things might have been fine, but did you not say to Dr Reid, "What are you doing with this patient?"?
F A I was not there.

Q No, but did you become aware that that is what had happened, that he had reduced the dose that you thought was necessary by a half?
A Yes.

Q Did you take it up with him?
G A No.

Q Why not?
A Because I did not think it was necessary to take it up. I had had my opinion of how she should be treated that morning. He had a different opinion that afternoon. He had changed the dose of the analgesia. That was absolutely fine.

H Q But did you say to yourself, "Well, one of us must be wrong"?

A No, neither of us were wrong. It was a clinical judgment on both occasions as to what dose you give that patient in front of you.

Q What then happens is that, having reduced the dose, it appears that a nurse, either by mistake or deliberately, doubled the dose of midazolam.
A Yes, that is apparent.

B Q Dr Reid himself described that as "astonishing". This was a doubling up – I was going to say it was Nurse Hamblin but I am not sure that that is right. Do you find it surprising that a nurse would think it appropriate, if that is what happened?
A I can only think that that was the instruction that she thought she had gotten from him. I was not there. I cannot make any further judgment other than that, but she may have understood him to say, "Put them both to 40", or something like that. I can honestly give you no more intelligent answer than that.

C Q The ability to increase that dose by doubling it was allowed for by our prescription, was it not?
A Yes, it was.

Q Professor Ford described your starter dose as definitely excessive. You do not accept that, do you?
D A I do not accept that.

Q And he also commented that even reducing it by as much as a half, with the midazolam, you could not now assess how the patient was. You agree with that, presumably, because she would be unrousable.
A I did not assess her. I did not see her that night.

E Q And the patient died at 1.15 the following morning.
A Yes.

Q Do you accept that it seems very likely that this patient died as a result of the sedation that she was on?
A No.

F Q You put down her cause of death as CVA.
A Yes.

Q What was that based on?
A The evidence of my nurses when they saw her on that Saturday morning, and the evidence of what I saw when I saw her on the Monday morning. Again, I did not record anything.

G Q If you had recorded her cause of death as being a direct result of over-sedation, would that have initiated an inquiry?
A I have no idea.

Q Did you consider that she might have been over-sedated?
A Not at all.

H

Q Even after you knew that Dr Reid had reduced the dose by a half?
A Not at all. I felt that on that Monday she was dying, and the initial dose that I gave her was appropriate for her condition.

MR KARK: That is all I ask you about Mrs Spurgin. Sir, I wonder if in the circumstances that would be a convenient moment.

THE CHAIRMAN: I think it would be a very convenient time, thank you. Mr Langdale?

MR LANGDALE: May I just mention a matter which may arise in connection with all witnesses. I know from what my learned friend has indicated to me, he anticipates his cross-examination will go some way into tomorrow morning but will conclude before lunch time. I would have thought such re-examination as I have for Dr Barton will not take any great length of time.

There is a witness whom the defence are anxious to call. It is a nurse. She is in real difficulties in terms of holiday arrangements, as I understand it, if she is not called tomorrow afternoon. The Panel are not sitting on Thursday. I understand it would or might be just about possible for her to give evidence on Friday, but that would be causing her some difficulties. I just wonder whether the Panel would be kind enough to consider whether it would be appropriate for her to be called tomorrow afternoon. I do not think she is going to take anything like all afternoon. Those besides me think not.

THE CHAIRMAN: If there would be no objection to the Panel delaying their questions, then I think we could accommodate you. I think in any event, the Panel at this time are feeling very much again that we have been moving very fast, and they would wish to have an opportunity to look at transcripts beforehand, so it may be in fact that that would work well and I could say now, yes, by all means arrange the witness for such time after Mr Kark has finished, and hopefully after you have completed your re-examination. Do you have any sense of how long that witness is likely to need?

MR LANGDALE: Mr Jenkins says maybe up to an hour. He will be taking the witness. She is not dealing with lots of patients. There is only one patient she deals with. I doubt if Mr Kark's questions will be particularly lengthy with her. Something of that order.

THE CHAIRMAN: I think we have no difficulty in doing that and I have to say now that we would rise then at the end of that period, whenever it was. Given that the following day is a non-sitting day, it will not be possible for the Panel to be using that day for its review, so we would probably be trespassing into Friday. I think what I will say is, when we rise tomorrow – at whatever time it is – we will then give an indication of a "not before" time for the Friday morning. We would do our independent study, and you would not need to be here waiting on us, in effect.

MR LANGDALE: Thank you very much

THE CHAIRMAN: Very well. Thank you very much, ladies and gentlemen. Tomorrow morning please at 9.30.

(The Panel adjourned until Wednesday 22 July 2009 at 9.30 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 22 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 THIRTY)

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.

JANE ANN BARTON, Re-called
Cross-examined by MR KARK, Continued

Q Dr Barton, we were going to the case of Mr Jeffrey Packman. Could you turn to Patient J's chronology, please. This gentleman I think was 68 years old when he died at your hospital. Yes?
A Yes.

Q I think we will all recollect with a certain vividness the circumstances of his admission to hospital, having had that period in his bathroom in his home on 6 August. Can we turn to page 8 of the chronology? We can see that on 16 August, so we are now some 10 days or so after his admission, he was obviously being considered for a bed at Dryad Ward at your hospital but he was still at the Queen Alexandra Hospital. He is seen by Dr Tandy. I will not go through her note. If we then go down to 18 August, we can see that he is reviewed by a registrar. There is a note that the wounds looked better and to "stop antibiotics from tomorrow. Continue as planned" and then the registrar has commented on another review by Dr Tandy. "P sores" – that is pressure sores, is it not?
A Yes.

Q "Pressure sores – extensive. Feeds himself. Not mobilising. Black stool overnight – nil today." We have examined already the possibilities in relation to that black stool. Certainly one possibility is that there was a gastro-intestinal bleed. Yes?
A Yes.

MR KARK: "No pain." Then a comment about the abdomen. "Check haemoglobin". "R/O bleed"? (Pause) I am glad it is not something I have simply forgotten. I think Dr Smith is giving me some assistance.

THE CHAIRMAN: He said "rule out".

MR KARK: Possibly. Can we go over the page, and if we go to 20 August, again there is a review by the registrar and we can see that there is no nausea and no epigastric pain. Would there necessarily be epigastric pain if he had a GI bleed?
A No.

Q It can be a relatively silent condition?
A Particularly if he was taking Clexane.

Q We will look at Clexane, obviously, but he was on Clexane at this time, I think?
A Yes.

Q Then towards the bottom we can see: "Following full reassessment of pressure sores, the wounds though malodorous don't appear to be as deep as first thought. Until necrotic tissue is removed, the wound appears to be a grade 3", which is a very high grade of sore – yes?
A Yes.

Q "All dressings changed. No complaints." Of we go to 23 August, this is the day of

his admission. He is recorded as being obese, which we know; he had arthritis in both of his knees; he was immobile; he had pressure sores. He was on a high protein diet, the purpose of which would have been what?
A To improve the chances of his tissues healing.

Q But his mental test score is noted to be very good and, despite his pressure sores, he does not appear to be in pain.
A Yes.

Q We heard something about this the other day. You would agree, no doubt, that the depth of a pressure sore does not necessarily indicate the severity of the pain that the patient actually feels?
A At any particular time, it may not be particularly painful.

Q "Better in himself." We know his legs were oedematous but apparently the word is illegible. "Chronic skin change. Ulcers dressed yesterday. Need review later this week." This was a review on Dryad Ward by Dr Ravindrane?
A It was.

Q I will not go back to looking at his clinical note but that is the sort of clinical note that I expect you wished you had made all along? It was a rather full and proper assessment, was it not?
A Very.

Q You would say, would you, that he had longer than you did?
A No. I would say that he wrote a better admission note than I sometimes did, although I tried usually to cover the problems and a plan for the patient being admitted.

Q Professor Ford's view of this patient was that the vast majority of rehabilitation wards would have tried to mobilise this patient. First of all, do you agree with that?
A Yes. Dryad was not, strictly speaking, a rehabilitation ward and, as you have already heard, we were limited in the facilities that we had. This chap was totally immobile and it was going to be very difficult with the physio and OTT cover that we had to get him back on his feet, even if we managed to heal the pressure sore.

Q I understand that but the whole purpose of giving this man a high protein diet and dressing his pressure sores was, hopefully, to get him up and out of bed?
A It was part of his general palliative care; it was to give him a chance.

Q And until this point, until his admission to your hospital, I think I am right in saying that all of his pain had to that point, over the 17 days that he had been at the QAH, been controlled by paracetamol?
A Yes.

Q They had not needed to go to stage 2 of the analgesic ladder, nor to stage 3?
A No.

Q Can we go over the page, please? He was prescribed, and this is Dr Ravindrane accepts I think his prescription, Doxazosin, frusemide, clexane and paracetamol. At that stage, there having been only one indication of a GI bleed, not wholly inappropriate to give

clexane but something which perhaps, on refection, might be better not to have been prescribed?
A It might have been appropriate, in view of the black stool on the acute ward, before he came down to consider whether it was appropriate to continue it.

Q And a blood sample was sent for analysis on 24 August to see what was happening with his haemoglobin?
A And it had dropped to 12 grams.

Q I am not going to go back to the notes but we know that I think from page 212. How significant a drop is that?
A From 13.7, over that short period of time, it could have been significant.

Q It is something that needs to be watched?
A It is something that needs to be watched and Dr Ravi I think indicated in the admission note "need review later this week". I would think he was probably referring to the blood count as well as the leg ulcers and the bottom ulcer.

Q The next day, on 25 August, the patient was passing fresh blood per rectum and then "Query clexane" and Dr Beasley quite rightly directed that Clexane should be stopped. Yes?
A Yes.

Q And you were going to review him in the morning. Passing fresh blood per rectum is indicative of what sort of GI bleed?
A At the rectum or the anus. He probably had a pile. I do not think it was the same that was causing the malena stool earlier on and later on in the case. It is much more likely to be a local cause, being fresh blood

Q Because it would be a bleed in different parts of the bowel?
A In order to appear as fresh, it would have to be very close to the opening.

Q What are the causes of a GI bleed? What makes it happen?
A From the top end of the bowel to the bottom end of the bowel causes a blood vessel to break and blood to be lost into the bowel.

Q And presumably that could happen in two areas of the bowel?
A It could happen anywhere in the 30 feet.

Q So not impossible that this unfortunate patient had a high GI bleed and a low GI bleed?
A I think it is very likely that he had two separate pathologies occurring.

Q So the Clexane was stopped. Go over to page 13, please, when you reviewed him. There is a note by Sister Hamblin. "Fairly good morning. No further vomiting. Dr Ravi contacted re clexane. Advised to discontinue."

In fact, that had already been done. "Repeat haemoglobin today and tomorrow. Not for resuscitation."

There is this query as to where that comes from. Yes?

A A Yes.

Q "Unwell at lunchtime. Seen by Dr Barton this afternoon – await results of haemoglobin. Further deterioration – complaining of query indigestion, pain in throat, not radiating – vomited again. Verbal order from Dr Barton diamorphine 10 mg stat – given at 18.00 hours."

B I think you were asked previously by Mr Langdale what the significance of "stat" is. What does that mean?
A Immediately

Q So it is not a particular type of injection or a particular type of diamorphine. It just means give it now?
A Yes.

C Q The reason for you doing that was because you were concerned about a possible myocardial infarction?
A I was.

Q Is it given because it relieves the pain of a myocardial infarction?
A Yes. It relieves the pain. It relieves the anxiety. It helps with the cardiac function. It
D is altogether an appropriate thing to do if you think someone is having a myocardial infarction.

Q The fact that he had, as we saw a little earlier, pain in his throat but not radiating, does pain in throat ---
A It can be from pain in the heart.

E Q This is not generalised pain. This is very specific pain, is it not, which you put down to a possible MI?
A I did.

Q We then see that his haemoglobin is now down to 7.7 from 12 a few days earlier, and that is a significant drop, is it not?
A It is a significant drop. I was not aware of that on 26 August.

F Q I was just about to remind you. You told the Panel that you did not see this until two days later.
A Correct.

Q Part of the problem seems to be that the pathology lab were trying to get through to your switchboard but could not? Yes?
G A Yes.

Q You also said this, and I just want to confirm that this is your evidence, that you do not know why you did not get the information "but the result would not have altered my management of him. He had a GI bleed".
A If he had a GI bleed. My impression was, following the conversation between Sister Hamblin and Dr Ravi that he was not for resuscitation and that in my mind equated
H completely with not fit for transfer up to the acute unit. So whether he had or had not had

A a myocardial infarction or whether he had or had not had a gastro intestinal bleed, which I did not know at that time, I would not have transferred him up to the acute unit because he was not well enough.

Q Let us pause there for a moment because we have heard a lot of evidence about what "not for resuscitation" means, have we not?
A Yes.

B

Q Whether it is not for 555 or not for 444, however you want to describe it.
A Yes.

Q What we heard that it means is that if a person has a heart attack you are not going to give them cardiopulmonary resuscitation?
A Yes.

C

Q You are not going to apply the paddles and all the rest of it, the reason being because the likelihood of them surviving is very low.
A Yes.

Q What it does not mean is that you do not continue to treat the patient?
A I did treat the patient. I gave him appropriate analgesia for his presumed myocardial
D infarction. I did not consider six people putting him on a trolley, transferring him into an ambulance, bumping him up the 10 miles to the accident and emergency department, a transfer then before anyone was able to even put up a drip and cross-match blood and consider giving him blood and any further endoscopy and treatment. It just was not practical; it was not possible for this man.

Q Is what follows from that this that if you had known on 26 August 1999 that this
E man's hemoglobin had gone down to 7.7 you would from that have strongly suspected a GI bleed, would you not?
A Yes.

Q So far as you were concerned, this man is on what we have called his terminal pathway?
A Yes. He seemed the following morning to have stopped bleeding. He seemed
F comfortable and stable and that bleed in itself was not a terminal event.

Q I understand that but I just want to understand your thinking ---
A But I would still not have considered him fit enough to transfer him to the acute unit.

Q In other words, even if you had known for certain that this was a GI bleed, so far as you were concerned, no curative treatment would have been offered to him?
G A Yes.

Q Would you have discussed that with the patient before you took that life-ending decision?
A I discussed it with his wife.

Q We will look at what you said to his wife. Were you giving his wife the option that
H he could go back to the Haslar for treatment?

A A Not to Haslar, back to Queen Alexandra. I was not offering her a choice as much as making clear the stark realities of his situation and that he would not survive the transfer.

Q What Betty Packman told us was this. She got to see him at the QAH. He had been looking a lot better, she said. He improved quite a lot. He was making jokes. He never complained of being in pain. He was transferred to the GWMH for rest and rehabilitation. I visited him every day. On 26 August Dr Barton asked me to come to another room. She B told me his organs were not working properly, he was going to die. I was shattered. I went back and he asked me what she had said. I did not tell him. Now, the patient was compos mentis. He had a good mental test score. Why, if you were making this life-ending decision for him, did you not discuss it with him?
A I cannot be sure at this remove of time what I did or did not say to Mr Packman.

Q Dr Barton, just think about that. You have never suggested in your statement, in the C coroner's inquest, anywhere, have you, that you discussed this life-ending decision with Mr Packman?
A Well, if I said that I had and I had not, I would be telling a lie. I simply cannot remember how Mr Packman was dealt with by myself and the senior nursing staff after this event on 25 August.

Q If you had had such a conversation with Mr Packman and he had said, "It is all right, D doctor, I am happy to die where I am", that is something I expect you might have recorded?
A Yes.

Q You would have recorded it, would you not? I know you did not have much time to make a note but that is a note you might have made?
A It is possible.

E Q Would there be any reason for not saying to Mr Packman, "Mr Packman, we have got two choices here. I can give you pain relief and I can make sure that you are comfortable but you are going to die in the next week or so".
A He was not necessarily going to die. If he survived the myocardial infarction, which he had at that point for 24 hours, if he had no further gastrointestinal bleeding, even with haemoglobin of 7, he could have survived. He was not automatically on a terminal care pathway because of what had happened. It was because of what was possible that was going F to happen.

Q But if the GI bleed continued, what then?
A If he had a further bleed, if he had further chest pain his chances were reduced.

Q I also have a note – I have not checked it and perhaps I will have to – that somewhere there is a nursing note at this time that he was bleeding into a towel.
G A Sorry?

Q He was bleeding into a towel on the bed. I will check that. Obviously you do not have a recollection of that.
A No.

H

Q We will see if that is right. It is a note I have made on my chronology. It is for 26 August. Can we go over the page, please, to page 14? We then have your own clinical notes of that visit. You describe him as being,

"Pale, clammy and unwell. Query MI. Treat stat diamorphine and Oramorph overnight. Alternative possibly GI bleed but no haematemisis",

Meaning no vomiting blood.
A Yes, there was no blood in the vomit.

Q "Not well enough to transfer to acute unit".
A Yes.

Q "Keep comfortable".
A Yes.

Q "Happy for nursing staff to confirm death".
A Which, as you know, was a formality to ensure that should the worst happen, that a duty doctor did not have to be called in from outside to confirm death before the body was moved to the mortuary.

Q I understand that you say that is a formality, but we heard from a number of nurses who said they would read those words, "keep comfortable" --
A As being palliative care.

Q Exactly. And for "palliative care" we can normally read "end of life care", can we not?
A Becoming end of life care, yes.

Q Professor Ford said about your comment,

"Not well enough to transfer to acute unit",

"I cannot follow the logic of that", your logic being basically that, because he was so large, it would be difficult to get him back to the main hospital and he would not suffer the journey well.
A Absolutely.

Q Did you think at this stage, given what was happening with this patient – possible MI taking place, certainly the real possibility of a GI bleed and the possibility that you were making an end of life decision for this patient, the possibility of that – that you should take a consultant's advice?
A I had, in the form of the telephone conversation between Dr Ravi and Sister Hamblin, what I considered was the locum consultant advice. The doctor who had admitted him to the ward, the doctor who had seen him 48 hours earlier and was aware of his general medical condition had said, "Not for resuscitation".

Q I am sorry, Dr Barton --
A Dr Ravi was well aware what we were able to do or not able to do at Gosport War Memorial. When he said, "Not for resuscitation", he was not referring to, "Do not jump on

A his chest, give him CPR, give him oxygen". We could do that, just, but we could not do anything else. So if he had been even for CPR, he would have had to be transferred.

Q Dr Barton, "Not for resuscitation" does not mean, "Do not treat a GI bleed", does it?
A It is not for transfer up to the acute unit where resuscitation is possible.

Q That is not what, "Not for resuscitation" means.
B A That is what it meant to me when I read that, when I heard that from the sister on the ward and when I looked back through this gentleman's medical notes.

Q Let us pause there for a moment. It follows from that that for any of these patients, if you have seen in their notes, "Not for 555" or "Not for resuscitation" or "Not for 444", if that patient becomes ill by reason of something other than their heart, that patient is never going to be fit for transfer back to the main hospital. Is that right?
C A You cannot make a generalisation like that about a whole group of very ill patients. You can make that comment as regards this particular patient. He was too unwell for transfer. He was too unwell for CPR, for 555.

Q Dr Barton, I am sorry. I understand that it may have been your professional, your clinical judgment that this patient was too unwell for transfer.
A It was.
D
Q What I am examining with you is how you interpreted, "Not for resuscitation". It does not mean, necessarily, "Do not send the patient back", does it?
A It means, in your clinical judgment, is this patient fit to even transfer back, and he was not.

Q That is what you think it means?
E A I do.

Q I see. Let us move on to what you did for this patient. At that time you wrote out a prescription for him. First of all we can see diamorphine 10 mg intramuscularly, and that was given to him.
A Yes.

F Q You prescribed Oramorph, 10 mg four-hourly, and also Oramorph, 10-20 mg four times a day, plus 20 mg at night. Now, the first of those Oramorph prescriptions, that means 60 mg a day, does it not?
A Yes, and he was given the first dose of that at night.

Q The second dose of Oramorph, the second prescription of Oramorph means up to 100 mg a day.
G A Certainly.

Q What was the point of writing up those two prescriptions at the same time?
A I gave the nurses a range between 5 and 10 ml, between 10 and 20 mg to be given four times a day and 20 mg to be given at night to see him through the wee small hours.

Q Right, but what was the point of writing out two prescriptions for Oramorph?
H

A A Because the second one was a larger dose than the first, you would not expect the nurses to use both. They would use the superseded larger dose rather than the smaller dose.

Q But the second dose is from 10 to 20 mg.
A Yes.

Q The first dose is for 10 mg.
B A Yes.

Q So the second dose subsumes the first, does it not?
A Yes, it is a larger range for nurses to choose.

Q I am just asking, was there any thinking behind writing up two prescriptions for Oramorph which in fact allow technically nurses to give this man 160 mg of morphine.
C A Because that is what I felt was an appropriate dose to give him at that point in time.

Q Professor Ford again said,

"This man was not destined to die. At least there should have been a discussion with the acute physician".

D You yourself did not pick up the phone to Dr Ravindrane, did you?
A I did not.

Q Let us look and see what happened to him. Page 15, please. On 27 August, there is no clinical note by you but Nurse Hamblin makes a note,

"Some marked improvement since yesterday. Seen by Dr Barton this am – to
E continue with Oramorph four-hourly – same given, tolerated well. Some discomfort this afternoon specially when dressings being done. Wife has visited this afternoon and is aware that condition could deteriorate again".
A Yes.

Q The Oramorph on this second day of his morphine medication is now being given to him at a rate of 60 mg a day.
F A Yes.

Q For what? Why was he being given 60 mg of Oramorph a day?
A Because he required relief from anxiety and distress, and presumably some pain, particularly when those hideous dressings were being changed and his legs were being dressed. He was comfortable on that medication.

G Q The only conceivable reference to pain is "some discomfort", is it not?
A Yes, but that is some discomfort on the medication. It probably would have been very uncomfortable for him without the medication.

Q You say that. Up to this stage again, there had been precious little reference to pain, had there not?
A Yes.
H

Q Except for the pain in his throat, which you had taken to be a sign of myocardial infarction.
A Yes.

Q In fact although these pressure sores were very deep and extremely unpleasant, offensive – however you want to describe them – there had been notes earlier that despite that he was not in pain from them.
A Yes.

Q Until the day before this man was opiate naïve, was he not?
A Yes.

Q Can we take it effectively that this man was now on a terminal pathway?
A I think that over the weekend he became terminal. I think he was still on a palliative care pathway which the nursing staff and I felt was quite appropriate and I think over the weekend he became terminal.

Q We can see that the weekend is 28 August.
A Yes.

Q And the 29 August when he carries on with that same dose of morphine.
A Yes.

Q Although in fact the nurses obviously had the ability to give more if they felt he needed it.
A Yes.

Q Then we come to 30 August, page 17. Sister Hamblin has made a note.

"This mane 30/9/099 complaining of left abdominal pain. Condition remains poor. Syringe driver commenced at 14.45. No further complaints of abdominal pain. Very small amount of diet taken, mainly puddings".

So it is obvious that he is still able to take nourishment and certainly liquid.
A Yes.

Q "Recatheterised. When possible encourage fluids. Dressings renewed".

If we look at the prescription that was written up that day, and this was your prescription, was it?
A Yes.

Q You prescribed him, or you had prescribed him – we had better look at the drug chart at 174. Can you turn up, please, Patient J, pages 174 and 175? Your prescription, I think, appears on page 174. Is that right?
A Yes.

Q You wrote out a prescription for 40 to 200 mg.
A Yes.

Q Did you date that?
A It looks as if I dated it 26 August.

Q This is a daily review prescription, is it not?
A Yes.

Q When we were looking at this earlier --
A I pinched one of their squares. I probably should not have dated it. I dated it the day I actually wrote the prescription, which was unusual.

Q Right, because when we looked at it earlier – I think it was in the Spurgin's case - you were saying that there was not a space for you.
A That is right, yes.

Q So you appear to have written this out on 26 August. I think we may want to amend our chronology, page 14, and just make a note of that, because this prescription does not appear there. I am not suggesting that we redo the chronology, but it may just be worth popping in an asterisk on page 14.
A It is at the top of page 15, so presumably it still comes under 26 August.

Q Sorry. I think for the first time I am looking at an old version of chronology, but it is there, is it? It is under 26 August?
A Yes.

Q Let us come back to page 174. On 26 August you prescribed 40 – 200 mg of diamorphine and your usual prescription of midazolam.
A Yes.

Q Why were you starting higher than normal on 26 August, please?
A Because he was 26 stone and I was minded that when I did, if I did need to start the syringe driver, 20 mg would not be an adequate dose.

Q But at that stage, on 26 August, there was no indication that you would need to start a syringe driver, was there?
A There was an indication to me that he might well deteriorate, but no, at that point there was no indication.

Q That is right.
A It was an anticipatory prescription.

Q But at that stage you were dealing with what you thought to be a myocardial infarction.
A Yes.

Q Which you would not be dealing with by way of syringe driver, would you?
A Possibly.

Q What do you mean, "possibly"?
A Possibly if he had gone into congestive cardiac failure or if he had not recovered from the myocardial infarction the syringe driver would have been appropriate.

Q All sorts of things are possible.
A Yes, and that is why I wrote it up anticipatorily.

Q Can we go back please to page 17? On 30 August we have been through the note. Can you just help me with, "abdominal pain"? Is that something you would normally want to give diamorphine for?
A Not as an isolated symptom on its own, but in this particular gentleman whose condition remains poor, and a known possibility – by now I had seen the full blood count. I knew that he had had at least one gastrointestinal bleed. I would have wanted to treat him with adequate opiate and something for the anxiety and terminal restlessness.

Q This is inevitably, once you have started the syringe driver, the end of his life, is it not?
A He is not ending his life because of the syringe driver, but because of the underlying condition.

Q In general terms – I do not have his exact words – Professor Ford seems to think that it was inappropriate to use diamorphine to treat abdominal pain; would you agree with that as a generality?
A As a generality and Professor Ford was not standing at the bedside of this particular gentleman on that Monday afternoon. Up until this stage of course this gentleman had been on 60 mg of oral morphine daily; yes?
A Yes.

Q This was in effect, when you started this diamorphine, to double his dose.
A Yes.

Q And you added to that "infusion 20 mg of midazolam".
A I did.

Q That was to do what to him?
A To deal with anxiety and the possibility of terminal restlessness.

Q Up until this point, as we have seen, he had been taking some food – he liked his puddings. Was there any reason not to continue with oral morphine?
A The report from my nursing staff that he was continuing to deteriorate, and in discussion with them, we would have decided that that was the point at which to start subcutaneous analgesia.

Q Since we have the file open can we look at page 64? You suggested, as I understood it, in passing that the initiation of this syringe driver may have been on the orders of a duty doctor.
A There is no mention in the nursing notes as to who sanctioned the syringe driver on that day. I had written it up the previous week. It was a Bank Holiday Monday; it is possible that I would have gone in to see the patient; it is possible that a duty doctor saw him.

Q If it was a duty doctor it is very surprising indeed, is it not, that he has made no clinical note?
A Quite.

Q You agree with that, do you not?
A I do.

Q It is one thing for you who knows the staff well, you knew the patient, you knew the hospital.
A Yes.

Q But if a duty doctor walks in there and says, "Right, we are going to start this patient on his terminal pathway and put a syringe driver up it would be fairly astonishing if he or she did not make a clinical note.
A Absolutely.

Q And it looks in fact, does it not, as if this syringe driver was set up and started by Sister Hamblin.
A It is possible.

Q And she could have done that?
A In discussion with me at the time or in discussion subsequently, yes.

Q With or without discussion at the time with you.
A Yes.

Q Her dose doubling up the morphine is on the basis of your prescription because your prescription only allowed for a doubling up, did it not?
A Yes.

Q And you anticipated, did you, many days earlier that that is exactly what he had required?
A I did.

Q Your prescient knowledge of that would be based on what?
A Knowledge of the patient, having seen him the previous week and long experience of starting doses of subcutaneous analgesia when needed, faced with a particular patient.

Q Then at the bottom of page 17 we can see that he is said to be comfortable and having a peaceful night but he passes a large amount of black faeces and that is a clear indication, is it not, of a significant GI bleed?
A He has obviously had a further GI bleed.

Q But he passes a large amount of black faeces and that is a clear indication, is it not, of a significant GI bleed?
A He has obviously had a further GI bleed.

Q That is a GI bleed that has gone untreated since it was first suspected?
A It has recurred since it first occurred the previous week, yes.

Q He is reviewed on 1 September, as we can see, by Dr Reid, on page 18:

"Rather drowsy but comfortable."

A

Can we just look at this because his syringe driver is in fact increased by Sister Hamblin on the same day.

A At 19.19.

Q Dr Reid would have been seeing this patient when?

A That afternoon.

B Q He describes him as:

"Rather drowsy but comfortable. Passing [something] stools Abdomen huge but quite soft."

A Melaena stools.

Q Meaning black with blood in them?

C A Yes.

Q "Abdomen huge but quite soft, pressure sores over buttock and across posterior aspect of right/left thigh. Remains confused."

That is very likely to be the drugs taking effect, is it not?

A Yes.

D

Q This is the man who previously we have seen who had a high mental test score.

"For TLC. Wife aware of poor prognosis."

But underneath we see that the syringe driver is renewed by Sister Hamblin.

A As previous dose not controlling symptoms.

E

Q I was not going to stop. At quarter past seven in the evening:

"...with diamorphine 60 mg and midazolam 60 mg as previous dose not controlling symptoms. Dressings renewed this afternoon. Mrs Packman has visited and is aware of the poor prognosis."

F So in the afternoon he is described as comfortable. Sister Hamblin, on the basis of your prescription, increases the diamorphine from 40 to 60 and the midazolam goes up to 60. It looks as if it was tripled in a day, does it not?

A It does.

Q He was given 40 at 3.45 and then 60 at 7.15. That would have a profoundly sedating effect on him, would it not?

G A Which presumably the reason was that she wished to control the confusion mentioned by Dr Reid on his ward round, which she would have felt was terminal restlessness.

Q This is his wife's description of this patient on the same day, on 1 September:

"He was unable to talk, he was unconscious."

A I am unable to comment about what Mrs Packman saw when she visited her husband.

H

Q And his daughter said this, after he got to your hospital:

"He was fine for the first three days. Then we got a phone call saying that he had had a heart attack. We went down. He told mum that he had had a bad case of indigestion. Two days later he was away with the fairies. He was drowsy; he could not feed self or drink self. It was quite shocking. After that he was comatose."

A That does not really fit with still taking puddings at the weekend, but there had obviously been a profound change in him during the time that his daughter was visiting.

Q Her timing obviously may well be out.
A It may well be out.

Q And as we can see, if we stay with page 19, on 2 September, the day of the next day, his diamorphine is increased once again, up to 90 mg and his midazolam is now up to 80 mg. Can we just remind ourselves that he had been started on morphine on 26 August.
A Yes.

Q We are now on 2 September and there is no question, is there, that the drugs by this stage would have caused a rapid deterioration?
A His condition caused the rapid deterioration; the drugs were administered to alleviate the symptoms of the rapid deterioration. They were not necessarily causing it; they may have been contributing to the drowsiness but they were relieving his symptoms. The constant balance in terminal care of a patient.

Q Despite the fact that he appears to have been comfortable when seen by Dr Reid on the afternoon of 1st it was felt necessary to increase his diamorphine and his midazolam not once but twice.
A Dr Reid was seeing a snapshot view of a gentleman he had not, as far as I know, previously met. The nursing staff were dealing with him and seeing to him 24/7 and were perfectly competent to make a decision with reference to me, if necessary, as to what dosage of drugs he should have.

Q There is no question, is there, that this patient ultimately died, at least in part, from a GI bleed?
A Certainly.

Q Why did you record his cause of death as an MI?
A Because I felt that he had on the previous Wednesday, Thursday had a myocardial infarction and that had led on to the problems that he had. I should have put gastrointestinal bleed perhaps as number two.

Q Sorry, when you say it went on to cause the problems that he had?
A He had a myocardial infarction.

Q Yes. It did not cause a GI bleed though, did it?
A No, I do not think so.

Q He died, as you have told us, of a GI bleed.
A He died as the... I do not know what he died of. He died as a result of a subsequent GI bleed, I imagine. It is difficult to say what actually happens in that terminal phase, what

A the actual final cause of death was. But I felt that in his case the myocardial infarction was very significant.

Q Was there any concern in your mind when you wrote out that certificate that if you put down that he died of a GI bleed that somebody might inquire of you why he had not been treated for it?
A None at all.

B

Q Shall we move on to the next patient? That is Elsie Devine, Patient K.
I should just say that Mr Fitzgerald has looked to see if there is any support for my comment about bleeding into a towel and he cannot find it either. I am afraid I do not know where I got it from, so we should ignore it.

This lady on her transfer to you, which took place on 21 October 1999, had a – and
C I know what you are going to say about it but I am asking you to assist – good Barthel Score relative for her age and for the type of patients you normally received. She is Barthel 8.
A Yes, and I am going to say that that only reflects one aspect of her functioning.

Q I know you are.
A Her mental test score was not 20 out of 20.

D Q We understand that. And this was the lady who had been diagnosed with nephrotic syndrome. Can you just remind us again what that really means?
A She had an ongoing and progressive damage to her kidneys, which was eventually going to become terminal and had been decided by her consultants that it was not treatment.

Q I just want to ask you about this perhaps to clear it out of the way. She had been taking a drug called trimethoprim, had she not?
E A On two occasions.

Q I think you prescribed trimethoprim as well.
A I did. She had it I think once at the QA and I prescribed it. It is a urinary antibacterial for a presumed urinary tract infection.

F Q So that would be to deal with the UTI. Can trimethoprim have the consequence in increasing creatinine levels?
A We discussed this at the Coroner's inquest ---

Q You did.
A ...and was felt that if there was it was mild and transient and uncommon.

Q In any event, once she was at your hospital she was no longer taking trimethoprim.
G A No.

Q So certainly your view would be that that would not be effecting her creatinine levels?
A Not when she arrived, no.
Q Can we go to page 4, first of all, just to have a look at her admission into the Quee
Alexandra Hospital? She there had an episode of acute confusion. She was described as
being "confused, aggressive and wandering". Her diagnosis was multi-infarct dementia a
H CRF.

A the actual final cause of death was. But I felt that in his case the myocardial infarction was very significant.

Q Was there any concern in your mind when you wrote out that certificate that if you put down that he died of a GI bleed that somebody might inquire of you why he had not been treated for it?
A None at all.

B

Q Shall we move on to the next patient? That is Elsie Devine, Patient K.
I should just say that Mr Fitzgerald has looked to see if there is any support for my comment about bleeding into a towel and he cannot find it either. I am afraid I do not know where I got it from, so we should ignore it.

This lady on her transfer to you, which took place on 21 October 1999, had a – and
C I know what you are going to say about it but I am asking you to assist – good Barthel Score relative for her age and for the type of patients you normally received. She is Barthel 8.
A Yes, and I am going to say that that only reflects one aspect of her functioning.

Q I know you are.
A Her mental test score was not 20 out of 20.

D Q We understand that. And this was the lady who had been diagnosed with nephrotic syndrome. Can you just remind us again what that really means?
A She had an ongoing and progressive damage to her kidneys, which was eventually going to become terminal and had been decided by her consultants that it was not treatment.

Q I just want to ask you about this perhaps to clear it out of the way. She had been taking a drug called trimethoprim, had she not?
E A On two occasions.

Q I think you prescribed trimethoprim as well.
A I did. She had it I think once at the QA and I prescribed it. It is a urinary antibacterial for a presumed urinary tract infection.

F Q So that would be to deal with the UTI. Can trimethoprim have the consequence in increasing creatinine levels?
A We discussed this at the Coroner's inquest ---

Q You did.
A ...and was felt that if there was it was mild and transient and uncommon.

Q In any event, once she was at your hospital she was no longer taking trimethoprim.
G A No.

Q So certainly your view would be that that would not be effecting her creatinine levels?
A Not when she arrived, no.
Q Can we go to page 4, first of all, just to have a look at her admission into the Queen Alexandra Hospital? She there had an episode of acute confusion. She was described as being "confused, aggressive and wandering". Her diagnosis was multi-infarct dementia and
H CRF.

A A Chronic renal failure.

Q Thank you. Then she is reviewed by Dr Taylor, who is the Clinical Assistant in old age psychiatry. Again, there are comments about her dementia. With patients who suffer from dementia, again can we take it that they have their good days and they have their bad?
A Yes. It is not a steep, vertical slope; they may have plateau days. But overall the general impression is a downward progression.

B

Q I understand that. Top of page 6, please. She is reviewed by Dr Jayawardena, consultant geriatrician and transfer is arranged to your hospital. She is described as suffering from:

"Moderate chronic renal failure. Admitted with a history of UTI."

C She is described as being:

"Quite alert. Can stand. Rather unsteady when walking."

She was, I think, 88 when she was with you.
A Yes.

D Q "Chest clear. No evidence of cardiac failure. Suitable for a rehabilitation Programme. Will arrange transfer to GWMH."

And she was transferred to your hospital. In your view was that an appropriate transfer?
A Yes. This lady patently was going to need institutional care. There had been a lot of discussion with the family about where this would take place and whether they were going to have her back and she came to us as a holding operation while these things were sorted out
E within the family. So at that point she was medically stable and there was no problem about looking after her.

Q She needed a safe and secure environment; agreed?
A Yes.

Q She had had no pain whatever – not that is recorded, I do not think, in the notes.
F A No, no pain.

Q Do you disagree with that because we can look back through it.
A No, she may have had pain when she had her original urinary tract infection that took her into QA, but when she arrived on Dryad Ward she did not seem to be in any sort of pain.

Q And as far as I can see I do not think she had had any significant analgesia at any
G stage?
A No.

Q Then she comes to your care on 21 October.
A Yes.

Q And you have made a note that she transfers with one and you set out her previous
H medical history; you accept, I think that the myeloma is wrong.

A A Was incorrect, yes.

Q "So far continent, needs some help with activities of daily living."

Not a particularly good mental test score, is it, nine out of 30?
A No.

B Q And that is a result of her dementia.
A Yes.

Q But her Barthel is 8 and we have both commented on that.

"Get to know. Assess rehabilitation potential. Probably for rest home in due course."

C Was that your genuine view?
A Yes.

Q "Needs minimal assistance with ADLs. Very pleasant lady. Appetite not good. Can be a little unsteady on feet. Both feet swollen. Seen by Dr Barton."

Then we come to your prescription and you have given her thyroxine for her hypothyroidism.
D A Yes.

Q Frusemide?
A A diuretic for her renal function, to reduce the oedema in her legs.

Q Temazepam to help her sleep at night, presumably?
A Yes.

E

Q And Oramorph. And your comment about the Oramorph, similarly with a patient we looked at yesterday evening was, "I felt she was entitled to this." Do you remember that?
A Should it become necessary for any reason in the future. It is written on the prn chart and I was not expecting it to be used unless it became necessary for any reason at all, and it never was administered.

F Q No, it is just your prescription that we are looking at though, and your basis for writing it. And your basis for writing it was that ---
A Should she need it at any time in the future; if she developed an acute illness or an acute problem the nursing staff had something available to give her for analgesia.

Q This was a patient who, as far as we are concerned, effectively had not had pain?
A Absolutely.

G

Q There was no reason to think that she was going to have pain at this stage of her admission, was there?
A None at all.

Q So you were writing out a prescription for the third category in the analgesic ladder because she might – even though there was no basis for it at all at that stage – one day have
H pain?

A A Yes.

Q Let us move on. We can see that the next note that we have after your clinical note of 21 October is on 25th. She is seen by Dr Reid and she is getting herself about and she can dress herself. She is continent but she has got chronic renal failure. On Monday 1 November, the next note is by Dr Reid. He notes that she is "Physically independent but needs supervision of washing and dressing..... Continent. Quite confused and disorientated. B Unlikely to get much social support at home, therefore try home visit to see if functions better in own home."

Then over the page we can see that you prescribed Amiloride, is it?
A Yes, an additional diuretic to work in conjunction with the frusemide.

Q Then on 10 November we see that she is said to be "Confused during the night, C wandering around ward. Refused night sedation". So this is the beginning of something of a problem presumably for her and also for the nursing staff?
A That is superimposed on a very gradual deterioration noted by Dr Reid at each of his ward rounds and the common things commonly occur. We assumed that she might have a urinary tract infection so that a mid-stream urine sample was sent off and she was started on Trimethoprim.

D Q You also prescribed Thioridazine.
A I did.

Q Which is?
A A major tranquiliser.

Q I was going to say, a major tranquiliser. The purpose of that was what – to make her E less agitated?
A Yes, make her less agitated, make her wander less, hopefully, and make it, I am afraid, easier for the nurses to look after her.

Q She stays on that major tranquiliser which is administered to her I think twice a day.
A Yes.

F Q If we go to page 11, she is seen by Dr Reid. He is described as being very aggressive at times. "Ask Dr Lusznat to see". Dr Lusznat we remember was ---
A The psychogeriatrician.

Q Thank you. She has begun on occasion refusing her medication, as we can see. Can we go on now please to page 13 because she was actually reviewed by Dr Taylor. Is Dr Taylor also a psychogeriatrician?
G A Yes.

Q "This lady has 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."

H Mulberry Ward of course being effectively the geriatric psychiatric ward in the hospital?

A A Yes.

Q And that would be a secure ward, would it?
A It would be more secure than our ward, yes.

Q "Mrs Devine is now at Dryad" having been transferred on 21 October. She is "aggressive, wandering, moving other people's clothes, refusing medication, poor appetite.
B Reviewed on ward. Happy, no complaints."

So there are periods for this lady where she is happy and contented and all right but obviously there are periods when she is confused and agitated?
A I fear that she was probably happy with no complaints because the fentanyl patch had been administered at 9.15 that morning and the level was beginning to build up and was making her feel more comfortable, slightly euphoric and happier than she had been when the
C referral was made to psychogeriatricians.

Q We have not yet got to the stage which takes place the next day I think when she is very aggressive?
A No. This is 24 hours before.

Q Exactly. You prescribed fentanyl – to deal with what?
D A I felt that Elsie was entering the end-stage of her dementia superimposed on end stage of her renal failure and, as it turned out, there had been a marked deterioration in her creatinine. The result I think was not available until the next morning, but I felt that clinically she was going downhill quite quickly and I was minded to deal with her symptoms of restlessness, agitation, fear, anxiety in an appropriate way by using a transdermal opiate. I know it is licensed only for pain relief and I know also that in palliative care you often go outside the licence of a particular drug if you feel it is appropriate for that patient in front of
E you.

Q I think you also told the Panel that because it was a synthetic drug, you thought there was something about it ---
A Being appropriate for people with renal problems.

F MR KARK: I am going to show you both the patient leaflet and also what we have been able to get from the manufacturers of Durogesic. I have given Mr Jenkins a copy of this yesterday. I will give you a copy and the defence another copy. (Copies distributed) I am afraid, as the Panel will see, one of the copies has sadly, particularly in the area that you need it most of course, been lopped off on the right-hand side.

THE CHAIRMAN: Are you going to give this an exhibit number?

G MR KARK: I was going to suggest, if this is convenient and appropriate, to put it at the back of our BNF section where we are looking at all the other drugs. I do not know if that would be sensible.

THE CHAIRMAN: Mr Langdale, you have not objection? Very well. We will place these at the back of the BNF tab in volume 1.

H MR KARK: It is tab 3 in panel bundle 1 and this will be pages 54 onwards. I am not going

to put it away just for the moment. In due course that is where it will go. Dr Barton, I will give you a moment to look at this and then I am going to ask you to help us about various aspects of it because we have looked at fentanyl but we have not really seen much about it so far. The first three pages, as I understand it, are the leaflet that comes with the ---

A The patient leaflet, yes.

Q The patient leaflet. Can we just go through this together before coming back to ask you to look at Elsie Devine. If we look under the column on the left hand side, we can see the heading

> "What is the name of this product and its ingredients?
> The name of the produce is Durogesic."

That is the same as fentanyl.

> "1. The Durogesic 25 patch contains 2.5 mg of fentanyl and gives a dose of 25 micrograms of fentanyl every hour."

If we look under the next heading "What is Durogesic" we see the last words of the first paragraph: "Each patch lasts for three days." The next heading is

> "What kind of medicine is the Durogesic patch?
>
> Durogesic patches contain fentanyl. Fentanyl is one of a group of strong painkillers called opiods, which must be used only under a doctor's instruction."
>
> "What do Durogesic patches do?
> Durogesic patches help relieve very bad and long-lasting pain. They do this by slowly letting the painkiller, fentanyl, pass from the patch, through the skin and into the body."

On the right-hand side; "Who cannot use Durogesic patches?" At the second bullet point:

> "Durogesic patches are only suitable for long-lasting pain and are not suitable for pain which lasts only for a short period."

Pausing there, the reason for that is because the patch is meant to be on for three days.

A The patch takes 24 hours to build up to its steady state level of activity and lasts for three days. It would not be appropriate to give it for somebody who was having a mild cardiac infarction. It will not give you an acute level of pain relief or anxiety or distress relief.

Q Rather like a syringe driver, it is not there for instant pain relief, is it?

A It is much slower to reach its steady state than the syringe driver.

Q "What shall I know before using Durogesic patches?

> If any of the following apply to you then please tell your doctor before using....
>
> - problems with your lungs or breathing

A

- problems with your heart, liver or kidneys
- headaches or head injury

If you are very ill, very thin or elderly, you may be more sensitive to the effects of Durogesic patches."

So far as that is concerned, the thin and the elderly you would have been well aware of?

B A Yes.

Q I want you to understand this in context. Professor Ford was not overly critical of the use of the fentanyl but it is what happened thereafter and the addition of other drugs, you will remember, that he was most particularly concerned about.

A Yes.

C Q We can see, just following on in that section:

"Like some other strong painkillers, Durogesic patches may make some people unusually drowsy and breathe more slowly or weakly than expected."

Then it tells the patient what to do if that happens to them, one of which is to take the patch off immediately. Can you go half-way down the page; "Can I take other medicines if I am

D using Durogesic patches?" At the second paragraph:

"There are some medicines that we know can affect the way Durogesic patches work. These medicines include some other painkillers, sleeping pills" et cetera "Your doctor will know which medicines are safe to take with Durogesic."

You would have to be very, very careful at prescribing opiates of a type if a patient had a

E Durogesic patch on, would you not?

A You would not be looking for prescribing them at the same time for any length of time.

Q That, you would agree, would be a very bad practice?

A It would be inappropriate to run them both. What we had to do the following day was to take the patch off and then institute the syringe driver in the same way that we had done in

F a previous patient and allow the level of the Durogesic to diminish as the level of the syringe driver increased.

Q But again you would be aware – and we will see this I think as we go on through the leaflet – that even once you have taken the patch off, the effects of it are going to continue because the drug is still going through the skin?

A And diminish through that next 24 hours. I was aware of that.

G

Q We will look at it in a moment to see how long it takes to diminish. We do not need to look at the next page, unless anybody is keen to do so. Can we go to the last page of the patient leaflet:

"Occasionally Durogesic patches can also cause the following:

H

- sickness or feeling sick

- drowsiness
- hallucinations
- skin rashes
- dizziness
- confusion
- feeling 'high' or unusually care-free
- difficulty going to the toilet".

All of this you would have been aware of?
A Yes.

Q Can we go to what I have marked as 57? It is the one with close type and three columns. If we look at the left-hand column, we can see, two-thirds of the way down, "Durogesic" is the heading. It describes how the system works, releasing fentanyl into the systemic circulation over a period of 72 hours. Then under "Uses",

"Durogesic is indicated in the management of chronic intractable pain due to cancer."

Although it is rather technical, could we look three lines underneath that?

"Durogesic provides continuous systemic delivery of fentanyl over the 72 hour administration period. After the first Durogesic application, serum fentanyl concentrations..."

Does that effectively mean fentanyl in the blood?
A Yes.

Q Just to keep it simple.

"..serum fentanyl concentrations increase gradually, generally leveling off between 12 and 24 hours and remaining relatively constant for the remainder of the 72-hour application period."

Yes?
A Yes.

Q Please go a few lines on to the middle column and the first paragraph:

"After Durogesic is removed, serum fentanyl concentrations decline gradually, falling approximately 50% in 17"

– and that is the median hours, the range being between 13 and 22 hours. Let us pause there for a moment. On average it takes 17 hours to lose half its strength. Is that a reasonable way of putting that?
A Yes.

Q "Continued absorption of fentanyl from the skin accounts for a slower disappearance of the drug from the serum than is seen after an iv infusion. Fentanyl is metabolised primarily in the liver."

A A That was why it was appropriate for a lady with problems with her renal function.

Q We will look at that in a moment but I understand that that is what you say. You see a little table, and we have looked at this before; I am not going to take any time over that. It is the same table that appears, I think, in the BNF. Underneath that do you see this?

B "For both strong opioid-naïve and opioid-tolerant patients, the initial evaluation of the analgesic effect of Durogesic should not be made before the system has been working for 24 hours due to the gradual increase in serum fentanyl concentrations up to this time."

Yes?
A Yes.

C Q At the bottom of the page, please, same column:

"*Disconsolation of Durogesic:* If discontinuation of Durogesic is necessary, any replacement with other opioids should be gradual, starting at a low dose and increasing slowly. This is because fentanyl levels fall gradually after Durogesic is removed; it may take 17 hours or more for the fentanyl serum concentration to decrease by 505. As a general rule, the discontinuation of opioid analgesia should be
D gradual."

Then it deals with elderly patients, which this patient undoubtedly was.

"Data from intravenous studies with fentanyl suggest that elderly patients may have reduced clearance, a prolonged half-life and they may be more sensitive to the drug than younger patients."

E

Can we just pause? A prolonged half-life means that it is going to take longer in that range that we have looked at earlier?
A This is a study done using the drug intravenously. It does go on to say that pharmacokinetics did not differ significantly from young patients though serum concentrations tended to be higher. I do not think you can extrapolate across what happens when you give the drug intravenously to using it transdermally.

F

Q That is a legitimate point and I accept that. Can we move on to see what it says next:

"Elderly, cachectic" and it should be "debilitated patients should be observed carefully for signs of fentanyl toxicity and the dose reduced as necessary."

That would apply, would it not, to the patch equally?
G A Yes.

Q Then,

"Contra-indications, warnings, etc."

"Durogesic is a sustained-release preparation indicated for the treatment of chronic
H intractable cancer pain and is contraindicated in acute pain because of the lack of

A opportunity for dosage titration in the short term and the resultant possibility of significant respiratory depression."

Then we can see "Respiratory depression". If at any time you find me filling in part of the word on the right-hand side and you disagree with my interpretation, then I am sure you will let us know.

B "As with all potent opioids some patients may experience significant respiratory depression with Durogesic; patients must be observed for these effects. Respiratory depression may persist beyond the removal of the Durogesic system."

So that is the long-lasting effect of fentanyl, is it not?
A Yes, the following 24 hours.

C Q If you look below, you will see that there is specific comment about those with hepatic disease and renal disease. We are dealing with renal disease, are we?
A Yes.

Q Let us look at that:

D "Less than 10 per cent of fentanyl is excreted unchanged by the kidney and, unlike morphine, there are no known active metabolites eliminated by the kidney. Data obtained with intravenous fentanyl patients with renal failure suggest that the volume distribution of fentanyl may be changed by dialysis".

A Again that is not appropriate in this administration.

E Q "That may affect serum concentrations. If patients with renal impairment receive Durogesic, they should be observed carefully for signs of fentanyl toxicity and the dose reduced if necessary".

A Absolutely.

F Q Does that provide any support, as it were, to your contention of this being a sympathetic drug?
A It says that less than 10 per cent of fentanyl is excreted unchanged by the kidney, and it does not produce active metabolites. So it was an appropriate drug to use in that lady in those particular circumstances.

Q Can we look, please, at drug interactions, and this is the last passage I will ask you about. It is at the top of the next page, left hand column,

G "Drug interactions, the concomitant use" –

meaning at the same time.
A Yes.

Q "of other CNS depressants, including opioides may produce additive depressant effects, hypo ventilation",

H

A meaning lowered breathing.
A Yes.

Q "hypo tension", meaning lowered blood pressure.
A Yes.

Q "and profound sedation or coma may occur. Therefore the use of any of these drugs
B concomitantly with Durogesic requires special care and observation".

A Yes.

Q Finally, "Side effects", two paragraphs down,

"The most serious adverse reaction as with all potent opioids is hypo
C ventilation. Other opioid-related adverse reactions include nausea, vomiting, constipation, hypertension, somnolence, confusion, hallucinations, euphoria, pruritus".

What is that?
A Itch.

D Q Thank you, and "urinary retention". That is all that I want to ask you about that document. I was proposing to go on with this patient, unless doctor you need a rest at any stage. I am entirely in your hands again.
A I am fine.

Q I am just aware that we have been going longer with this patient than normal. So she is given a fentanyl patch at 9.15 on the morning of 18 November. That night we see that
E there is a marked deterioration overnight, yes?
A Yes.

Q She is described as being confused and aggressive. Her creatinine is now up to 360.
A Yes.

Q The fentanyl patch commenced yesterday. Today further deterioration in general
F condition. Needs subcutaneous analgesia with midazolam".

Now this is your clinical note, is it not?
A Yes.

Q "Son seen and aware of condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death".
G

This lady, I expect you would say, is now on her terminal pathway.
A I would.

Q We know that she was in fact because she died two days later. She is described as "extremely aggressive", and we heard that vivid account of this patient holding on to the rails at the side of the ward. Is that something you witnessed yourself?
H A Yes.

A

Q It is. Were you called to that incident?
A I arrived on the ward to find this incident going on at 7.30 that morning.

Q So what happened to this lady from hereon in, you would have been very well aware of.
A Yes.

B

Q You would have been well aware of the fact that this lady was already on fentanyl.
A Yes.

Q She was refusing help from staff and at 8.30 you authorised the use of chlorpromazine.
A I did.

C

Q That should have had an immediate calming effect.
A It is a major tranquiliser, hopefully to sedate her and allow them to get her into bed.

Q Is it the sort of thing that is used in mental hospitals?
A Yes.

D

Q It is a shot in the arm or the buttock, presumably, which quietens the patient right down.
A Yes.

Q So that is given to her at 8.30. Fifty-five minutes later a syringe driver is commenced.
A Yes.

E

Q You would have known how important it was to have removed the fentanyl patch prior to that starting.
A It needs to be removed approximately at the same time so you can start the process of the fentanyl level lowering as the syringe driver level, as Professor Ford said, does not immediately kick in but the level begins to build up. So you want to achieve a seamless cross-over of the two agents to keep the patient comfortable.

F

Q Dr Barton, as we have just seen in the leaflet, it takes an average – not for an old person but an average – of 17 hours for that fentanyl to reduce to half its potency.
A Yes.

Q So with an elderly frail person who would be particularly susceptible to the effect of opiates, you need to be particularly careful, do you not?
A Yes.

G

Q Otherwise the danger is that you are going to over-sedate them and possibly kill them.
A She needed sedation badly at that stage. I was not minded to allow her to rev up again and cause herself damage later on in the day with a recurrence of the behaviour that I had seen at 7.30 in the morning. I had to provide adequate sedation for her.

Q I understand your reasoning, but the danger that I have just put to you is that, with this
H lady who was very elderly -- she had fentanyl in her system -- there is a considerable danger,

A is there not, with her particularly, when you use opiates that if you do not get the dose right you are going to over sedate her and kill her?
A There is a danger of over-sedation, yes.

Q How long does the chlorpromazine last?
A Four hours.

B Q Four hours, before it begins to reduce or is gone completely?
A No, I would think if it was given intramuscularly that it was down to its second or third half-life by lunch time.

Q With a syringe driver, we have spoken a lot about syringe drivers, but the drugs from a syringe driver start immediately, do they not?
A At a very low dose.

C Q At a very low dose.
A And build up.

Q The drug that you had decided to administer to this patient, at its lowest – we can see at page 15 – was 40 mg of diamorphine. Yes?
A Yes, which was pretty much by my reckoning, an exact cross-over from the dose of
D the fentanyl patch.

Q With the fentanyl patch at its full strength.
A Which it was.

Q Which it was.
A Which it was.

E Q At the time that you start the syringe driver you are well aware that the fentanyl patch is at full strength, are you not?
A Yes.

Q She has been given chlorpromazine, which is a major tranquiliser.
A And she is acutely aggressive, anxious and frightened, so I have to give something
F with the diamorphine in the syringe driver to control that anxiety and aggression and fear, and that was the midazolam.

Q At the time you started the syringe driver, Dr Barton, she was none of those. She was in bed, was she not?
A Because she had had 50 mg of chlorpromazine and I was not going to give her any further chlorpromazine.

G Q I understand that, but at the time you started the syringe driver she has now got fentanyl in her system. Yes?
A Yes.

Q She has now got chlorpromazine in her system, which is going to last four hours or so, and you set up a syringe driver with 40 mg of diamorphine in an elderly patient, and 40 mg of
H midazolam.

A A Yes.

Q Professor Ford described this as "extremely excessive".
A I do not agree. I felt that the dosages were appropriate for the clinical condition that I was faced with that morning in that particular patient.

Q He said of your use of midazolam,

B

"This demonstrates a misunderstanding of the use of midazolam".

You do not agree with that.
A I do not agree with that.

Q He said,

C

"The fentanyl would be persisting in its effect and you are exposing the patient to much greater effects. Conservatively you are adding 20 to 30 mg of diamorphine".

This would have had a profoundly sedating effect upon this patient, would it not?
A If you agreed with his calculations, yes.

D Q Well, let us take your calculations for a moment. The fentanyl patch at the time the syringe driver started, you had not in fact organised or directed or ensured that the patch was removed, had you?
A Nursing staff understood that once they had got everything else sorted out and organised, they would then remove the patch from this lady, and that was done at 12.30.

Q Sorry, everything else "sorted out and organised"?
E A After they had got her into bed and got her washed, and got her comfortable because she had been in her nightwear hanging onto the bars in the corridor of the ward. It was not their first priority to remove the patch. It was the first priority to get her into bed, get her comfortable and get the syringe driver set up.

Q It should have been their first priority, should it not?
A That is a nursing procedure.

F

Q No, Dr Barton. You authorised this syringe driver, did you not?
A Yes, and I authorised that the patch be taken off.

Q Why did you not direct or ensure that it was taken off immediately or do it yourself?
A Because I was going to do a ward round on the rest of the ward and the other ward and go and do a morning surgery. I was not in the habit of handling fentanyl patches.

G

Q You were not in the habit of handling fentanyl patches.
A No.

Q I see. Let us look at this lady's condition at about 10.30. The syringe driver is up and running, beginning to put 40 mg of midazolam and 40 mg of diamorphine into her. She is still under the effect of the chlorpromazine, is she not?
H A Yes.

Q And the fentanyl patch is at its peak.
A Yes.

Q Are you concerned in any way about that now, with the benefit of hindsight?
A No, I am delighted that she is now comfortable and they have been able to get her into bed and nurse her properly.

Q You see nothing wrong with that situation?
A Nothing at all.

Q When you saw her daughter on 19 November that afternoon.
A Evening.

Q I beg your pardon. Freda Shaw saw her on the afternoon of 19 November and simply said to her,

> "'She will not know you, love. She has been sedated to be comfortable'. Mum squeezed my hand, otherwise she gave no reaction. She did not open her eyes. I met Dr Barton around 5 o'clock. She did not introduce herself. She said, 'Follow me'. She said, 'You know your mother has multiple myloma', and she said that she was in shock".

She said that she did not know. She said there was no discussion about the syringe driver or fentanyl that day. That is a pretty unsatisfactory state of affairs if that is right, is it not?
A If that is correct. That interview, it does not sound as if, having come back from having finished a duty surgery in the evening, that I would have neglected to mention the treatment that her mother was having and the concerns we were having about her general condition.

Q You unfortunately made no note about it.
A I made no note about the conversation, no.

Q On the Sunday, on 21st, the patient is still on her diamorphine and the midazolam and she dies at 8.30 in the evening. Yes?
A Yes.

Q In your view her cause of death was chronic renal failure.
A It was.

Q Would you accept that with that amount of opiates in her body, a significant cause of death may have been opiate sedation?
A I still consider that the cause of her death was chronic renal failure.

MR KARK: Sir, we are about to move on to the last patient. Would that be a convenient moment?

THE CHAIRMAN: Thank you very much indeed, Mr Kark. We will come back just before 11.30 please, ladies and gentlemen.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Mr Kark, before you commence, a little bit of timetabling. May I please formally inform the parties that this Panel will rise early on Tuesday 28 July? A Panel member is required elsewhere and efforts were made to minimise the disruption and that is the result of it. It will be a 3 o'clock rise, so we will lose two hours. If it looks, Mr Langdale, as if in any way that is going to cause difficulties then we will look at ways in which we can sit earlier – shorter lunches or whatever.

MR LANGDALE: I am sure we will be able to work round it, sir.

MR KARK: Dr Barton, we are moving on to the last patient, Mrs Jean Stevens and I am going to take you back to 30 April, which we find at the bottom of page 5 of the chronology and over the page. This patient had, just to remind ourselves, she had collapsed at home. She had had chest pain and I think the diagnosis was that she had had a probable right infarction in her brain.

A Yes.

Q So she had had a stroke.

A A major right-sided stroke.

Q Then we can see that on 30 April she is described, at the top of page 6, as "bubbly". Suction with no effect. She has no gag reflex and the nasogastric tube is down, query, aspiration. Patient very distressed. Then they x-ray her and they found that although the nasogastric tube is in, it cannot be seen on the x-ray and it appears that it has been somehow misplaced and so she has been receiving her liquid supplements, I suppose it is, straight into the lungs.

A Yes.

Q Which would have done her no good. Professor Ford commented that it is certainly possible that her pneumonia would have been caused by that. That having been rectified, if we go over to page 7 we can see on 5 May she is described as taking food, or beginning to take food orally,

> "To start foods as directed by speech therapist. She has got some residual weakness and sensory inattention but improving. Referral to Dr Lord: 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 the acute medical side".

Over the page, again, there is a reference to aspiration, pneumonia, in respiratory failure, "Poorly ++. In distress". She was given small doses of diamorphine that day. At the bottom of that entry on page 8, we can see, "remains for 444", but over the page, at the top , on 6 May, we can see,

> "Discussed with consultant. Not for resuscitation".

A Yes.

Q Then we can find a review by Dr Lord. She is described as being,

A

"Extremely unwell. Very dense left hemiplegia, left ventricular failure and aspiration pneumonia. Swallow not safe. On intravenous fluids. Too unwell for transfer to GWMH. Overall prognosis poor. If Mrs Stevens survives and is stable next week, happy to take her to slow stream stroke care bed at GWMH towards end of next week".

B

You would trust Dr Lord, would you not, to make that assessment? If she views that she is fit for transfer, then you would be happy to accept her.
A Yes.

Q On occasions she is given over the next days intravenous diamorphine in small quantities, I think. Then can we go to the top of page 11, which reflects 10 May:

C

"Reviewed by Dr Tandy. Appeared to improve over weekend. Barthel is zero. She has dense flaccid hemiparesis."

Can you help us with what that is?
A She had complete weakness down the left side of her body, arm and leg.

Q That is the result of her stroke?
A Of the major stroke.

D

Q "Can only obey simple commands. Tolerating nasogastric feeds so far (this morning). She developed further central chest pain. Don't think stable enough to transfer to GWMH."

So she is still unwell?
A Yes.

E

Q Then can we go to the bottom of page 12 – and I am not going through all of these, but if you think that any are particularly relevant I have no doubt you or Mr Langdale will comment.

F

"12 May 1999. Reviewed on ward round. Feeding well through nasogastric tube. Complaining of chest pain which is relieved by GTN. Obs stable. 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 in ITU, if she had a further MI or respiratory failure/arrest."

So that is not saying not for treatment; it is saying that if she has a respiratory failure or another heart attack she is not going to be ---
A Ventilated or given any heroic measures, yes.

G

Q Over the page, page 13, she was given on 14 May diamorphine, 5 mg at night to assist her to settle. Your comment was, "This coincides with my view of the use of diamorphine"; yes?
A Yes.

H

A Q Can we go on now to the bottom of page 15, when things appear to have got a little better. She is reviewed on a ward round. Liaison between Royal Hospital Haslar and GWMH.

"Patient sitting in chair. Observations are stable."

She has had blood test results.

B

"Liaised with GWMH. Happy to take Mrs Stevens with above results. Tolerating nasogastric feeding well. Seems to have recovered from aspiration pneumonitis. Slow improvement in orientation, speech and strength. Still faecally incontinent and requires a catheter in situ."

So she is not well but she is well enough, it would appear, for transfer.

C A Yes.

Q Over the page, please, 19 May reviewed by physiotherapist. She has a cough again. Then on 20 May, the following day, she is transferred. I have not taken you to each of the references but can I just remind you, whilst at the Royal Haslar she was given intravenous diamorphine on 5 May, 6 May, 2.5 mg each; and 14 May and 15 May 5 mg each. And that, you say, would coincide with your view of an appropriate use of morphine?

D A Yes, she had two series of acute deteriorations and they very appropriately used diamorphine during the management of those.

Q And that appears to have helped to settle her.
A Yes.

Q They plainly did not feel that she needed any form of constant diamorphine.

E A No, but it seems as if there is a note on the 20th:

"Still complaining of general aches and pains despite regular co-dydramol."

So she is having regular stage two analgesia just before she is transferred.

F Q Let us have a look at what happens on her transfer. She comes to Daedalus Ward and she is in fact receiving aspirin and various other drugs – and I will come to the prescription that you wrote out and diagnosis and treatment in hospital/stroke for rehabilitation at your hospital. This is the transfer record, I am sorry.
A Yes.

Q And we see a nursing referral. History of angina and IBS. Has had aspiration pneumonia now resolved. So that problem seems to have gone. But she is still plainly

G suffering from the problems from her stroke.
A Yes, and when the nurse there mentions irritable bowel syndrome, she had considerably more bowel pathology in her past medical history than just irritable bowel syndrome; she had had a sigmoid colectomy and bowel adhesions subsequent to that, and she had had bowel problems throughout the years up to this acute admission.

Q That had been a chronic condition, had it not?

H A And we had looked after that in general practice for her.

Q She had had pain, unfortunately, through the years from her stomach.
A Yes.
Q If we go to page 18, her speech is said to be slurred slightly, but:

"Jean appears quite alert of her surroundings. Has a dense left weakness."

What does "dense" add to left weakness?
A No voluntary movement in either the arm or the leg – a very severe stroke.

Q And she is reviewed by you.
A Yes.

Q She is described as, as you have now corrected the note, SSSR – slow stream stroke rehabilitation patient.
A Yes.

Q You set out her previous medical history, which I am not going to go through. She needs help with activities of daily living, she is catheterised and transfers with a hoist. Barthel zero. Did you have any plan for her?
A The initial plan would have been to assess how she coped with the major trauma of the transfer from the acute hospital to our hospital and hopefully she would have made a slow, gradual improvement from her stroke.

Q If we go over the page we can see that she is described as "orientated" and under the heading of pain "not controlled" is ticked:

"Complaining of abdominal pain due to history of bowel problems."
A Yes.

Q So her pain, at this stage certainly, is the chronic pain that she has always had on and off?
A Yes.

Q If we go to the next entry:

"Requires assistance to settle and sleep at night. Oramorph given 5 mg. Complaining of pain in stomach and arm. Condition poor."
A Yes. So that is even on arrival her condition is said by the nursing staff to be poor.

Q Professor Ford commented as follows: opiates are not good at engaging people's ability to recover. Do you agree with that?
A No.

Q Can we see what you decided to prescribe to this patient who was, at this stage of course, you would agree, opiate naïve?
A Yes. She had had opiates but she was not receiving level 3 opiates on transfer.

Q Absolutely. I can go back through it if you want.
A It looked as if she was on co-dydramol but she had had no morphine for several days.

Q Exactly. Her last morphine had been on 15 May and that would have been entirely out of her system and we should regard this patient as opiate naïve, should we not?
A We should.

Q Page 20 of the chronology. You prescribed her Oramorph as required, 5 to 10 mg and that was given to her in fact three times on her arrival.
A Yes.

Q At 14.30, 18.30 and at night.
A So that was prn; that was at the discretion of the nursing staff when they saw to her and assessed her and felt that she needed analgesia.

Q That was in fact the same amount of morphine in total as she had received by way of injection in the whole of her time at the Haslar.
A Certainly.

Q Then you prescribed for her what I am going to describe and I expect you would accept, your usual prescription – 20 to 200 of diamorphine and 20 to 80 midazolam.
A And hyoscine.

Q And hyoscine. She had been at the Haslar for a month, effectively with minimal amounts of diamorphine irregularly and you approved, as you told us, of that sort of treatment.
A Yes.

Q What was your clinical basis, please, for allowing the nurses on their own initiation to start this lady on a syringe driver at these rates of diamorphine and midazolam?
A If it was felt in my clinical judgment or their clinical judgment that this lady needed the diamorphine and the midazolam in those doses that they were able to give it to her.

Q So this was one of your "in case" prescriptions, yes?
A It was very much in case because this lady was only just medically stable when she arrived on the ward and she was at a baseline level extremely ill. Even though she was not at that point suffering from pneumonia or heart failure she was not a well lady.

Q But the doses that she had been given up to that stage, which you have agreed controlled her symptoms all the way through that month at the Haslar, was either 2.5 or 5 mg.
A Intravenously or intramuscularly, not by continuous infusion. So you cannot make a direct comparison between those doses and their use in the urgent clinical situation that they were used in Haslar and, in my case, to give her palliative care.

Q Dr Barton, let us pause for a moment. If the way that the diamorphine had been used was effective, as you have agreed, in controlling such pain as she had, why did you not write out that same prescription?
A Because we did not use in those days prn subcutaneous for administration by the nurses.

Q Why not?

A A We did not consider it appropriate in these cases. As you saw in one of the cases, I would use subcutaneous or intramuscular diamorphine in an emergency situation, but I would only want to give that either as a verbal order and then follow it up by going in to see the patient or at the time of seeing them. I did not allow the nurses to administer that; I did not write it up prn.

Q Can we just examine that for a moment? If these nurses start this patient on a syringe
B driver that, as we have discussed, is in effect the start of a terminal path, is it not?
A In her case it would have been. If she had been sufficiently ill that the Oramorph was not controlling her symptoms then she was on the terminal pathway.

Q Is Oramorph any more or less effective than a 5 mg injection intramuscularly?
A Equally effective.

C Q So at this stage the nurses had the ability to deal with this patient in the same way that she had been dealt with for four weeks at the Haslar.
A And that is what they did, for the first day.

Q There was absolutely no necessity at this stage to set up a prescription for a syringe driver.
A The reason, as always, was that I was not going to be available. This particular
D weekend I was not going to be in the country so that if her condition deteriorated and she needed terminal care it had to be written up for her.

Q But Dr Barton, as you have agreed, the syringe driver does not actually deal with immediate pain, does it?
A She had Oramorph for immediate pain.

E Q Yes, exactly. I am trying to understand what the necessity would be, if the nurses decided to do so, for having urgently to start a syringe driver – the palliative terminal route. What could be the urgency about that decision?
A Because the patient was deteriorating; her swallow was not very good. She pulled her tube up. She was then in a position she was not going to be able to take oral agents. We had no other choice if we felt that she needed analgesia and from anxiety and terminal distress than to give it subcutaneously.

F Q Dr Barton, you did, as you told us, in an emergency you could authorise an intramuscular injection.
A I was not there.

Q Why not write it up – "Phone me before you ever administer this but it is there if you need it."
G A I was not in the habit of using intramuscular or subcutaneous diamorphine in that way.

Q Instead of which what you effectively did was you handed the nurses the power to start the path for this lady's death.
A I did.

H

A Q Let us look at what happened to this lady thereafter – and not very long thereafter, the following day. If we go to page 21 of the chronology, she is given Oramorph at 7.35 in the morning and then she is given, on the basis that a prescription that you wrote out on the Friday, two doses of 10 mg.
A Yes.

Q The prescription that you wrote out just for the oral medicine allowed the nurses to
B give this patient up to 60 mg a day.
A Yes.

Q For this lady who until her admission the day before had been opiate naïve.
A Yes.

Q You would agree that she was an elderly ---
C A She was having the equivalent of 30 mg of oral morphine through the co-dydramol she was receiving at the Haslar Hospital before she was transferred across.

Q Are you saying that she was receiving the co-dydramol daily?
A It does say there in your chronology that she was having regular co-dydramol.

Q I will come back to that. In addition to which, in addition to the 60 mg that you
D allowed for, you also in fact allowed to be instituted later that day – in fact in the evening – the syringe driver.
A Yes.

Q Can we just look at the basic for that, please? In the chronology on page 21 she had GTN spray at 11.30. That would be to relieve chest pain.
A Yes.
E

Q She is given regular Oramorph.
A Yes.

Q Then at 18.00 hours Philip Beed comments:

F "Uncomfortable throughout afternoon despite four-hourly Oramorph. Husband seen and care discussed, very upset. Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life."

She was actually given that day 25 mg orally, was she not?
A Yes, and counting in ---

G Q Take your time, obviously. She is given 5 mg at 7.35 ---
A Three times.

Q Then 10 mg at ten o'clock and two o'clock.
A And you must count in the night time dose the night before – another five, possibly another ten.

H Q Hold on ---

A A You are looking at a 24-hour picture, so at the time he decided to institute the syringe driver she had had 70.

Q Go back to page 20. Within that 24-hour period we have to include the 22.45?
A Yes.

Q So that is 5 mg. Then over the page, another 5 mg given at 7.25?
B A Yes.

Q And then at 2, 10 mg.
A Yes.

Q I think that is 30 mg. Yes?
A Thank you.
C

Q The equivalent dose in fact would be 10 mg, would it not?
A By the BNF and palliative guidelines calculation.

Q And 15 mg if you wanted to give her an increase, a small increase?
A And 20 mg if you wanted to give her what I had written up as the lowest dose available on the PRN.
D

Q Telling her husband, and I appreciate this was not you, that you would agree to commence the syringe driver at the equivalent dose to Oramorph was somewhat misleading, was it not?
A Yes. He was not able to do anything else at that time unless he called ---

MR LANGDALE: In case there is confusion, I put the matter to Professor Ford in relation to
E the amount of Oramorph that the patient had received and the conversion over to diamorphine and he agreed that it was broadly similar. I think his calculation came out at 2 mg below. That is my recollection of his evidence. So it is not right to suggest that it was not broadly equivalent.

MR KARK: I am just going on the figures that we have got here.
A And Philip Beed was not able to give lower than 20 mg of diamorphine because that
F was what I had given him permission to give on my PRN prescription.

Q You are not blaming Philip Beed?
A I am not blaming Philip Beed, no, but he was not able to do anything other than what I had allowed him to do on the prescription, and he did that and I think that it was not unduly misleading to reassure the husband that she was not getting a massive increase in dosage of diamorphine but a roughly equivalent dose to make her comfortable.
G

Q Her only complaint at this time, if we go back to page 19, was complaining of pain in her stomach and arm?
A I think possibly she was complaining of chest pain because she had GTN spray and I suspect that she was a very unwell lady. I did not see her on that day because I had left.

Q When her husband Ernest visited her, he said this: He was pleased to see her at the
H Royal Haslar Hospital. He described her as developing sufficient swallow for the transfer to

GWMH. He described her as being in good spirits. When he came to see her, after her admission, he thought this was on 20 May and so that would be at the time that she was receiving I think Oramorph but before the syringe driver had started. Yes?
A Yes.

Q If he has got his dates right, he described her as lying in bed in a coma. I did not know why she had deteriorated so quickly. A nurse called Phillips said she was in a lot of pain and wanted permission to double her morphine. So it may be that in fact he is referring to 21st May rather than 20th. He said: At GWMH she never made a sound, gave any indication of pain or discomfort – obviously that would be to him. Yes? Her daughter described her as unrecognisable?
A The nurse arranging the transfer, Nurse Neville, suggests "speech slurred slightly but Jean appears quite alert to her surroundings" and that was before she had her first dose of Oramorph, I admit, but she was not unconscious immediately as she arrived at the Gosport War Memorial.

Q Her speech would be slurred of course because of her stroke?
A Yes.

Q The following day, if we just follow this through, the diamorphine and midazolam are continued. You said this, and I think that this was your comment about the starting of the syringe driver: It was not started by you as you were not in the country.
A Yes.

Q The clinical notes for this patient, and you can turn them up of course if you would like to, are at page 1292 of the bundle, and the only clinical note is that made by you on her transfer on 20 May?
A Yes.

Q The next note in the clinical records is that the patient has died and that is a note by a nurse.
A Yes.

Q Again, if a visiting duty doctor had directed that this lady be put on to a syringe driver, it would be a fairly astonishing omission for such a doctor not to make a record of it?
A I do not think he visited. I think he gave a verbal order for hyoscine on the Saturday morning but he did not visit the ward.

Q No, I understand that. His verbal order was to increase not for hyoscine but to increase the hyoscine?
A Beyond the range which I had written up.

Q Yes.
A Yes, and Professor Ford did not criticise him for not visiting the patient at that point.

Q Let us just concentrate on where we are, which is the syringe driver. Yes?
A Yes.

Q Are you suggesting that the syringe driver was started by Dr Beasley?
A No.

Q It may have been altered by Dr Beasley, but it appears to have been started by the nurses?
A Yes.

Q And it was started by the nurses, this terminal event in this patient's life, because of your prescription which allowed it?
A Yes.

Q So I accept that there is a verbal order from Dr Beasley to increase the hyoscine because there was no doubt a bubbling, which we can see is recorded at 10.20, and that is why he was contacted, but whether you were in the country or out of the country, this was an event which was started by reason of your putting your pen to the prescription sheet?
A Certainly.

Q And the patient died, we see, that day. Yes?
A Yes.

Q At no stage was the same sort of treatment which this patient had been receiving for a month at the Royal Haslar, which was so effective to control her problems, used at your hospital? You gave her Oramorph? Yes?
A Yes.

Q And within a day she was on a syringe driver?
A I gave her Oramorph and she undoubtedly either had a further myocardial infarction or went into congestive cardiac failure and that caused her death, with or without the opiates administered to make her comfortable.

Q If this patient had remained at the Royal Haslar, it is quite conceivable that she would have lived on, is it not?
A I cannot comment on what her clinical progress would have been at the hospital.

Q There was, I suggest, and it is illustrated by this patient, a culture at your hospital of initiation of a syringe driver when it was not in fact necessary?
A I disagree with that entirety.

Q I suggest that diamorphine and midazolam were started too early and too high. You understand that as a broad allegation against you?
A I still do not feel that unless you were there or had seen that patient that morning and knew what their actual clinical condition was in front of you that you can make a generalised statement like that.

Q That sort of generalised complaint, though, was the substance of the complaints made 18 years before Mrs Stevens died, was it not?
A Yes.

Q And of which you were aware?
A Yes.

Q Eight years, I beg your pardon – eight years earlier the same complaints had been

raised?
A Over that eight years, over the whole 12 years, we looked after thousands of patients. These 12 patients had been picked out because they were the most difficult cases to look after and, in some cases, the most contentious of cases to look after. We did not have a culture of initiating and using syringe drivers inappropriately or too early in patients who had reached the end of their life.

Q Can I ask you to take up the heads of charge, please? There is just one I want to ask you specifically about and that is head of charge 14(iv). Just to put it in context, head of charge 14 alleges:

> "You did not keep clear, accurate and contemporaneous notes in relation to" all of the patients "care and in particular you did not sufficiently record,
> (i) the findings upon each examination
> (ii) an assessment of the patient's condition
> (iii) the decisions made as a result of examination"

Then (iv) is "the drug regime" and (v) is "the reason for the drug regime prescribed by you" and (vi) is "the reason for the changes in the drug regime prescribed and/or directed by you."

You have admitted all of those except for (iv). Yes?
A Yes.

Q May I just ask you this? If we more closely define the drug regime as meaning when the drug should be used and in what circumstances it would be used, do you accept that in general terms you did not make a sufficient record for the nurses?
A I did not make a written record. I wrote up an appropriate drug regime which was understood by the nursing staff that I worked with.

Q By all of them?
A By all of them.

MR KARK: That is all I ask. Thank you.

Re-examined by MR LANGDALE

Q Dr Barton, I have a number of questions to ask of you in re-examination. I am not going to go over all the ground all over again. I am going to try to follow the order followed by my learned friend Mr Kark, but there is one question I want you to deal with at the outset which does not follow the order he took you through matters. It starts with just about the last matter he put. He was suggesting to you that there was a culture at Gosport War Memorial Hospital of starting syringe drivers too early. You have given your answer to that in terms of yourself. Had there been such a culture of starting syringe drivers too early, is that something that would have been apparent to the consultants?
A Yes.

Q Was Dr Logan somebody who would have countenanced in any way at all a culture of starting syringe drivers too early, in your experience of him?
A No.

A Q Would Dr Tandy have been the sort of person who would have countenanced such a culture?
A No.

Q Same question with Dr Lord: would she have countenanced such a culture?
A No.

B Q Dr Reid?
A No.

Q I would like you to deal, please, with something relating to Dr Logan. Can you go back to file 1, tab 6. You remember you were asked questions about general matters with regard to prescribing and so on and the appropriate dosage to control pain. You said in your evidence, in answer to questions from Mr Kark, that you would go to a higher dose in order C to give adequate pain control and to give it more quickly.
A Yes.

Q I would like you to look at a document that is in the file at tab 6, page 29. This is a letter written in July of 1991 by Dr Logan. He is writing to Steve, who is Stephen King, whose name was referred to in the papers we have already looked at in relation to the matters that were being discussed in 1991. I am not going to read all of the first paragraph but he D says about three or four lines in in relation to the concerns which the staff hold:

> "It seems to centre round the feeling that it is wrong to start with subcutaneous diamorphine by pump for <u>any</u> patient who
> 1. Has not tried 'lesser' analgesia first
> 2. Could take oral (or rectal) diamorphine
> 3. Does not have patient-voiced pain (even though they may be obviously E restless and distressed)
> 4. Has not been discussed at a full staff conference."

So that was him setting out what seems to be the position. Over the page Dr Logan said this:

> "To me the important points to make in answer to these questions would be.
>
> F 1. Patients with distressing pain need adequate analgesia first – once pain is controlled reductions or changes in dosage can be made."

Is that a view with which you agreed?
A Entirely.

Q "2. The s/c route is more convenient for many patients and overcomes problems G of vomiting back analgesics, variable absorption. The continuous infusion may allow lower total dose to be used."

Would you agree with that?
A Entirely.

Q "3. Opiates are analgesics but also euphorics, and thus psychologically beneficial H for many patients. Many distressed, uncomfortable frail elderly are unable to report

A their discomfort."

Would you agree with that?
A Entirely.

Q "4. Prompt treatment is the best."

B Again, we can take it that you agree with that?
A I do.

Q You made reference in your evidence, in terms of the drugs that you used in relation to subcutaneous analgesia, to the fact that to you it seemed to make sense to get to know a small group of drugs and use them rather than experimenting?
A Exactly.

C

Q Those are more or less your words. Looking at that same file, can we look, please, at the tab containing the BNF, so that is tab 3, page 7? On the left-hand side, about half-way down the column, it says "Guidelines". Can we see what it says for "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."

D

Is that something of which you were aware in terms of the BNF?
A Yes.

Q Was it something that you endeavoured to put into your practice or not?
A I did.

E Q In the same file I want us to go back to tab 6 to deal with another matter that was raised with you later on in your evidence: tab 6, page 25. You will remember you were asked questions about the meeting at which you were present, which involved Dr Logan and the other people we have already had identified more than once. You were asked about whether there was an issue as to a written policy and as to whether any of the nurses spoke out. Do you see at the top of page 25 that at this meeting, which involved all the relevant nurses that we are concerned with at this period of time, that there was general discussion and

F answering of staff questions. Does that accord with your recollection?
A Yes.

Q "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. Comments raised during discussion were",

G and there then follows a summary of comments with those things being raised by the nurses.
A Yes.

Q Was there any difficulty so far as you could tell, at that meeting, with the nurses voicing their concerns?
A None at all.

H

Q In relation to the question as to whether the nurses were pressing for a written policy, would you look just over half-way down that page? There is a sentence by itself,

> "Mrs Evans spoke to the remaining nursing staff. Staff were asked if they felt there was any need for a policy relating to nursing practice on this issue. No one present felt this was appropriate".

Does that accord with your recollection?
A Yes.

Q I want to move now, please, to the patient histories and first of all I want to move to the patient history of Leslie Pittock. In relation to this patient history I just want to ask you a question relating to the prescription on 15 January. That is in the patient history at page 15 of Patient L. On page 15, in relation to this patient, we can see dated 15 January the first administration of any subcutaneous analgesia. The anticipatory prescription had been written up some days before. You were asked about the amount of diamorphine and midazolam that was administered to him on that day, Monday 15 January, and it was being suggested to you that it was too high. You said you had given him the dose he needed by assessing his clinical state that morning.
A Yes.

Q Can I just ask you this? Would there be any reason for you, your experience, your practice, your method of operating on these wards, would there be any reason for you to give him more than you thought he needed?
A Absolutely no reason.

Q You were also asked about the starting of the syringe driver and so on. It was being put to you, because that was a Monday, that if he appeared distressed over the weekend, why not put him on the syringe driver then? Why did the nursing staff not do that? But when you reviewed this patient on the Monday and looked at what the picture was on the weekend before, if you had thought that the nurses had not taken action when they should have done – for example, if you thought they should have instituted the syringe driver over the weekend – would you have done something about it?
A I would have discussed it with them.

Q Moving on, please, to Patient D, Alice Wilkie, again using her patient history, I want to try to clarify the sequence of events in relation to this patient. Go, please, to page 8 of the patient history for Alice Wilkie. There we can see recorded on that page events taking place on two separate dates. At the top it is Monday 17 August, and at the bottom it has moved on to Thursday 20 August. You will remember that you were asked questions about the dating of what appears to be an undated prescription. This was an anticipatory prescription and you were being asked questions, I think, suggesting that it was written up on 20 August. You indicated at one point that an educated guess might be that it was, and then you said, "I cannot help you as to when I wrote up the scripts".

Just looking at the picture, in relation to 21 August, over the page, there is an entry in the clinical notes made by you referring to the previous days,

> "Marked deterioration over last few days. Subcutaneous analgesia commenced yesterday. Family aware and are happy".

Does that signify to you that you were present on the day that it was administered, in other words, at the hospital on the day it was administered on the Thursday, or that you do not appear to have been present, where it says,

"Subcutaneous analgesia commenced yesterday".

A My feeling is that I would have been present on 20th, sanctioned the start of the subcutaneous analgesia and then written it up the following day when I went in, and made a record of the fact that it had been started and that it seemed to be appropriate for the patient and for the family.

Q In that case I do need to refer you to a particular document in the file, page 145, to see if that helps. If we look at page 145 we can see that the prescription you wrote out in relation to diamorphine, Hyoscine and midazolam is shown on that page. Right?
A Yes.

Q Then whose handwriting is it where we can see the date, over to the right, at the top of the page where it says, "20 August"?
A It looks too tidy to be mine. It looks as if it must be Philip Beed's handwriting.

Q Yes. We can see his initials and he is the person who administered that.
A Yes.

Q What I am trying to get at is to see if it clarifies, and maybe it does not, in terms of the date when you wrote the anticipatory prescription. If you had written that on 20th, the Thursday, what would the position have been with regard to any dates you might have put?
A It would have been the same date that Philip was going to write when he dispensed the prescription.

Q Because as we understand it, in one instance, I think, which was drawn to your attention, you had used the date column over on the right to give the date on which in fact you had written the anticipatory prescription, but that does not appear to have been the case here.
A Which would signify that I knew that he was going to be writing that same date because we had agreed to put the syringe driver up that day, once he had spoken to the family.

Q That is as far as I can take that. Looking at the same patient history though, that we were looking at a moment or two ago in respect of that issue, again at page 9 of the patient history, in relation to the history set out there, it refers in the note that you made to, "marked deterioration over the last few days", etc. Nurse Joyce records at 12.55,

"Condition deteriorated during morning. Daughter and granddaughter visited and stayed. Patient comfortable and pain free".

In relation to your entry on 21st, are you able to say whether the patient was unconscious or not?
A I am not able to say whether the patient was unconscious. I made no note as to whether she was unconscious or not.

Q If she had been unconscious at the time that you saw her, would you have considered reducing the dose of diamorphine?
A Certainly.

Q You also indicated that in relation to this same patient, if there had not been the problem caused by the disruption – that is the word I will use with regard to what was happening so far as Gladys Richards and Gladys Richards' relatives were concerned – if it had not been for that problem, Philip Beed and you would probably have started Alice Wilkie on Oramorph earlier than 20 August. I just wanted to ask you to explain why that was?
A Because there had been a general deterioration in her condition over the weekend of 17th, and he and I would probably have agreed on that Monday when I came in that she now needed some palliative care for her general distress and discomfort. We would probably have taken more notice of her general symptoms instead of allowing it to go on until the Thursday before instituting going straight on to subcutaneous analgesia.

Q If there was a culture of starting too early, if there was any truth in that suggestion, what would you have expected to be the position?
A There was no culture of starting syringe drivers before they were absolutely necessary. She would only have got subcutaneous analgesia when it was appropriate for her.

Q On please to the next patient in terms of the sequence, Patient E. Can we look please at that patient's history and go to page 10? Again I am simply concerned with the sequence of events to see if we can clarify. If we look at page 10 with regards to Patient E, that shows the position when she was transferred back, having gone back to the Haslar to have her hip sorted out; the transfer back on Monday 17 August. We can see that at some stage on that day she was reviewed by you.
A Yes.

Q The evidence was that when she was transferred back, that Leslie O'Brien, one of her daughters, had got to the hospital at about lunch time and the lady, Gladys Richards, was screaming and she summoned assistance and spoke to Nurse Couchman. It appears that you were not at the hospital at that time.
A No. She was not screaming when I clerked her into the ward on that Thursday.

Q What I am trying to get at is, is it possible that you in fact saw her at some time after that incident rather than before?
A After she had had a dose?

Q Yes.
A She had been made comfortable on the bed and had had a dose of Oramorph.

Q If we look at page 11, we can see that she had had a dose of Oramorph, because Oramorph was administered.
A It was administered at 13.05.

Q First of all looking at the bottom of the page, it was administered three times during the day. Right?
A Yes.

A Q That was 5 mg. As you rightly point out, at the top of the page Nurse Couchman recorded that shortly after one o'clock,

> "In pain and distress. Agreed to give Oramorph to 1.5 mg. Dr Barton contacted and ordered an x-ray".

Is it consistent, therefore, with that note that you came in later to see the patient?
B A Yes, and ordered an x-ray but did not make a note of it.

Q Yes, we can see with regard to your entry in the clinical notes, it talks about the readmission, "Remained unresponsive for some hours" in relation to what happened at the Haslar.

> "Now appears peaceful. Plan, continue haloperidol. Only give Oramorph if in severe
C pain. See daughter again".

A Yes.

Q So looking back at that, what is your view as to the sequence of events? That you saw her in fact after the arrival incident, at some point after Oramorph had been administered?
A And that she was now comfortable and on discussion an x-ray was ordered to check that the prosthesis remained in the right place.
D

Q It turned out, I think, that there was no problem revealed by the x-ray.
A Yes.

Q Then on please to Patient F. You were asked questions about matters, not only this particular passage but also about other matters, but I am focusing on just one passage relating to page 17 of the patient history. Patient F page 17. On page 17 there are two dates shown,
E one of them is Wednesday 19th, and the other is Thursday, 20th. We have got the entry by Nurse Hallman, which we have looked at more than once, setting out what the position was on the morning of the Wednesday, 22 July 2009

> "Oramorph 10 mg given. Doctor notified. Pain only relieved for short period. Very anxious",

and so on. The commencement of the syringe driver, and then on the Thursday 20th, the day
F after,

> "Condition appears to have deteriorated overnight. General condition continues to deteriorate",

And so on. "Ruby rousable and distressed when moved". It was being put, I think, that her condition had deteriorated because of the subcutaneous analgesia. Was this patient, so far as
G you can judge it, unconscious?
A No.

Q Can we look, please, in relation to her, at one document in the file – another reference to a document in the file I need to make – at page 388, Patient F? Bearing in mind that we were just looking at the dates of 19th and 20th, and we see what the nursing care plan shows for the night before and the following two nights at 388, showing on the 18th that she settled
H and slept well from 10 o'clock until midnight.

A

"She woke very distressed and anxious and said she needs someone with her".

That is also recorded on the patient history. She is given Oramorph with little effect.

"Very anxious during the night. Confused at times".

B Then we move on to the night of 19th, that is the night, as it were, after the syringe driver has been established in the afternoon of the 19th,

"Comfortable night. Settled well. Drowsy but rousable. This am sips of oral fluids tolerated. Syringe driver satisfactory".

Does that indicate to you a patient who was unconscious or not?

C A Not unconscious, not over-sedated.

Q The night of 20th is set out in the patient history. Then on to Patient G. I would like you to look at the patient history, please, for Mr Cunningham. Then on to Patient G, Mr Cunningham. Again, I would like you to look at the patient history, please, at page 14. Looking at page 14 it deals with matters which took place on 23 September, the Wednesday, when he was reviewed by you and Nurse Hallmann has recorded that fact and what the

D situation was, and relates to
Mr Farthing asking in terms of the deterioration if it was due to the commencement of the syringe driver, and he was informed that Cunningham was on the small dosage which he needed. Then became a little agitated at 23.00, so 11 o'clock in the evening.

"Syringe driver boosted with effect. Seems in some discomfort when moved."

E Mr Farthing's evidence was that he was unconscious and unrousable; what do you say about that?

A He was neither.

Q When you reviewed him on the morning – if it was the morning – of Wednesday 23, was he unconscious and unrousable?

A I am unable to say from the recorded here, but I imagine that he was not otherwise

F I would have taken the chance to review what was put in the syringe driver.

Q I was going to ask, if he had been unconscious and unrousable would you have checked on that?

A Then I would have reviewed his medication.

Q And perhaps we can just look on to the following day, please, Thursday 24, when you

G saw him again – page 15:

"Reviewed by Dr Barton on the Thursday. Remains unwell. Son has visited again. Subcutaneous analgesia is controlling pain – just."

Does that indicate to you a patient who is unconscious and unrousable?

A Not at all.

H

Q Then in relation to Patient H, Mr Wilson, if we look on the patient history for Mr Wilson to page 13, on the date 4 October, top left, the section dealing with his situation – that is when he is in Queen Alexandra still, of course – one can see on the last two lines of that entry.

> "Morphine 2.5 mg given at two o'clock in the morning as unsettled and uncomfortable."

That is an intramuscular injection.
A Yes.

Q Because you were asked later on questions by Mr Kark about the amount of subcutaneous analgesia he was given later and a reference was made to the fact that this was a massive increase – those were the words used by Mr Kark – on what he had had back on 5 October. Bearing in mind that that is intramuscular or intravenous, what do you say about that?
A It is very difficult to make comparisons of the two because that is a stat dose given for acute pain and I was looking at giving a steady infusion dose to control pain. But the actual amount of morphine in the system would probably have been very comparable.

Q Still on the same patient, a more general question. You were asked questions about whether you would take into account his previous alcoholism and the liver problem or liver disease, whatever the correct expression would be, and it was suggested to you that you had not taken those things into account in prescribing your anticipatory prescription. I would like you to deal with that. What impact did the history of his previous alcoholism and liver disease – in what way did you take that into account and why did it have no bearing on what you actually did?
A If he needed adequate analgesia he needed an opiate.

Q The question was also put to you that his alcoholism and his liver problem meant that the opiates would be more potent in treating pain. Do you agree with that or not?
A I do not think they are more potent. I think they may be handled by the body in a slightly different manner, but I do not think that they are more potent in any way. I think they would be equipotent with somebody who had a normal liver in the effect that they had on relieving his pain.

Q Looking at page 26 of the patient history for this same patient, that shows the situation on 15 October, a Thursday, and we can see in the second box down on the left a note that his condition had deteriorated overnight. You indicated in your evidence that this deterioration mirrored his cardiac failure, not the effect of the opiates.
A I did.

Q I would like you just to explain that. On what basis are you saying that that mirrored not the effect of the opiates but the effect of his cardiac failure?
A Because he had become chesty. He had retained an enormous amount of fluid while in Queen Alexandra. He was verging on the edge of cardiac failure when he arrived with us and that night he undoubtedly tipped into cardiac failure, and Oramorph would have been a very appropriate drug to give him to help relieve his symptoms. That is not the picture of Oramorph toxicity.

Q On that same issue, in relation to his background of alcoholism and the liver disease, and the suggestion that you should not have given so much Oramorph, did you, seeing this patient, see any signs that the Oramorph was having any adverse side effects in relation to him, such as encephalopathy or anything else?
A I did not at any stage see any signs of encephalopathy in this patient.

Q I move on to Patient I. If we look at the patient history for Patient I, Enid Spurgin, it was suggested to you at a certain point – and we can pick it up at page 11 of the patient history – that the 25 mg of Oramorph that she received as a result of your prescription on that day was too high.
A Yes.
Q The evidence of Dr Reid was that in his view it was perfectly sensible. But leaving that aside for the moment, the suggestion is that it was too high, too much in other words. Looking at the next day, on page 12, 27 March, the following day – and bearing in mind what the note says half way down on the left, "Still in pain" – what do you say to the suggestion that the Oramorph she had received was too high?
A It patently was not enough rather than too high a dose to relieve her symptoms.

Q You will remember in relation to this same patient the suggestion being made that you should have referred her back so that an orthopaedic surgeon or an orthopaedic team could have considered her position. You have given your reasons as to why you did not think it appropriate to transfer her back, but can I just ask you this; would there have been any problem, any difficulty for you in referring her back if you felt it was appropriate?
A You can see how easy it was to do when you looked at Gladys Richards falling on the ward and dislocating her prosthesis. It was the matter of making a phone call. But I did not feel that in her case it was clinically indicated to ask at that point for an orthopaedic opinion.

Q I will move on to Patient J, Mr Packman. Once again, I want to ask you about something in relation to the patient history. In relation to Mr Packman, would you turn up please page 10 of the history? When dealing with the review by Dr Ravindrane when he admitted him to Dryad Ward on 23 August you were reminded of the evidence of Professor Ford to the effect that a vast majority of wards would have tried to remobilise this patient. I am going to remind you of what Dr Reid said about this patient; he said that he would disagree fundamentally with any suggestion that the patient had been sent to Dryad because there was a potential for mobilisation. In Dr Reid's view he had no such prospect. In relation to what you said when you saw him yourself, which I think was some time later, which was 26th, three days later, were you able to form a view as to whether mobilisation was something that was still worth considering or something that really was, for practical purposes – my expression – not on?
A It was not on.

Q In relation to that particular time when you saw him – and this is page 13 of the patient history – you were indicating to the Panel what you understood was the view of Dr Ravindrane in relation to whether this patient was somebody who was suitable for transfer back. Looking at page 13 we can see the note that was obviously available to you and which you used to form your view about this. I would like you to explain a little bit more about this. Dr Ravi, as he is described in the note, is told about the problem and says, "Discontinue the clexane" – no difficulty about that.
A Yes.

Q And asking for repeating tests on the haemoglobin today and tomorrow and "not for resuscitation". We know what "not for resuscitation" means in a particular set of circumstances but I would just like you to indicate to the Panel more fully than you already have done, if it is possible, as to why this did not mean simply not for resuscitation for what I am going to call the sense we have seen it with regard to other patients, and that it gave an added meaning in the case of this patient. I would like you to explain that.
A In my view it went further than simply saying not for cardio pulmonary resuscitation; it meant that he knew that we did not have available at the Gosport War Memorial intravenous infusions, the capacity to cross match and administer blood and the facility to do endoscopy and to try and determine the cause of the bleeding. So when he put "not for resuscitation" he meant that Mr Packman was to stay where he was and to receive palliative care.

Q Was there any uncertainty or doubt in your mind as to that meaning?
A No and that accorded completely with my clinical impression when I met Mr Packman that week.

Q It was suggested – if we can look on to the last page of this patient history, at page 20 – in terms of the death certificate where you had recorded – although it is not set out there I think you had recorded myocardial infarct, is that right?
A Mm.

Q The suggestion was made to you that you did not put "GI bleed" on the death certificate, as either one of the causes or the cause of his death, because it might cause an inquiry as to why he had not been treated. What do you say to that?
A There is no way that that sort of inquiry would be instituted. The family take the death certificate down to the registrar and the registrar registers the death. Unless it is something that is completely inappropriate or something that they will not accept the registrar will register the death. There is no question of anybody instituting any inquiry at that point.

Q If anybody had instituted any inquiry – and can we look back at page 14 – what would they have seen with regard to your review of the patient shown at page 14?
A That my clinical assessment of this patient was that he had that morning had a myocardial infarction.

Q And what else were you considering, does your note show?
A The possibility that he had had a gastrointestinal bleed.

Q Was there any attempt by anybody to hide anything with regard to the possibility or the record of any history which was consistent with GI bleed?
A There was no attempt to hide anything.

Q I move on to Patient K. I am going to ask you about the time that you were asked particular questions in relation to the fentanyl, and I think probably the best page to use – to remind ourselves – is page 14. With regard to Patient K, Elsie Devine, you were asked a number of questions about the fentanyl and we looked at the literature and so on, and you explained your reasons as to why you thought it was appropriate in her case, and so on, and there does not appear to be any particular criticism of the use of fentanyl by Professor Ford. What Mr Kark was putting to you was that when you take into account the fentanyl that she had received – and she had received, as it were, 24 hours of fentanyl so it was at its top level.

A A Steady level, yes.

Q Taking it off, the chlorpromazine having been administered at half past eight in the morning; the syringe driver started an hour later with the diamorphine and midazolam, both at 40, that this was wrong and it was – my words – far too much. What were you thinking in terms of how the changes were working and the effect of these drugs? The fentanyl is coming off ---

B A And the level is beginning to reduce in the bloodstream.

Q What sort of calculation are you making, even if it was not a precise calculation, as to the diamorphine and the midazolam being infused and therefore coming up and the fentanyl going down?

A The BNF calculation for fentanyl is up to 135 mg of oral morphine, so if you divide that by 3, it comes out as a figure of 40 mg of diamorphine.

C

Q If you are using the one-third?

A If you are using the one-third. I did not need additional pain relief sedation, so I was minded to do a direct conversion from the transdermal to the subcutaneous delivery system and give her the same level of pain relief, but I needed to add in the midazolam. At that point of time, I did not want to go on giving her intramuscular chlorpromazine. I wanted to give her sedation and relief from her restlessness and agitation by adding the midazolam to the

D diamorphine. That was the rationale for changing over from the transdermal patch to the subcutaneous administration.

Q Did you consider in your assessment of the correct dosage of these drugs that the midazolam was going to have a profoundly sedating effect?

A I was hoping that it would have a sufficiently sedating effect to make her comfortable and less aggressive and less frightened.

E

Q I have used the expression "profoundly sedating" because I think that is the expression my learned friend Mr Kark used, referring back to what Professor Ford said. "Profoundly sedating": I appreciate it is not a medical term.

A I would not have expected it to produce profound sedation.

F Q I am asking you the question on the assumption that that is over-sedation or equivalent sedation.

A Yes.

Q Lastly, Patient L, Jean Stevens: can we just note certain things with regard to the picture so far as she was concerned? You were asked questions about why you had not followed the same approach in terms of the administration of diamorphine as had been adopted by the Haslar. I want to ask you to consider these matters in relation to what appears

G to have been the reason for administering diamorphine at the Haslar and the reason you applied when you sought to administer diamorphine.

A The two scenarios were completely different.

Q I just want you to demonstrate that. Sorry, I cut across you. I was going to ask you about the patient history, just to illustrate the point, and if I have cut you off from saying anything, please go ahead and say something further. Looking at page 8, we can see that

H

A small doses of diamorphine are administered to keep her comfortable; in other words, no record of pain control. All right?
A Yes.

Q That is intravenous I think.
A I certainly did not have the facilities to administer intravenous diamorphine or intravenous anything to anybody at the hospital.

B

Q What I am concentrating on is what the records show as to why diamorphine was administered at Haslar. If we move on to page 9, we can see at the bottom of the page Dr Lord's notes, and we heard evidence from her about it: diamorphine was to be administered for distress.
A Yes.

C Q And indeed, at the top of page 10, it was administered apparently for distress. There does not appear to be any mention of it being administered for pain. Correct?
A Correct.

Q And then can we look, please, at page 13 in the patient history? 14 May, still at Haslar: does it show diamorphine, bottom left, being administered?
A Yes.

D

Q And the purpose?
A To assist the settling, with good effect.

Q So again no mention of being administered for pain. Is that right?
A Not overtly in pain.

E Q Then on page 14, 15 May, diamorphine given with good effect; no mention of pain. The following night she slept well without diamorphine. Then, when we come to her admission to Gosport War Memorial Hospital, page 17. She is on a prescription, is this right, from Haslar for PRN, in other words subcutaneous diamorphine as required.
A Yes.

Q When you were concerned to prescribe diamorphine, and can we look at page 21,
F page 21 shows the reason why Philip Beed from whom we heard evidence commenced the syringe driver, and does that set out that it was for pain relief?
A Yes.

Q So what do you say to the suggestion that small intravenous immediate doses of diamorphine which had been administered apparently to relief distress and administering subcutaneous analgesia for pain relief ---
G A No, you are not looking at two similar scenarios. If we had been able to do it, to give small doses of intravenous diamorphine would have acted immediately and given instant relieve from presumably the cardiac pain that she was suffering, or the acute pulmonary oedema that she was suffering. She now needed something more steady state throughout the 24 hours to relieve pain and discomfort.

Q Was that what you had in mind when you wrote out your anticipatory prescription?
H A It was.

Q Lastly, and I hope it really is lastly, this: page 19 of the patient history. Page 19 refers to a particular point with regard to this lady, 20 May, top left-hand corner, "Complained of abdominal pain due to history of bowel problems. Oramorph given on arrival". Is that right?
A Yes.

Q Was the Oramorph being given for abdominal pain or for some other reason?
A It would have been appropriate to give it for abdominal pain for or generalised pain and discomfort following the transfer to the hospital.

Q Professor Ford said that you would not treat chronic abdominal pain with opiates. What do you say to that?
A I can see no reason why you should not treat chronic abdominal pain with opiates, provided that you had a pretty fair idea what was causing the abdominal pain, which we indeed knew. We knew she had a history of adhesions and had had a sigmoid colectomy.

Q Does this come back to the point I think you made earlier in your evidence: for abdominal pain by itself you would not necessarily use opiates?
A If it was a new symptom and you did not know the reason for it, you would not, but we knew about this lady's pre-existing problems.

Q The matter you were asked about in relation to this same topic was Professor Ford's view about opiates and patient recovery. He in effect was saying that if you are intending to rehabilitate or re-mobilise somebody, you would not start with opiates. What do you say about that?
A We had hundreds of patients in whom they would have had opiates for a specific problem or on arrival who came off their opiates and went home or went to their nursing home. It was not an automatic pathway on to terminal care.

MR LANGDALE: Thank you. That is all I ask by way of re-examination.

THE CHAIRMAN: We will rise now and sit again at 2.05 when I understand, Mr Jenkins, you have a witness to interpose?

MR JENKINS: Yes.

THE LEGAL ASSESSOR: I just raise the issue of when Dr Barton is able to communicate again with her counsel, because that may be something very much in her mind at the moment.

MR LANGDALE: Sir, as I understand the position to be, she is still technically in the witness box and, apart from a 'good morning' or a 'good afternoon', unless there is a particular thing she wants to raise, there will be no communication between her and her legal team. Subject to those two minor exceptions, I shall be proposing to treat her as if she was still in the witness box because plainly she is. She has further questions to come.

THE CHAIRMAN: You are absolutely right. Thank you very much indeed.

MR LANGDALE: I can also add that Dr Barton knows that if at any time she thinks, having reflected on something, that she wants to communicate something, she simply needs to indicate to us that she wants to communicate something and it can all be sorted out.

THE CHAIRMAN: Thank you.

(Luncheon adjournment)

THE CHAIRMAN: Mr Jenkins, before we begin, there are two preliminary matters. I will raise the first if I may. Best laid plans of mice and men: I announced this morning that we would rise on Tuesday at 3 o'clock to accommodate the need for a member of the Panel to be elsewhere. During the course of the morning that panellist has been told that they are now required at the front end of Tuesday instead of the back end. The amount of time that we will lose is going to be about the same. The proposal now is that we will start business at 11.30 on the Tuesday morning and then finish on Tuesday at the normal time or perhaps a little later.

Does that cause any difficulties? I am just hoping nobody has made arrangements in the interim?

MR LANGDALE: I am sure we can work around it. Thank you.

THE CHAIRMAN: I understand there is also a matter concerning the presence of the Doctor in the room when the forthcoming witness gives her evidence.

MR JENKINS: She was told to wait outside or that she would be outside and we have sorted out with Mr Kark's agreement that the Doctor should be in.

THE CHAIRMAN: I have to say that I agree too.

MR JENKINS: She is obviously entitled to hear the evidence.

MR KARK: That certainly did not come from our side. The Doctor can be here during the whole of the case.

THE CHAIRMAN: I think it is an administrative input from somewhere down the line. Everybody in here is agreed. We will proceed in the normal way.

YVONNE ASTRIDGE, Affirmed
Examined by MR JENKINS

(Introductions)

Q Please give your full name.
A Yvonne Astridge.

Q Would you give us your professional qualifications and experience?
A I am a state-registered nurse. I qualified in 1981. I have been practising as a nurse since then. I only stopped for two six-month periods during that time.

Q I think you worked in London hospitals at the start of your career?
A Yes, I did. I trained at St Thomas' and then did work at the Royal Free and St Thomas' and did some agency work.

Q Did some of that involve looking after elderly patients?
A Absolutely, yes; the majority of patients are elderly.

Q Did you then work in Abingdon in Oxfordshire for a couple of years?
A Yes, I was in a hospital there, in the GP unit.

Q Did you then work as a nursing officer at a nursing home for a period in the 1980s.
A Yes.

Q Did you subsequently go to Gosport War Memorial Hospital?
A Yes, I did.

Q Are you able to tell us roughly when you got there? Was it in the Eighties?
A It was in the Eighties; it was in the late Eighties to my recollection – '87/88.

Q In the 1990s, which is the period with which we are concerned, were you still working at the War Memorial Hospital?
A Yes, I was. I did not leave until '97/98.

Q What role were you taking on during the 1990s?
A I was a senior staff nurse on Daedalus Ward.

Q I think we have heard that the sister at that time was Sister Joines.
A Yes.

Q And we know that the ward manager was subsequently to become Philip Beed. Were you there when he was there?
A Yes, I was.

Q For the early and mid 1990s, Sister Sheila Joines was in charge of the ward on the nursing side. What do you do now?
A I am a clinical manager of something called the multidisciplinary response team, which is a community team of nurses and therapists whose main aim is to prevent acute hospital admission. We crisis-manage health problems at home.

Q To summarise, you have been a nurse and a senior nurse for 25 years and more?
A Yes.

Q Can I take you to a file on your left labelled B. This is in relation to a patient we know as Elsie Lavender. I think you remember the name but perhaps not the patient.
A I remember the name simply because of being asked for the police statement, yes.

Q I understand. I think you were asked as long ago as 2004 by the police and you gave a statement to the police about entries in the medical and nursing records for Elise Lavender?
A Yes.

Q I am not going to take you through these notes in any detail at all, but, just to reorientate ourselves, the Panel have spent six and a half weeks looking at these documents, so they are pretty familiar with most of them. I wonder if we can just go through very briefly, just to remind ourselves of this lady? If we were to look at page 136 in the records, and it is not done deliberately to confuse but you will find that there are two numbers at the bottom of every page. The 136 I want you to look at is an ambulance report form. This shows us the date of 5 February 1996 in relation to Elsie Lavender. It is an ambulance form showing that she was found at the bottom of the stairs and it gives her address in Gosport and her age as then 83. If we were to go over the page to 138, we will see this is a clerking note by a doctor; he described it as an EA, meaning emergency admission, via casualty. If we go over to page 139, we will see part of that clinical note at the hospital. If you look about eight lines down, you will see as part of the history the word, "Social. Lives in house with stairs. Bed downstairs".

If you look six lines below that, it says,

> "Can walk about 10 yards. Uses a stick. Does not usually go upstairs".

A Yes.

Q If we go on a few pages in the notes to page 143, again another entry in the medical records at the hospital where she was treated before going to the War Memorial Hospital, we see towards the bottom part of that page, "D/W son", which would normally mean "discussed with". Yes?
A Yes.

Q "She fell down the stairs. Large pool of blood at the top of the stairs ?Hit head at top of the stairs and fell down the stairs".

That I think is the event that led her to be in hospital in the first place.
A Right.

Q If we go on, and the Panel will remind themselves of the evidence we have heard, we see that some 10 or 11 days into that admission, Mrs Lavender was seen by a Dr Tandy. The Panel have the letter relating to that at page 935 in the notes, and Dr Tandy has written under "Diagnosis",

> "1. Probable brain stem stroke. 2. Insulin dependent diabetes mellitus.
> 3. Registered blind. 4. Now immobile. 5. AF",

Which we have heard would refer to "atrial fibrillation".
A Yes.

Q We see the terms of the letter, and over the page at 936, Dr Tandy offering the view that the most likely problem here is that there was a brain stem stroke leading to her fall. In other words, causing her to fall down the stairs.
A Yes.

Q We have got an indication, lower down in the letter,

A "I will get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible".

We have got the corresponding note in the clinical notes for that record back at page 151 of the medical records. The Panel have seen it before and will recall that on the second page of the notes, at page 152, towards the bottom of the page Dr Tandy has written,

"Impression: probable brain stem stroke".

B

A few lines down she has written,

"Sounds as though only just managing at home prior, but would like to get back",

Meaning, presumably, the patient was hoping to get home.

C A Yes.

Q If you would look just over the page, just above the signature in the top one third of the page Dr Tandy has written,

"I am not sure whether we will manage to get her home but we will try".

D A Yes.

Q We know that it was a few days after that that Mrs Lavender was transferred to Daedalus Ward. We have got Dr Barton's entry at page 975, and we see five dated entries by Dr Barton. I do not know that people have remarked on it before, but if you were to turn the page to 976, you will see this relates to an admission to hospital seven years before when in fact it was Dr Barton who was admitting Mrs Lavender years before. We have nursing

E records for Mrs Lavender starting on page 1003. The pagination, I am afraid, may not be the most helpful for the nursing records and perhaps you could tell us, but would page 1003 be a continuation sheet of the nursing care plan?

A Yes.

Q It is not the first part of the nursing care plan.

A No.

F

Q If we go over the page to 1004, this is the starting page of a nursing care plan.

A Yes.

Q It names you as the named nurse for this patient.

A That is right.

G Q Can you tell us, how is the named nurse selected, or how was it in the mid-1990s?

A At that time it was usually the person who admitted the patient because they were the person that gathered the details as they arrived.

Q So as we go through the nursing documentation and a number of care plans, we see your name a number of times. Let us stay with 1004. You are named. Did you write the entries dated 24 February 1996 on that page?

H A No.

Q She was admitted two days before.
A Yes.

Q If we go to page 1006, a couple of pages on, that is obviously the start of another care plan relating to an in-dwelling urinary catheter. That is dated 22 February 1996, the date she was admitted. Is that your writing?
A No.

Q It is not? There are other care plans, again 1008 is another one. This one is the same date, 22 February. This one deals with a leg ulcer on the right leg. I think we have seen the previous care plan dealing with the reddened broken sacrum, on page 1004. Are you able to tell us whether your writing is on any of those?
A No, it is not.

Q What about 1012?
A I did the one on 1010.

Q That is you?
A Yes.

Q I am grateful. I was not going to take you through a number of your entries, or the detail of them, but I think if we just flag some up I think we can see your signature. If we go to page 1003, I think we have got your signature along the line for 2 March 1996. Is that you? There are two signatures at the end of the line for 2 March, "All dressings replaced", and yours is the higher of the two signatures on that line.
A That is my name but not my signature.

Q Why would that be done, that somebody would sign on your behalf in your name?
A At that time the requirement generally was that a trained nurse should countersign everything that an untrained nurse had written, and I suspect that what has happened is the person who wrote it put my name there as well to save me having to do it.

Q Does it follow that you would have been involved in that episode of care for this lady?
A Probably. It means that I was in charge of what happened to that patient during that episode, yes.

Q I understand. I think we have the same thing happening on several occasions. If you go to 1011, the same date, 2 March and your signature written above somebody called J Ross.
A Yes, it is somebody who has obviously done the same thing.

Q A couple of pages on, 1013, which may be an important page for other reasons, but on 2 March the same thing happening.
A Yes.

Q If we go on to page 1015, yet another care plan for Mrs Lavender, this one dealing with constipation, there is another entry for 2 March detailing an enema that was given. Is that your signature along the line?
A Actually it is not.

Q But would you have been present, assisting with the care of the patient?
A I am assuming that as my name is put there, then yes.

Q What we see with this patient is, in addition to the diabetes, the diagnosis of probable brain stem stroke, her difficulties with upper limbs and pain, and the fact that she is registered blind, we see that Mrs Lavender is experiencing pain on a number of occasions over a number of days. We have just looked at page 1013. It is not clear whether this relates to the care plan on 1014, the care plan relating to a problem of painful shoulders and upper arms where the desired outcome was to relieve pain and make Elsie more comfortable. That would certainly fit in with the dates, I think. If we look at the first entries, 27 February, and the dates follow on, on page 1013, the care plan contents deal with pain.
A Yes.

Q Again, is it clear from that document, amongst others, that Mrs Lavender was experiencing pain over the period that she was in Gosport, and the pain was not being controlled by the medication that she was being given?
A Yes.

Q I think if one were to go to page 1022, this is not a care plan, but the summary or a continuation rather of the summary. There are entries over a number of days about pain, drugs prescribed and being given for pain.
A Yes.

Q By the time we get to early March, 4 March, the patient is still complaining of pain, getting extra analgesia as required, meaning Oramorph, and the morphine sulphate tablets being increased by Dr Barton.
A Yes.

Q The following day it suggests her pain was uncontrolled and at that time a syringe driver was started.
A Yes.

Q If we go back one page, that is the summary that shows the admission to the ward and I think, do we finally arrive at your signature?
A You do, yes.

Q Did you know what Dr Tandy's view was when you made that entry, that this was a probably brain stem CVA, meaning cardiovascular accident?
A Yes. Yes, I would have done, because we got the faxed copy of the letter regarding the patient before the patient arrived.

Q I understand. You say you give the date, 5 February, which was the date the ambulance crew rescued her.

> "She now has problems with her grip in both hands and also experiences pain in arms and shoulders. Can transfer with two nurses. Seen by Dr Barton. Medication prescribed".

"Transfer with two nurses", we know that on Barthel activities of daily living charts, whether a patient was able to transfer at all or whether they needed some help or two people to help, that was a relevant consideration.
A Yes.

Q Where was that information coming from, "Transfer with two nurses"?
A Generally speaking when somebody came through the ward you would type that from the transfer letter you got from the nurses from the ward the nurses came from.

Q In your experience in the mid-1990s at Gosport, was the information on the transfer letter as to how the patient was doing, was that always borne out by the patient that you saw?
A No, it was not.

Q In what way was there a mismatch between the two?
A Quite often the letter would actually state that the patient could walk or transfer with two people, but when they came to the ward it became apparent actually that maybe they could transfer, but it was with difficulty and they certainly could not walk any distance. I suspect it may have had something to do with the fact that a lot of the nurses at the naval hospital were sailors.

Q Sailors?
A Yes, gentlemen who were quite burly.

Q At the Royal Haslar?
A Yes, and they actually took a lot more weight of the patient than would generally be recommended.

Q I understand. I was not going to take you through any more of the records save to ask you if you were involved in giving medication to this lady. We have got prescription sheets in the bundle. They start at 995 in time.
A Do you want me to look through and tell you what I gave?

Q I think the first drug there, is recorded as an "as required" prescription, and it is hydrocodeine, written up by Dr Barton on the day that we know Mrs Lavender was admitted on the ward, 22 February. Are you able to help us with the handwriting for any of the occasions when that medication was given? Is your writing there?
A It is not. Do you want me to identify it?

Q No, I do not think it is necessary. I just need to ask when you gave any medication. If you go on two pages to 997, you will see in the middle of the page morphine sulphate tablets were written up, 10 mg is the first of them, and that prescription is dated 24 February, so two days or so into her admission at Gosport. Can you tell us if your writing is there as any of the nurses giving medication for that morphine sulphate from 24 February?
A Not the MST 10, no.

Q MST 20 is written up as well, below.
A Yes, I gave it ---

Q That is from 26 February we see is the first time that that was given so clearly an increase in medication for Mrs Lavender from about that time. You were going to say you gave some of those?
A Yes, I gave it at 10 a.m. on 27th and 2nd.

Q If we go on we can see that the prescription was changed. I should ask you to go back to page 992 – going on in time but going back in the pages. The second entry down says "Oramorph" and it is also written in as MST. The date is 4 March 1996.
I think you will tell us that neither of those entries for administration are by you?
A That is right, they are not me.

Q If you go back one further page to 991 we can see what the Panel are familiar with – a syringe driver written up on 5 March 1996 and diamorphine has been written up at a dose of 100 to 200 mg and were you involved in the administration or setting up the syringe driver on 6 March?
A Yes.

Q And Mrs Lavender had had the same dose the day before, on 5th?
A Yes.

Q I think if we go to a different part of the records we have looked at page 995 before and we can see that a syringe driver was prescribed, as it were – diamorphine, midazolam and hyoscine have all been written up on 26 February 1996 at a different dose and the diamorphine then at 80 to 160 mg, but never given.
A Yes.

Q Of the syringe driver that you instituted on 6 March what would you say about the reason for giving it and the appropriateness of giving it for this patient, as far as you can recall?
A I cannot remember the patient at all. The only information I have is from the documentation. Looking at the amount of pain that this lady had that was very difficult to be controlled and the prognosis I would suggest it was put up because she was in a great deal of pain and distress.

Q But if you had had concerns about any dose that a patient was written up for, what would you have done?
A I would have spoken to Dr Barton about it.

Q And if you could not get hold of Dr Barton or she was not able to speak to you at that time, would you have given the drug?
A If I had had concerns?

Q Yes.
A No, I would have got somebody else in.

Q I am closing that file now because I have asked the questions I want to ask. Can I ask how approachable was Dr Barton during the time that she was looking after patients on the ward you were working on?
A I always found her extremely approachable – very easy to work with, more than happy to listen to what was said and engage in conversations about patients.

Q Were all doctors as easy in conversation with nursing staff as Dr Barton was?
A No.

Q I am going to ask you to expand on that. You do not have to identify any doctor but you have obviously worked with a lot of doctors over your 25 years in nursing.
A Yes.

Q Tell us, there is clearly a range of modes that doctors may have when dealing with nursing staff.
A Yes. Some doctors do not listen to what nurses say, do not take on board the information that they are given and disregard information that they are given regarding patients generally and also their beliefs and their families, and act without consideration for the information that they are given.

Q How common is that nowadays or was it in the 1990s.
A It is getting less common.

Q Good. How common was it in the 1990s?
A Some of it depended on how long you worked with a doctor for, as a generality, because obviously there is a relationship of trust that needs to be built up. It was more common than it is now.

Q And so far as patients on Daedalus Ward were concerned, we know that Dr Barton was only there for a limited period of time. I am not going to ask you what hours she was there because I think we have heard all that information over the last six weeks or so, but can you tell us how important was it for Dr Barton to receive information about her patients from nursing staff?
A It was very important because we are the people that were there 24/7 and we are the people that can relay the information about what is actually going on with the patient.

Q If a patient's condition changed or the family wanted to speak to the doctor how would Dr Barton learn that information?
A We would tell her. If she was not around at the time, if she was at the surgery we would ring her if it was urgent; and if it was not we would wait until we saw her either first thing in the morning when she came round or later in the day when she came back. We would ring her at home, yes.

Q How did she deal with receiving calls when she was not in the hospital or when she was at home?
A Very well. She always appeared – what is the word? – happy to receive the information. You never got the impression that actually you were wasting her time or telling her inappropriate things. Even in her own time she was more than happy to talk about patients and their care.

Q I do want to ask you about her level of commitment to medical care for the patients on the ward. So far as you were able to judge how committed was she to patients?
A Extremely. I have no doubt about that. It is unusual to find doctors who are happy to talk to you about their patients in their own time.

Q Was that the impression you got, that some of Dr Barton's time that was her own time was spent dealing with patients?
A Absolutely.

Q And attending the hospital.
A Yes.

Q Can I ask about how busy Dr Barton was during the time that you saw her on the ward and during the times that you might have been making phone calls to her or trying to communicate with her about patients?
A My impression at the time was that she was a very busy lady. She would come in first thing in the morning, then go to her own practice and then come back. When she left us she was always going somewhere else to do something else with patients.

Q Can you tell us about consultants on Daedalus Ward? We know that there was a period when one of the consultants was on maternity leave or was off for a long period of time.
A Sorry, I am trying to remember.

Q Do not worry about that; are you able to tell us how often you saw a consultant on the ward?
A Once a week.

Q And that was for a ward round?
A Yes.

Q And what we have heard is that Dr Barton would attend for a ward round every second week.
A Right.

Q What would you say about the level of medical cover that there was for the patients that you had on Daedalus Ward in the 1990s?
A I would say it was too little. The patients became increasingly complex and the workload went up – very slowly – as the patients would come to us less well than they did initially. Certainly generally over that ten-year period-ish originally the continuing care patients that came to us are patients that these days would go nowhere near continuing care funding.

Q We have heard that continuing care patients – some of them – would be there for years.
A Mm.

Q They would be ambulant, they would have minimal medical needs.
A Yes.

Q And few nursing needs.
A Yes.

Q They just were not able to live in the community at that time.
A Yes.

A

Q But the mix changed, clearly.
A It did.

Q What sort of patients were you getting as time went on in the 1990s?
A We were getting rehabilitation patients – stroke rehab patients initially on Daedalus, which in themselves they were sicker people and needed more care than the continuing care
B patients did. They became poorly more often. They were more difficult and more complicated to manage from a medical point of view and a nursing point of view than the type of continuing care patients that we had had. The continuing care patients, as the criterion started to change, also started to become more complicated and iller – taking more time.

Q Were patients being transferred to Daedalus from other hospitals?
C A Yes, they were, and generally over time they were coming to us iller than they had been originally. It is very slow; you do not sort of notice it because it happens slowly. But was there any increase in nursing cover ---
A No.

Q ...over those years, to accommodate the change in the workload that you were dealing with in Daedalus?
D A No.

Q Was there any change in the cover by doctors over that period of time?
A No.

Q So how would you say the nursing staff were able to deal with the change in the complexity of the work that you had to do?
E A We had to learn fast and we had to react more quickly and get things done in a faster way. Probably, as always happens, if you get busier and busier there are things that perhaps you do not do as well as you would like.

Q Yes. What do you mean by that?
A I am looking at that documentation I did not sign, and that is what I am thinking.

F Q If nursing is done properly the records would be full.
A Yes.

Q Tell us, as a consequence of increased workload over time, were there any consequences for the paperwork generally?
A I think generally, yes, because it is really hard to... Generally we go into nursing because actually we want to make people better and if you have a patient who needs
G something done now – you know, if they want the toilet they want the toilet, and if they need something done they need it done now. And if as a result you forget to do your paperwork because you are doing something else for the patient to make a difference now, then that is what goes.

Q What about Dr Barton and the increased workload on her – how did she seem to be coping with it?
H

A I have to say that she always seemed cheerful and committed to her job. She was always approachable. It did not seem to affect her in that sort of fashion.

Q What about her paperwork or notes that she was keeping?
A It is difficult because I think they were briefer than perhaps they could have been. But when you work with somebody for a long time and you see what they do, that just becomes the norm.

B

Q Did the brevity of her medical notes ever cause any problems?
A Not that I can recall, no. We always had the conversation so we knew what was happening.

Q Can I come back to the state of patients arriving with you. What you have told us already is that some patients were described, perhaps coming from the Haslar, as more
C mobile than in truth they were.
A Yes.

Q What about the medical state of patients, leaving aside their mobility – did that change over time? You have told us that they were iller as patients arrived.
A Yes, they were. They would come over with temperatures, perhaps, whereas previously they would have been medically well and they come with a temperature and you
D have to find out why they had a temperature and treat them accordingly – that sort of thing. But generally speaking they came frailer – there were more drips and drains and tubes.

Q We know with this lady – because we have looked at the record, your commencement of the summary – that you had Dr Tandy's note or letter because you copied out some of the contents of it.
A Yes.

E

Q Dr Tandy, clearly one of the consultants agreeing to admit this patient.
A Yes.
Q If you got transfer letters written by doctors from other hospitals were they always accurate as far as the medical condition of the patient?
A I am not sure that the nursing staff ever got transfer letters from other doctors from other hospitals. We would get nursing transfer letters and if patients were transferred from
F QA they would just come with their notes.

Q You have given us an example of patients who might come with a temperature. Can I just ask, were the patients always stable?
A No.

Q They were not, when they were transferred?
G A Yes.

Q I do not know, but as nurse I think you were second in command on Daedalus Ward.
A Yes.

Q Did you ever say anything about that?
A I think it was well known and certainly Dr Lord knew.

H

Q Would it have been your place to say anything?
A It would have gone up the chain of command nursing-wise and that would have been well known – my boss and my boss's would have known that actually these patients were generally sicker.

Q In your experience if patients who were sicker over time or patients transferred when they were not stable what consequences might there have been for those patients?
A They did not have access to the facilities of an acute general hospital so we could not scan them and treat them possibly in a way that they may have needed, and some of them needed to go back.

Q Was it always possible to send them back?
A It is a while ago, is it not? I think that if they acutely needed to go back and they were really poorly, really ill, then they went back. But if we felt we could manage it we would keep the patient with us because actually an ambulance ride from wherever they had come from is an exhausting, traumatic thing, and patients who are unwell do not respond well to extra transport. So if we felt we could manage it my recollection is that we would keep them and try and manage them.

Q I understand. I am going to ask you to expand on what you mean by "do not respond well to transport". You do not just meant that they were not happy?
A No.

Q You mean more than that?
A Yes, I do. It is exhausting for patients and patients who have had a stroke are exhausted already. It is very tiring; they get cold; they can get disorientated; it is uncomfortable and in fact for people who have pain an ambulance trip can be a very painful thing.

Q What about patients who may be disturbed in some way, perhaps because of dementia or confusion? How did they respond, if you can help us, to being transferred from one environment that they may have got used to to a new environment?
A Any confusion that they had would worsen. It is a new environment; not only is it the journey, it is the fact you have got different people at the other end and a different environment.

Q As time went on during the 1990s, would you have had as much time to talk to relatives as you did once you first moved to Daedalus Ward?
A Not as much as I would have liked, no.

Q If patients are iller, do you need the same or more time to talk to relatives?
A You need more.

Q Tell us why that is?
A Because it takes time for people to come to terms with what is happening to their families and quite often they just need time to sit and absorb what is actually going on and to be able to ask questions at a later date. It is quite often several conversations as opposed to one when they are ready for those conversations.

Q You say "when they are ready"; why do the relatives need be ready?

A Because when you are stressed and anxious and scared ---

Q Are you talking of the relatives or the patients or even the nurse?
A It depends on the day. The relatives: because if you know a member of your family is unwell, it is a very frightening thing because the ultimate disaster is possible. You might lose them. People come to terms with that in very different ways and over very different timescales. Some people are able to take that information on board; other people are not. Other people get very angry at situations or do not ask questions because actually they do not want to be told what they know they are going to be told.

Q Are nurses always able to have those conversations or might there have been some conversations that nursing staff would prefer that the doctor had? Do you know what I mean?
A I do.

Q If someone is perhaps in the terminals stages or something very serious has happened, would the nurses always feel comfortable having that conversation and getting that information?
A To some extent I think it depends upon the relationship that you have with the person to whom you are giving that information. There is also an element of the professional expectation, that relatives expect to hear news from the doctor because they are the people that know, in inverted commas. I am not disputing that they do know, you understand; it is just that they are the people the patient's relatives have that view of.

Q As time went on and you were dealing with iller patients, you told us there was a greater need for nursing staff to have conversations with relatives.
A Yes.

Q What would you say about the need for the doctor to have conversations with relatives as patients got iller over time?
A There was more to talk to them about because of the possibilities of the progress of their disease.

Q You have told us that there was no more doctoring time because none was allocated. Are you able to tell us how Dr Barton was able to deal with those conversations with patients and their families?
A She would ask if relatives wanted to talk to her. Quite often we would know that she wanted to know that so that when the relatives come in we would ask them if they would like to talk to her.

Q Was this conversations between you and Dr Barton about when she might speak to the relatives or whether the relatives would have wanted her to speak to her?
A Yes, and if the relatives asked us to speak to the doctor, then we would talk to Dr Barton.

Q Would you arrange it with Dr Barton so that she would come in and appointments effectively would be arranged with relatives?
A Yes.

Q Would you have been present during any of those conversations that Dr Barton may have had with relatives?
A Yes.

Q How did she deal with those conversations?
A My recollection is that they were always very calm, that she explained what was happening, what was wrong with the patients, what the likely outcome was going to be and asked if they had any questions for her.

Q What would you say about her manner? The Panel have heard some concerns expressed by relatives that she was brusque or rude. What would you say from the conversations you will have witnessed?
A I would say when I was in the room I never walked away thinking: oh, that was a bit not right. Dr Barton calls a spade a spade and she is very clear about what is happening. I do not remember at all a time when I think she was actively unkind or certainly not rude. Some patients and relatives have difficulty receiving the information because they actually do not want to hear it and they become angry.

Q Again, it may be difficult to recall but are you saying patients became angry because of the way Dr Barton was talking to them?
A No, because they did not want to know that Mum was dying.

Q You have used the expression "Dr Barton would call a spade a spade".
A Yes.

Q Of the conversations that you saw, was that an appropriate way to deal with matters or did you feel it was an inappropriate way?
A I think it felt appropriate to me from the conversations that we had, that I was present for. She explained what was happening and the likelihood of the prognosis. It was given with an explanation. It was not, "Oh, by the way, your mother is dying" – sorry, but it depends what you mean by brusque. I think it was just clear actually.

Q What you have told us is that some relatives got angry
A Yes. I have one recollection of one family who did get angry specifically, but we had been very gently trying to explain that Mum was not well and was not expected to live because she had stopped eating and drinking and she was not responding to anything that we were doing, so we tried to have those conversations with them and they were just blanking the information.

Q What would you say of the level of nursing care and medical care that was given to the patients during the time that you and Dr Barton were dealing with patients on Daedalus Ward?
A I thought it was good. I thought the patients were well looked after and comfortable and their relatives the same actually.

Q And you include the medical care in that as well, I think?
A Yes.

THE CHAIRMAN: Mrs Astridge, you have been giving evidence for about an hour and normally after an hour we reckon a witness may have had enough. If you would like to take

A a break now, you can certainly have one. If you are happy to go on for a few more minutes, then we will do that.
A I am happy to go on.

Cross-examined by MR FITZGERALD

B Q Mrs Astridge, just to fill in the background very briefly, you were senior staff nurse on Daedalus Ward during 1996.
A Yes.

Q The reason that you have only been asked about one patient, Elsie Lavender, is because she is the only patient that you dealt with personally in this case.
A Right.

C Q You remained in that position until about 1998; is that right?
A About then. It gets a bit vague after a while, I am afraid.

Q You then went off to work in St Christopher's Hospital in Fareham for about six years?
A Yes.

D Q And then you returned to the Gosport War Memorial Hospital: is that right?
A Yes.

Q You took up a position as the clinical manager on Dryad Ward?
A Yes.

E Q In 2004?
A Yes.

Q That was the position that we have been talking of as sister?
A Yes.

Q And you did that from 2004 till when?
F A Two years ago.

Q Before you came on to Daedalus Ward in 1996, is it right that you had had some training in setting up syringe drivers or did you have that on the job in the ward of Daedalus?
A It was on the job.

G Q When we talk about training in that context, does that mean training really in how the driver functioned in terms of how you would set it up, how it would operate?
A Yes.

Q Rather that of course the medication to be used or correct doses, matters of that nature?
A Yes, although we did have access to some Countess Mountbatten training as well, if I remember rightly.

H

Q I will come back to that in a moment. You were obviously one of the people who were spoken to by the police. Particularly in 2004, you made two statements. There is a copy of this if you would like to see it. If I just read a paragraph from the statement you made in October 2004, you said: The term 'Wessex Protocols' refers to the palliative care book used for guidance in what drugs are to be used in that care. I believe that these guidelines were used at the Gosport War Memorial Hospital.
A Yes.

Q And so the guidelines are from the Countess Mountbatten body – is that what you are talking about?
A Yes.

Q Those guidelines that we have been referring to in this case as the Wessex Protocols?
A Yes.

Q Was it your understanding that those guidelines would be followed on the ward?
A Yes.

Q Is it as a result of that that you were comfortable with the use of diamorphine on the ward?
A Yes.

Q You still have the file for Elsie Lavender, is that right?
A Yes.

Q First of all, you have no recollection of Elsie Lavender?
A No.

Q When you were referred by the police to certain entries in the notes, the same entries that you have looked at today, you had no recollection of the notes?
A No.

Q That is no criticism whatsoever; it is the passage of time and no doubt you dealt with a huge number of patients but you simply did not remember.
A No.

Q And so anything that you have to say about the patient or what happened is based simply on what we have there in the notes?
A Yes.

Q In terms of your own dealings with her where there was any mention of pain or discomfort, you have been referred to two entries, but firstly from the admission, because you wrote up some notes of admission, did you not ---
A Yes.

Q They are in our bundle at page 1021. It might be sensible just to look at it so that you can follow what I am saying. The first entry for 22 February, that is your writing?
A Yes.

Q It has been written up on admission and it is the one where it says that she experiences pain in the arms and shoulders?
A Yes.

Q And that she can transfer with two nurses. You have clarified I think that sometimes that sort of information, for example on whether a person could mobilise, would simply come from the transfer letter?
A Yes.

Q Sometimes presumably it would come from looking at the patient and dealing with them?
A Yes.

Q Is it right to say that because you do not actually remember the patient, you cannot say in this case where that has come from?
A That is right.

Q But there is obviously a reference to experiencing pain there and that is your entry?
A Yes.

Q The only other entry which you have made, or in fact not made by you but your name appearing, is on 2 March, and that is on page 1013. Do you have that?
A "Slight pain in shoulders when moved".

Q Yes. So it is the entry for 2 March: "Slight pain in shoulders when moved". Your name features along with someone else's.
A Yes.

Q In fact it has been written out by the someone else but it is an indication that you must have been present at the time?
A Yes.

Q And so, in terms of your experience of this patient and any pain that was being registered, that is it really, is it? You have not been referred to any other notes or anything else that shows that you have personally seen what condition she was in?
A Not that is here, no.

Q If you look at the drug chart on page 991, this is where we see the syringe driver being started. This is the page of the drug chart with diamorphine and midazolam on it.
A Yes.

Q The first administration is on 5 March.
A Yes.

Q That was not you, was it?
A No.

Q Do we see that in fact your role here was limited to recharging the driver with the same quantities of diamorphine and midazolam on the morning of 6th?
A Yes.

Q After it had been certainly running for a day.
A Yes.

Q There is no other note by --- Excuse me. We will see what other note there is in fact about her condition if we look at page 1023, please. First of all, it is right to say, apart from what we have looked at already, there is no other note by you of this lady's condition approaching the syringe driver being set up, is there?
A That is right.

Q But what we do have on page 1023 is, at the top of the page, an entry for 6 March and is that your writing?
A Yes, it is.

Q So this is you and the entry says: Seen by Dr Barton. Medication other than through syringe driver discontinued as patient unrousable."
A Yes.

Q And when you made your statement to the police you confirmed that "unrousable" means that she was deeply asleep or comatose?
A Yes.

Q Having seen that you recharged the driver at around 9.30 in the morning or so, and this is a reference of being seen by Dr Barton, does that suggest that that must have been after Dr Barton's morning round that you wrote the note?
A Yes.

Q Because she would normally come in first thing in the morning.
A Yes.

Q And that is when the condition would have been reviewed.
A Yes.

Q And obviously a decision made that the other drugs would have to be stopped because she was not in a condition to take anything other than through the syringe driver.
A That is right.

Q What the Panel know from the notes is that when the syringe driver was started, the day before, the 5th, the starting dose of morphine was 100 mg.
A Yes.

Q And the starting dose of midazolam was 40 mg.
A Yes.

Q This was a patient who had, at that point, been on an oral dose of morphine of 60 mg a day.
A Yes.

Q Would you agree that the starting dose of morphine is very high?
A I think it is difficult unless you can actually see the patient in front of you.

Q In terms of adding midazolam to the mix for such a patient, what would you say about those as doses of an opiate and a sedative? Would you say the same?
A I would really.

Q Did you have any knowledge yourself at the time of the conversion rate, the proper conversion rate between oral morphine and diamorphine?
A Yes, it was in the Wessex Protocol Guideline book.

Q So you would normally expect that guideline, that conversion rate to be followed?
A Generally. If we were setting up a syringe driver the nurses would follow that guideline, yes.

Q Do you think, and please say if you simply do not remember or cannot say, but do you think that you actually gave any consideration in this instance as to whether or not it was an appropriate dose, given that it had been set up the day before by someone else?
A I do not think I can say. I do not remember the lady at all.

Q Just one or two very quick matters in addition to that. You were making the point that as time went on, your years on Daedalus Ward, your workload increased.
A Yes.

Q At one stage you said that you thought the medical cover was too little.
A Yes.

Q But you have also mentioned that Dr Barton seemed to you always to remain chatty and comfortable in what she was doing.
A She was cheerful, yes, and approachable.

Q Approachable, and that the care that you provided for patients on the ward was always good.
A In my opinion, yes.

Q So you are not saying, are you, that as a result of how busy you were or because of a lack of medical cover, that Dr Barton's care for the patients suffered?
A No, I am not.

Q The last topic is about transfers that you received from the acute hospitals. You first spoke about transfers and how their mobility might be represented in a transfer letter compared to how they would be when they got to you.
A Yes.

Q When you were explaining how there might be a difference, you said that sometimes they would come from a hospital where there were maybe burlier men doing the job of supporting the patient.
A Yes.

Q And therefore I suppose the note would not be inaccurate, so to speak, but there may be a difference from what you would experience.

A A Yes. However, with manual handling guidelines and manual handling issues, I would probably question whether what they were doing was actually in the patient's best interests, or theirs actually.

Q Correct me if I am wrong, but you are not saying that the mobility of the patient was actually being misrepresented to you in the letters.
A No.

B

Q You also mentioned that some of the people who came to you were so poorly that they needed to go back to the acute hospital.
A Yes.

Q And that that could happen if the person was acutely unwell.
A Yes.

C

Q But that sometimes, weighing up the dangers or risks of transferring back, if you felt that you could manage the patient more appropriately on the ward, then you would do so.
A Yes, that is my recollection.

Q So is it right that for each patient there will be a weighing up of the risks of transfer.
A Indeed.

D

Q As against what was going to happen if the patient did not get the acute treatment.
A Absolutely.

Q And that would very much depend on the particular patient.
A Yes.

E MR FITZGERALD: Those are all the questions I ask. Thank you.

Re-examined by MR JENKINS

MR JENKINS: I am just going to ask a few questions arising out of what you have just been asked. For any acutely unwell patients who have arrived at Daedalus Ward, you told us you had to weigh up whether it was in their best interests to stay or to be sent back.
F A Yes.

Q You told us about the consequences that might flow if an unstable patient was transferred in to Gosport.
A Yes.

Q Would you have thought it appropriate to consider the possible consequences of
G transferring them straight back, a double transfer?
A I think we did.

Q You were asked about syringe drivers and any training that you had had, and you said that it was training on the job. Are you able to tell us roughly when you got it?
A No, I am sorry.

H

Q It is a difficult one. What we have heard in the evidence is that Dr Barton came to Gosport as a clinical assistant in 1988 and that it was about that time after she started that syringe drivers started to be used. We know that some concerns were raised in 1991, but I do not know if you were involved in that at all, concerns raised by nursing staff.
A I think that was at Redclyffe Annex and I heard about it but was not directly involved in it.

Q We know that those issues were raised during the second half of 1991. Are you able to tell us whether you had had your training by then or whether it came later?
A I am sorry, I really cannot remember.

Q I am just using that as a fixed point because we know the date of when those concerns were raised. You told Mr Fitzgerald that there was also some training from the Countess Mountbatten.
A Yes.

Q We have heard of the Countess Mountbatten. Remind us, is it a hospital, a hospice?
A It is a hospice.

Q It is a hospice?
A Yes.

Q Are you able to tell us who from the hospice came to give training or did you go to them?
A It was different things over the years. So there was times when they came to us and actually I believe the first time they came to us was after the 1991 incident, in answer to your question.

Q We have heard the name Dr Bee Wee.
A It rings a bell.

Q I think we have heard he was a consultant at the Countess Mountbatten.
A I think so.

Q You have been asked about the Wessex Guidelines and you told us those were followed.
A Yes.

Q The Wessex Guidelines, we know, involve approaching pain relief by going up in stages, as may be appropriate.
A Yes.

Q When you say they were followed on Daedalus Ward, do you mean they were followed by the medical as well as the nursing staff?
A Yes, I think so. It is difficult because I just remember reading the book and following what it said, so I probably would not have thought directly what was happening with the medical staff because I always associated it with the little green book you looked into to find out what you did next. But there was certainly a step by step approach.

Q If a patient presented who appeared to be in quite severe pain, was the approach taken that you would always start at the bottom?
A Yes.

Q Or might people come in at a slightly higher stage on the ladder?
A There is always some element about balance, seeing the patient and what that patient needs at the time. There is no point giving someone paracetamol if they are in lots and lots of pain. You need to do something about it.

Q I understand. You have made the point that you need to see the patient in order to assess what treatment they should get.
A Yes.

Q Your attention was drawn to the records with Elsie Lavender and the fact that you have got entries referring to pain on 22 February 1996, the day she was admitted, and also on 2 March, three days or so before the syringe driver was instituted.
A Yes.

Q We have seen other entries in the records for different dates between those and following those where other nursing staff have indicated that Mrs Lavender was in pain; that her pain was not controlled with what she was on.
A Yes.

Q As the named nurse for Mrs Lavender, would you have been aware of any other entries made by other nursing staff?
A I would have been aware of the condition of the patient on handover, because it was always discussed.

Q At handover did you discuss every patient?
A Yes.

Q So for the entries that we have at 1021, towards the bottom of the page it is Sister Joines on 24 February, the day that we have seen already Dr Barton changed the prescribing,

"Pain not controlled properly by DF118" –

that is dihydrocodeine, I think.
A Yes.

Q "Seen by Dr Barton. Boarded for MST 10 mg b/d",

meaning twice a day.
A Yes.

Q "Boarded" means?
A Written up.

Q Would you have been aware of that?
A Yes.

Q Over the page, if you would, another entry by Sister Joines the next day, the 25th,

"Appears to be in more pain, screaming, 'my back' when moved, but uncomplaining when not".

Would you have been aware of that?
A Yes.

Q Reference to the son,

"Would like to see Dr Barton",

and then the following day, another entry by Sister Joines,

"Seen by Dr Barton MST to 20 mg b/d".

In other words, the morphine sulphate tablets were increased, doubled from 10 mg twice a day.
A Yes.

Q There is then an entry by Sister Joines about a conversation with the son and his wife that afternoon, 26 February. An entry just below that, the same afternoon, saying, "mattress needed changing" and so more morphine sulphate was given prior to moving Mrs Lavender on to it.
A Yes.

Q As we look further down the page, knowing that this is just one page amongst many dealing with this lady, would you have been aware, before you set up the syringe driver on 6 March, of the complaints of pain recorded here on the 4th?
A I would have been, yes.

Q She was getting Oramorph PRO as required, on top of the morphine sulphate tablets she was getting, and then the morphine sulphate tablets were increased by Dr Barton . That is two days before you gave --
A Yes, I would know the history about what has been going on. If I was not on duty that day obviously I would not be told then, but when I came back, yes, I would know about what had happened to the patient since I had not been there.

Q Obviously the entry for 5 March that, notwithstanding the change in medication, her pain was uncontrolled and she had had a very poor night. Did it happen from time to time that it was difficult to get on top of the pain?
A Yes, it did. Some people respond better than others to different pain killers. Sometimes it can be very difficult to control.

Q You were asked about the entry over the page at 1023, that the medication other than that through the syringe driver was discontinued because Mrs Lavender was unrousable. Tell us, were patients sometimes unrousable even if they were not on a syringe driver but were dying?
A Yes, absolutely.

Q If patients are dying, leave aside patients who are receiving opiates, but patients who are dying without opiates, they could sometimes be unrousable, could they?
A Yes, definitely.

Q Tell us why that was on your understanding?
A It is part of the dying process. As people die things shut down and they just go into coma. Some patients, not all, obviously. It just depends on the patient.

Q I understand. As an experienced nurse, now 25 years in nursing, would you draw any inference from the fact that this patient was said to be unrousable on the 6th as to what had led to that?
A I would not. I would just assume it was because she was dying.

Q I misled you, I think, I called a CVA a cardiovascular accident. It is a cerebo vascular accident, a bleeding to the brain.
A Yes.

MR JENKINS: Thank you very much.

THE CHAIRMAN: Thank you, Mr Jenkins. Mrs Astridge, I mentioned that a time would come when members of the Panel would have the opportunity to ask questions of you. I am just going to see if there are any questions. I am told that there is a need for a break first, so we will come back in 15 minutes. During that time, you will be taken somewhere and hopefully given some refreshment, but please do not discuss the case with anybody during that time.

(Adjourned for a short time)

Questioned by THE PANEL

THE CHAIRMAN: Welcome back everyone. Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Good afternoon, Mrs Astridge. These questions have been asked of many people, many witnesses as we have gone through the course of the hearing to date but I would just like to hear from you as well. Patients arrive, like this patient, the one that we have been talking about, Elsie, and they would come for mobilisation, rehabilitation, etc.
A Yes.

Q And then move through, maybe into palliative care and then into terminal care.
A Yes.

Q Talk me through about the standards that were set and how those decisions were actually made.
A The patients would be assessed when they arrived on the ward. Then there would be nursing assessments and medical assessments and physiotherapy assessments. A plan would be made for their rehabilitation. We would follow, nursing staff would follow physiotherapy instruction regarding moving and handling and positioning, which is very important in stroke rehabilitation. If they became more unwell, then obviously medical assessment would be made to decide what was happening and why. If it was decided that actually the patient was

palliative, then discussion would be had with the relatives and the patient if at that point they were able to participate in the discussion. Plans would be made for if they deteriorated further. Is that what you wanted?

Q That is what I am looking at and understanding. If I look at this patient and the notes on this patient, what we know is that once someone moves to the syringe driver, with the analgesic levels at the level that they are, it is the end of life, end of life care.
A Yes.

Q But what I do not see is where those decisions were made, that the pain was not controllable or able to be dealt with in any other way other than through the analgesic route. For instance, if I look in here, we are moving to a terminal care stage.
A Yes.

Q What I do not see is how that assessment is actually being made and recorded.
A I do not think it is being recorded, particularly. I cannot remember this lady but looking through the notes, there has obviously been a discussion with the family about the fact that this lady has got a poor prognosis, and in the notes there are notes about the fact that her pain is not being adequately controlled. In fact she is being kept in bed because the pain is so bad, movement is so painful for her.

Q Right. But that seems to fluctuate, does it not? On the 2nd, here I have got,

"Slight pain in the shoulders when moved",

which I think is signed off by you.
A Yes.

Q Then on the 5th I have got that then she has physio and three turns of the head to right and left, etc.
A Yes.

Q Which all seems to be part of the rehabilitation and mobilisation. The next one I am into, "Pain uncontrolled" and then we are on to the syringe driver and the sort of quite a high dose of analgesia. So we have moved from one treatment, which seems to me as a lay person, one treatment path to another treatment path and I cannot see the full assessment that has been made to move us from one to the other.
A Looking at what I have seen, because I cannot remember, the lady's pain probably would fluctuate because she has had increasing amounts of analgesia as she has gone along. So as the analgesia is increased one would hope the pain would be better, but my interpretation of what is written in the notes is actually, it might be better now but the next day it is worse. So again it is uncontrolled so the analgesia has been increased.

Q I suppose what I was looking for from how you described how decisions were made when going from one stage to the next stage, is that if that was common practice then I guess I would have expected to have seen in here how that assessment was made that you are now into the terminal stage with this patient.
A I know that these days we use something called the Liverpool Care Pathway where the documentation is really clear and expectations of how things are going to be managed is

A actually done. Then I do not recall any sort of formalised documentation about that process. Is that what you are asking?

Q It is a way because you set out there, when I asked you how it was generally dealt with, as though there were some reasonable standards in place and I am looking at how are they actually demonstrated, how do I know that they were being followed? Or how do I know that a patient does not drift into terminal care that was not at the terminal care stage of life?

B A There was no formalised way of documenting that sort of procedure in those days, that I am aware of. It was just a sort of set way – people would document as they went what they thought on the plans for the day, and actually this is what we are going to do because of X.

Q So how could you ensure that the patient was being properly protected – that the interests of the patient were being properly protected?

C A I think if somebody has pain we need to sort it out, in all honesty. It is very clear that this lady, the pain was not being controlled and it needed to be controlled.

Q But then it becomes quite difficult, does it not, to determine whether it is the analgesia that sent this person into a state of unconsciousness or the lady's process of dying that is sending her into unconsciousness if there is not the clarity before about that terminal stage – that they are actually now at the terminal stage of dying.

D A I would agree but I do not think in those days that people actually documented that as such.

Q That to me actually left the patient potentially – and I am not saying that it is that situation – it could have potentially left the patient open to moving into a terminal care pathway without a full assessment of a patient, but an assessment more focused on their pain rather than a full assessment of their condition.

E A I think I see what you mean but it is about the medical assessment of that patient that is where we should be.

Q So you are saying that you do not get that medical assessment documented, but they are now moving into that terminal stage?

A I certainly do not think that we did in those days, no. It is different now.

F

MRS MANSELL: Thank you.

THE CHAIRMAN: Dr Roger Smith is a medical member of the Panel.

DR SMITH: Just recapping, you worked on Daedalus for ten years as a senior staff nurse.

A Yes.

G

Q I think we have heard that through that period drivers were used but they were not used profligately because there were not many drivers, but they were not an unusual thing for you to handle, is that right?

A That is right.

Q Your attention has been brought to a prescription, an "as required", what

H

I guess we have been calling a prn prescription, for diamorphine and midazolam – it is on page 995, bottom left hand corner. That prescription was not actually carried out.
A That is right.

Q You are the senior staff nurse.
A Yes.

Q And often as not you may well be the senior nurse because sister is on her day off, or whatever?
A Yes.

Q How do you know when to start that treatment?
A It would never be started without discussion. It would be discussed with Dr Barton, the patient if they were able to have that discussion and if not their family and their next of kin. It would be used because they were dying and that discussion had been had.

Q It would be used because they were dying?
A And they were in pain obviously and they needed the medication, yes.

Q I am sorry I am going to ask you the same question that Mrs Mansell asked in a way, and in that context. How do you know when the patient is dying?
A If the prognosis is very poor; if it is an end stage of their life and if they have the symptoms that need those drugs then that is when we would use it.

Q And it is not written down?
A The fact that they are dying?

Q In this case that you have looked at, that you are involved with today, nothing is written down that helps you come to a conclusion on that, I think you said, because all you have is the notes?
A Yes.

Q And there is nothing in the notes to tell you that that change has happened?
A No, I would take the inference from the fact that there is documentation that Dr Barton says she has talked to the family regarding the poor prognosis. But that is an assumption reading notes back, yes; so I would agree.

Q What if Dr Barton had gone on holiday and left that prescription behind?
A We would talk to another doctor who was covering her.

Q You would always talk to a doctor before carrying out the prescription?
A As far as I am concerned I always did, yes.

Q You always would?
A Yes.

DR SMITH: Thank you.

THE CHAIRMAN: Mr William Payne is a lay member of the Panel.

MR PAYNE: Good afternoon. It is just to carry on from my colleague's question there. You said that nurses setting up the syringe driver would use the guidelines.
A Yes.

Q Am I right in thinking, though, that you can only work within the parameters of the prescription?
A Yes, indeed.

Q So if the prescription says this the guidelines do not mean anything, do they – you have to follow that prescription?
A We can refuse to give the prescription but apart from that yes, we have to use the prescription.

Q You could not either go lower or higher?
A No.

Q That is not your decision to make?
A No.

MR PAYNE: Thank you very much.

THE CHAIRMAN: Mrs Astridge, we have heard a lot about a phenomenon that has been described as anticipatory prescribing.
A Yes.

Q That is something with which you are familiar, is it?
A Yes.

Q Could you very briefly explain to us what the purpose of anticipatory prescribing is or was so far as you understood it at that time?
A My understanding is that it was there in case the patient needed it; in circumstances where we could not get a doctor quickly enough. If the patient has pain you do not want to wait until maybe on a weekend when the only doctor on call is out doing lots of visits and does not actually get back to the ward or get back to you for six hours or so.

Q So if a doctor could not be got hold of or was not available what was it that you would do?
A Not with the syringe drivers but with analgesics I would give the analgesic if somebody had pain.

Q Thank you. You say not with the syringe driver ---
A Excuse me, unless it had already been discussed at an earlier date with Dr Barton that actually the next step would be to do that and would be the appropriate thing for that patient, yes. So on a weekend maybe if we had had a discussion with Dr Barton that actually this patient was now terminally ill and actually if they needed more analgesia that was the right thing to do, then that is what we would do. We would not need to talk to one of her partners about it.

Q So merely writing up an anticipatory prescription for a syringe driver would not, in your view, be sufficient authority for nurses to implement or to administer the driver?

A A Not without prior discussion, no.

Q And in your experience, you are telling us, there always was such prior discussion?
A Yes.

Q What would be your view of circumstances in which nurses did not seek specific authority and there had been no prior discussion – if there were such a situation how would you regard it?
B A I would want to know why they had done that, if it was a member of my staff.

THE CHAIRMAN: Thank you very much. We are going to turn now to see whether Mr Fitzgerald has any questions arising out of the questions that have been asked by members of the Panel?

C MR FITZGERALD: No, thank you.

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: I do have a couple.

Further examined by MR JENKINS

D

MR JENKINS: What you have told us just now is that there was no formalised way then in the documentation of writing up that the patient was dying.
A That is right.

Q You have said more recently there is the Liverpool Care Pathway.
A Yes.
E

Q Which has its own documentation?
A Yes, it does; it is gold standard.

Q We have seen lots of care plans and those deal with particular problems or concerns – bedsores, ulcers and problems with incontinence. Would anyone ever write a care plan up for the patient dying and how it should happen?
F A Actually yes, but I think we came to write those later than this lady. We were more writing about symptomatic control in those days.

Q You were asked by Mrs Mansell about the indications that there are about pain for Mrs Lavender and you said that her pain probably would fluctuate because she had analgesia.
A Yes.

G Q What do you mean by that? Do you mean she had tablets?
A Yes, because her tablets have been increased steadily and her pain would probably be better when they were increased, but it was clear from the fact that every couple of days her pain control was increased that actually it was not adequate – her pain grew and she needed more pain killers.

Q What difference would a syringe driver make to fluctuating levels of pain?
H

A A You get an even dose of pain killer over a 24-hour period. If you take tablets you get highs and lows of concentrations.

Q What you said is that for any syringe driver that was written up, in answer to the Chairman, you have indicated that the fact it is written up does not mean that it should be given.
A That is required; it is as required and if it is not required do not give it.

B

Q And you have said that on Daedalus Ward where you were working there would always be a conversation with a doctor?
A Yes.

Q Dr Barton normally.
A In my experience, yes.

C

Q What conversation are you able to tell us, typically, would there have been between senior nursing staff and Dr Barton when the syringe driver was written up originally? Is that question clear?
A Yes.

Q We know that the syringe driver was originally written up for Mrs Lavender on
D 26 February. She was never put on that prescription at all; it was never instituted then, but instituted a number of days later.
A Yes.

Q On a separate prescription by 5 March, so a week or so later. Are you able to tell us what sort of discussion there would have been with the doctor before the original prescription was written up?
E A It would have been along the lines of this lady is obviously ---

MR KARK: I am sorry, this is purely speculative, about this patient at least.

THE CHAIRMAN: I think that must be right. If she does not have a recollection that should be it.

F MR JENKINS: That is fine. But are you able to tell us in general terms what your recollection is about discussions between nursing staff and the doctor before the doctor would write up an anticipatory prescription?
A Yes, we would talk about the condition of the patient, what the expected outcome for that patient was, and that you may or may not need to use this.

Q Before a syringe driver was ever started, if it was Dr Barton that was to approve the
G institution of medication would there have been regular contact between her and the nursing staff over the days since the prescription was written up?
A Yes.

Q And the syringe driver started?
A Yes.

H Q That would be contact when Dr Barton was there on the ward?

A Yes.

Q Or over the phone?
A Yes.

Q If I can just ask you to look back at this case – Mrs Lavender – page 1022, we know that that original prescription for a syringe driver was written on 26 February.
A Yes.

Q And we see from Sister Joines' note that that was the day that the son and his wife were seen by Dr Barton.
A Yes.

Q And the note suggests that the syringe driver was explained to the son.
A Yes.

Q Would that be typical, in your experience?
A Yes.

Q Whether noted or not?
A Yes.

MR JENKINS: Thank you very much, Mrs Astridge, that is all I ask.

THE CHAIRMAN: Mrs Astridge, that brings you to the end of your testimony. Thank you very much indeed for coming to assist us today. It is always very difficult for Panels to try to piece together forensically, as it were, what has happened often months or years in the past and we do rely on the testimony of witnesses such as yourself to assist us in that process, and for that we are most grateful. Thank you very much for coming and you are free to go.

(The witness withdrew)

THE CHAIRMAN: Tomorrow is a non-sitting day. As I indicated yesterday, the Panel is clearly going to require some considerable time to go through the transcripts of the doctor's evidence before they will be in a position to put their questions. What I am going to propose is that we give the Panel Friday morning to do that; so if I say not before two o'clock and then at two we aim to begin.

(The Panel adjourned until Friday 24 July 2009 at 2 p.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 24 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 THIRTY-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)

INDEX

JANE ANN BARTON, Re-called

THE CHAIRMAN: Welcome back everyone. I am sorry that we have taken rather longer in our preparations than I had anticipated.

Before we move on to the Panel questions, I had asked the Panel Secretary to photocopy and pass to the parties pages from the 1997 edition of the *BNF* to give you forewarning of the fact that a member of the Panel would wish to ask the doctor a question or questions in relation to something that is on one or more of those pages, and to give you the opportunity to indicate if you did not wish that to happen or if you had observations. Although the *BNF* 1997 edition is in part already before us as an exhibit, this is a part that is not, and so there is the issue of whether you felt that we were going beyond that which was before us and whether you had views on that. It is on that which I am inviting observations at this point.

MR LANGDALE: There is no difficulty.

MR KARK: I agree. Indeed, it is appropriate to put it on the transcript that the document has been circulated and there cannot be any objection.

THE CHAIRMAN: I am most grateful for that. It will follow that at some point in the questioning the panellist who wished to ask that question will indeed put the question and we will all hear then what it is.

Doctor, I am not going to trouble you with introductions to all the individuals. You are well aware of who we all are. I am going to begin by asking Ms Joy Julien if she has any general questions rather than patient-specific questions.

Questioned by THE PANEL

MS JULIEN: Good afternoon, doctor. My questions are general questions. They are questions that ask you to look retrospectively at the issues. The first question relates to your working conditions. You have told us that you were working between 1996 and 1999 in very difficult circumstances, mainly due to lack of resources, lack of sufficient supervision ratios, staffing ratios, and that that had an impact on your ability to write more detailed notes. You told us that you raised these issues informally, and I am just wondering now, with hindsight, whether you feel you should have raised them formally and at an earlier stage. I wanted to get your view on that.

A That is a very pertinent question, because I knew that the Trust for which I worked, the Healthcare Trust, was short of money. I knew there would not be money flowing to replace me or to add to the medical cover that I provided and I was sufficiently old-fashioned a GP to feel that the job in my community needed to be done, that I had been doing it for a number of years, and that while I could still continue to do it I would continue, albeit finding it increasingly difficult. Although my note-keeping suffered, I tried very hard to make sure that my clinical care of my patients and my staff did not suffer in the same way.

Q Now that you are here and you have been answering questions on these issues, where we are today, what is your view? Would you have done anything differently?

A No. I loved the job, I loved the people I was working with, I got great satisfaction from it, and I think it was only when the complaints began that I really realised that the job was beyond me.

Q Are you saying you would not have even formally raised the issues in writing?
A Of course I should have formally raised the issues in writing. Of course I should have made it obvious that it was becoming increasingly difficult for me and that I expected my consultants to do more to cover me and to help me. Of course I should.

Q You should have. At what stage do you now say that you should have raised it?
A 1998/99, when Dr Reid took over as clinical director, was the obvious time to do it, because there was a year without proper medical cover on Dryad ward where things became extremely difficult.

Q Still keeping with the retrospective view in terms of the individual patients, you have been giving evidence, you have been asked questions about the actions that you have taken and decisions you would have made, you have been criticised by Professor Ford on quite a few of the cases, and you have been specifically asked whether you consider your actions to be appropriate. You have answered throughout. You have said, yes, you felt they were appropriate. Really it is the same question: In retrospect, would that still be your answer in terms of all the cases? Would there be anything you would do differently?
A In the case of those 12 patients?

Q Yes.
A In the days and hours of their dying, I would have done nothing differently.

Q Nothing at all. There would be nothing that you would ----
A If I had had more medical cover, if we had had one-to-one nursing staff (as it sounded as if Professor Ford's unit had had), maybe we could have organised the terminal care in a slightly different fashion. But with what we had at that time and the way we did terminal care at that time, I have no regrets about the medication that any of those patients received.

Q So you would not have adjusted any prescription, you would not have referred a patient or asked for a second opinion.
A No.

Q In none of those 12 cases.
A No.

Q Even though you faced the criticism from Professor Ford, that is still your position.
A I have felt throughout that Professor Ford's criticism has been perfectly appropriate with the benefit of hindsight and looked at by a secondary care specialist with tertiary specialisation in palliative care – not a community hospital run by a part-time jobbing general practitioner: a completely different world of nursing, medical, everything treatment. I could not have provided the sort of care that he had at his fingertips in my cottage hospital.

Q Okay, putting aside Professor Ford's specific criticism, generally speaking is there anything now you have been going over these cases where you think, "Oh, well, maybe I should not have quite done that like that"? Is there anything?
A Nothing at all.

MS JULIEN: Nothing. Thank you very much.

MR PAYNE: Good afternoon, doctor. Can you see me okay?
A I can, thank you.

Q Because of Mr Langdale's boxes.
A I know. His wall. (Pause)

MR PAYNE: Yes, his defences, I think.

THE CHAIRMAN: Perhaps I could say for the transcript that the defence ramparts have moved six inches in the direction of Mr Langdale, opening up a clearer line of view between the witness and the Panel member.

MR PAYNE: I can say that because of your answers a couple of my questions are no longer relevant, which cuts the amount of questions I have down considerably. Could you turn to the transcripts of Day 25. Mr Langdale asked you a question and at the time I thought the answer did not fit the question, so then I looked it up on the transcript and I still felt that that answer did not quite fit the question. Would you turn to page 19E, where there is a bit of preamble before the question, and read it through and perhaps the question before. (Pause for reading)
A Yes.

Q I am going to ask you the question again, because I felt as though you answered the question and Mr Langdale carried on responding to that answer but I do not think the answer was the answer that the question should have prompted. "Was it always possible to think of a precise plan at that time or provide a precise plan?"
A The first part of my answer remains exactly the same: there were a few patients in which it was patently obvious what the plan was to be.

Q Yes.
A And that was the lady with carcinoma of the bronchus who had come to receive palliative care. There was a whole other number of patients who, having made my initial assessment of them, I needed to give a little time, to see what they were capable of. I knew what they had come to me for; for example, the people with a fractured neck of femur who had been offered the chance of gentle rehabilitation. On my initial assessment of them, that did not seem very likely, but I needed to give them time to get over the transfer and the journey and settle them into the ward before making a further assessment of them.

Q Was that your practice, then, that on initial entry to the hospital you made one assessment and then two days later or three days later ----
A A few days.

Q Whenever you felt it was appropriate, you made ----
A I felt we could then go back to the patient. The nurses then knew the patient, the patient had settled into the ward, and it became much more apparent what their potential and their capabilities were.

Q With that in mind – and I had crossed these questions off – there were times when you wrote the anticipatory prescription on the day.

A A Because it was obvious that they were not going to be able to be rehabilitated. They were really very seriously ill even when they arrived, and I was looking at them at some stage in the future needing palliative and terminal care.

Q With the greatest of respect, the prescription was 20-200 mg in virtually all the cases.
A Yes.

B Q Like one-size-fits-all.
A But subsequently one size did not fit all, because subsequently I altered the prescription. Or in large numbers of cases that you have never looked at and never seen, the prescription was never used.

Q So this was not a blanket coverage for every patient that you ----
A Absolutely not.

C Q It just so happens that it is these 12 patients – well, about ten of them.
A You are looking at these patients because they are out of the ordinary. They are out of the run of work that we did on the ward.

Q Thank you for that.
A Do you remember that Professor Ford said that on an acute medical ward he thought
D that between 30 and 50 per cent of people died on opiates?

Q I remember the reference to 30 to 50 per cent dying.
A I think that probably our figures were much the same. We had large numbers of patients who passed away very peacefully and gently without needing any opiates, without needing any anticipatory prescribing at all. These were 12 very difficult cases.

E Q Thank you. That is very helpful. The second question I have for you is on when patients were transferred to you. If you look at page 20H, at your answer there, you talk about imaginative scoring from the people sending the patients to you.
A Yes.

Q Also, at page 22D, you talk with regard to the patients' relations and their expectations. Quite frankly, I think you would agree with me that if somebody says to you,
F and you are a member of the family, that they are going for rehabilitation, you would literally believe them, surely.
A Of course. But it was not the truth.

Q And you have said that it was totally unrealistic.
A Yes.

G Q My question is: did you ever officially complain?
A No. To whom?

Q First of all, I would assume that you could go through your consultant or perhaps you could complain to the consultant of those wards that ----
A It was a time, if you remember, when continuing care was coming to an end. The National Health Service was going into a period of internal markets and prices for everything,
H and the acute beds in our district general hospitals were really stretched. They were really

pushed. They needed those beds desperately, so they passed patients on sooner and iller than they should have been to us. We understood why, but we then had to pick up the pieces and make a relationship with the relatives and explain that what they had in fact been told was not correct. I do not think that it would have been possible, even had I complained to everybody, to change the culture in the acute wards in the district general hospitals.

Q Thank you very much. There were some transfers back when people needed, perhaps, to be returned because they were not right; you could not handle the situation that they were in. You talked about being on an A&E trolley while they waited for a bed. Did you actually know that was a fact; that that was going to happen with every case - that was necessary? Could it not have been the fact that you could have bypassed that situation just by contacting the ward and saying: "Can we send this person straight back to you?"
A If it had been imperative that any patient needed to go back, like the lady who dislocated her hip, we could make the arrangements, but we knew that on the morning of discharge from an acute ward these elderly people were put into what was called the Discharge Lounge, on a chair, on a wheelchair – sometimes on a trolley – to wait for their transport down to us and while they were waiting for the transfer to us somebody else was in their bed.

Q So the situation was that acute at ----
A The situation, at times, was quite dire, so that you had to be absolutely certain that that patient was well enough to cope with a transfer back up through A&E and the waiting that would involve, and that it was appropriate for them to go at all. We did it, but it was not appropriate, again, for any of these people.

Q You just said, once again, "through A&E", but was that a necessity?
A There was no bed; their bed was gone; the bed was full.

Q You would not know that unless you enquired.
A I knew because each morning the bed bureau up at the acute hospital was asking how many beds we had; how many people they could transfer. That was not the situation of a hospital with beds sitting empty waiting for our patients to go back.

Q My experience of hospitals is relatively new but I was under the impression that that situation, where they asked what each individual ward had beds spare, happened on a daily basis throughout every ward.
A Yes.

Q And they would say: "We have three spare beds", or "We have no spare beds", or whatever. So that then they could hold the record of what beds were available.
A Yes.

Q My last question to you: could you tell me what the signs and symptoms of a midazolam overdose are?
A I am sorry?

Q Could you tell me what are the signs and symptoms of a midazolam overdose?
A Respiratory depression; over-sedation. It is a benzodiazepine and it is a relative of valium; if you give someone too much valium the picture would be the same; they would be unconscious and their respiration could be depressed.

Q Is it a serious medical situation?
A Well, an overdose of anything is a serious medical situation. It is quite quickly metabolised in the body, apparently, so that the amount in a syringe driver would reach a steady state quite quickly and remain at a fairly stable level.

Q It could go as far as a coma, though?
A If you gave a large dose inappropriate for what that patient needed it could.

MR PAYNE: Thank you very much indeed. Those are my questions.

THE CHAIRMAN: Thank you, Mr Payne. Mrs Mansell?

MRS MANSELL: Hello, Dr Barton. I just want to pick up on a question that Mr Payne actually asked you. This is regarding the rehabilitation, and a diagnosis or assessment about rehabilitation made by the one ward and then referred to you. You say sometimes they are over-optimistic and are giving the patient's relatives an over-optimistic view. However, they actually did not need to do that, did they?
A How do you mean "they did not need to do that"?

Q Because previously you had been very much into palliative care, terminal care, continuing care, so it could have been that they were saying to the relatives that the patient was moving to you for palliative care.
A They could have done, and that would have made life considerably easier for us.

Q I am interested in how those different assessments actually developed.
A I cannot help you with what was going on in the minds of the clinicians in the acute wards when they transferred people to us.

Q No, but you were not interested, then, to establish why you had this different view to how they were assessing somebody; what they were seeing that told them that this person could be rehabilitated, whereas when you were seeing them that was blatantly not obvious, as you have said. It was blatantly not obvious in some cases.
A I felt that it was possibly a cop-out on the part of the staff transferring the patient because is it not easier to tell a family: "Oh, we will send you to the Gosport War Memorial Hospital and they will get your mother back on her legs in no time" – is that not easier than saying: "I'm sorry; there's nothing further we can do; your mother's condition is likely to deteriorate over a period of time and she may well die"?

Q I accept that but could it, conversely, have been that you were overly pessimistic about a patient and their chances?
A I hope not. I hope that in all the thousands we looked after we were always neither optimistic nor pessimistic about anybody's chances until we were actually faced with their medical condition.

Q I think we have looked at cases where you have actually had your view as being slightly more pessimistic than the consultant's view who has agreed to their admission.
A Yes, and the consultant saw them in each of these cases before the admission and with the information that they were given by the ward looking after them at that time, and what I saw was what was in front of me when they arrived on my ward. So there was a difference.

Q As it is such a very critical decision whether someone is moving to palliative care and terminal care, would you not have felt, at times, it was in their interests to actually discuss that and check it out with other people who had seen something else in the patient other than you had?
A Yes, but at the end of the day you could discuss the patient with the previous clinician all you liked; but what you had was the patient there in front of you in the bed.

Q I am interested in how your assessment of that patient became challenged in any way or how you challenged yourself that you had got it right.
A You were constantly thinking to yourself: "Is this the right medication for the patient? Is this the right place for this patient? Are we doing the right thing for this patient?" You did that every day when you went round the ward and looked at each of the patients. That is the constant discipline you practise.

Q Then you go on to say that with some of the patients, although it might not have been the right place for them - although you may have been thinking that - nothing actually happened to change that situation.
A No. They could not go anywhere else at that stage; we must do our best and look after them.

Q You have said in your evidence that although you knew the guidelines of the *BNF* and the Wessex manual, etc, they were not necessarily followed. I think we have got quite a number of cases here where they were not followed in relationship to specific patients, because you looked at the patient and you knew that they needed additional opiates. What steps did you put in place to ensure a patient was not given too high a dose of opiates?
A Because the patient was being constantly monitored by experienced nursing staff who would be turning them, seeing to them, probably at hourly intervals during the day, and who would have noticed and remarked had there been any obvious, to them, side-effects of the medication. There was one example, Mr Pittock, where one of the experienced senior nurses felt that he was getting too much haloperidol, at which point she contacted the duty doctor and they agreed to stop it and change the medication for something slightly different. These were very experienced nurses constantly assessing those patients 24/7; I could only go in once, twice a day and hear what they had to say and make my own snapshot assessment of a patient.

Q Sometimes that situation, though, can generate of itself a degree of risk, can it not, in that people get so familiar with situations that it is sometimes difficult to stand outside and look objectively at the situation. What was being done to make sure those effective challenges were in place?
A I think the nurses went on training courses; I went on training courses. We are always taught, despite the fact that we are caring for a patient, to be objective about their care; we are always standing back and looking at what we are doing as we are doing it. That is part of the profession.

Q I was thinking more of the training on a day-to-day basis, really.
A By our discussion at hand-over and by discussion when I came on to the ward: "Are we doing the right thing? Are we giving the best medication?"

Q When I look at, say, Mr Pittock, for instance, I can really see that there was a real commitment to very high quality nursing care for the patient.

A A Very much so.

Q Talking about the mouth-washing, the gentle care, turning, etc, etc. But the patient is gradually moving up quite significantly in the dosages of opiates.
A Because he is dying.

Q I guess my question is: does it matter whether there is an overdose of opiates if a person is dying?
B A That is a very good question, is it not? If you believe that and you think that is true, why am I here?

Q I am asking you to tell me.
A Because I am accused of overdosing these people who were dying with opiates, and I think probably overdosing anybody with anything is wrong, is incorrect and is
C unprofessional. I think we did our best, at all times, to aim to get the level appropriate for that particular patient at that particular moment in time, as they were dying.

Q I think that was why it goes back to Mr Payne's question as well of you: how did you actually recognise when there was that overdose? Because I understand that, within people with dementia and end-of-life care, that judging is actually quite difficult.
A Extremely difficult because they cannot tell you.
D
Q That is why I was asking you those previous questions as to the safeguards that you were able to put in place.
A Yes.

Q And how you might, from time to time, actually challenge each other.
A Yes.
E
Q I am looking for when those challenges occurred, because as I look through the nursing notes and the clinical notes I am not actually seeing those challenges there.
A I think, perhaps, "challenge" is the wrong expression to be using; this is not an adversarial process ----

Q No, absolutely not, and I am not meaning it that way.
F A ---- "Why did you give that diamorphine? Why did you give that midazolam?" I think, in discussion on ward rounds, seeing to the patient, we constantly had a dialogue about whether what we were doing was appropriate and the best thing for that patient at that time. We constantly had the patient in the front of our minds as being our prime directive – the appropriate treatment was everything at that stage, during the dying process.

MRS MANSELL: Thank you.
G
THE CHAIRMAN: Thank you, Mrs Mansell. Dr Roger Smith.

DR SMITH: Hello, Dr Barton. Can I pick you up, first, on something you said to Ms Julien. You said this was a community hospital. That was not quite my understanding. You said it was a cottage hospital. That was not my understanding either. I understood that in another part of the hospital, at least when it had been redeveloped, Sultan Ward, I think, was the
H community hospital where you looked after your own patients.

A A Yes. Those were called the GP beds, but it was still – in that there was no resident medical staff, there were no resident consultants and there were no theatre or resus facilities – it was still, to my mind, a community or cottage hospital – a glorified nursing home, not a district general hospital.

Q That is what you thought of it?
A That is what I knew; I worked there.

B

Q Something has been puzzling me about some of the expressions you have used while you have been giving us evidence. For instance, you referred to "my nurses; my patients; my ward". Does that fit into the similar understanding of your position - that it was your ward? You were looking after patients who were "your patients" because it was a community hospital.
A Yes. I was the clinical assistant. I was under the supervision of consultants but the
C consultants were not on site and they were not there very often. I came to look upon them as "my wards; my patients; my nurses".

Q Did it go as far as you thinking, perhaps, the consultants advised on an exception basis?
A I am sorry – on a?

Q On an exception basis. They advised you.
D A I think that with the geographical difficulties and their time constraints they left a lot of the major decisions to me; I think they trusted me to make appropriate decisions for the management of the patients. So, in a way, they did act in an advisory capacity because they physically could not be there. If we had had a daily consultant visit, presence, in the hospital, as I understand that they have now, the day-to-day management of the ward would probably have been very different. Those major decisions that we have talked about in these 12 patients would probably not have been made by me, but that was the way it worked
E because of the geographical problems.

Q So did you see yourself, really, as a semi-autonomous doctor?
A You are either autonomous or you are not autonomous. I was not autonomous but I did see myself in charge day-to-day. It said that in my job description; that I was responsible for the running of the day-to-day ward and the care of the patients and the staff. That was how I saw myself doing the job since 1989.

F

Q Just to finish that theme then, the nursing was staffed, as I understand it (please correct me) to a hospital level; not a nursing home level, a hospital level.
A Do you know, I think, in many ways, it was staffed much more to a modern nursing home level than it was a district hospital. There are certainly no training nursing posts there; these were all people who were fairly long in the tooth, like myself, and had been there a long time; it was much more analogous to a nursing home.

G

Q Let us change tack completely. We have heard a theme, as well, of variability in patients' status and condition, and that variability that has been explored has been physical variability (we have heard about one patient graphically being described as "up and down, up and down") and other patients as "mentally up and down". First of all, do you generally agree that patients do tend to take variable courses; that something wrong with them today might be better tomorrow?
H A Yes.

Q Some things.
A Some things, yes.

Q Conceding, of course, that in the background there is a longer-term course in both physical and mental conditions.
A Which, in the case of these people, who were not particularly well when they came to me, was a general, overall downhill course towards death – some quicker, some slower, some taking plateaus as they went. But, generally, these patients that you are looking at, downhill.

Q Yes, so downhill with an "up and down" on it.
A Yes.

Q Rather like the Stock Market.
A Yes.

Q So you have a patient in pain. The patient complains of a pain – a pain – and you try to control it with Oramorph and you progress into MST, maybe, or you may progress into a fentanyl patch. For some reason, there comes a point at which they cannot take tablets, so you are looking for something that is not oral – or they cannot take liquid and you are looking for something that is not oral. Our impression on the generality of it is they go on to a syringe driver. I want to ask you, as others have, but just to try and crystallise this: why was there no possibility of the intermediate route; the route where they got intramuscular or subcutaneous doses on an "as required" basis? You did tell us a little bit about why you would not want to do that. Can you enlarge on that for us, why you would not do that?
A Because the intramuscular dose would be very uncomfortable and intrusive and the patient would constantly be suffering peaks and troughs of medication. The advantage of a syringe driver was that, once it had reached its steady-state level, you were giving them a steady rate of pain relief. I am not looking at a pain that the patient is just suffering from, a pain in isolation; we were also making the overall assessment of that patient, that they were going downhill, they were deteriorating. They were not going to be able to come off the analgesic medication. That was our understanding. So we wanted to give it in a steady-state form so that they were not hurt or drifting in and out of the palliative relief they were getting from pain while they waited for another injection. It would be fine for an acute pain but it would not be suitable for ongoing terminal pain.

Q So it is because you have decided that they are on a terminal pathway?
A Yes.

Q There cannot be an intermediate way of treating their pain, distress, because they are at the end of their lives?
A Yes, these particular ones that you have been looking at; yes. But of course you say, "Why are you using only the oral route and then the syringe driver?" but of course you have mentioned fentanyl and that is the ideal intermediate route that does not involve injections and does not involve oral treatments, which we tried and used quite successfully in a number of patients, not quite so successfully in the two you are looking at. There is not really anything else between oral tablets, oral liquid, and the subcutaneous administration in a nice steady-state level. It is not a death warrant. It is not putting you on the death pathway *per se*. You are on it because you are dying.

Q Mr Farthing, Mr Cunningham's step-son, asked if you could stop the driver or pull back so he could speak to his father. I think the word you used was that you would find that abhorrent to pull back on the dose because he would be in pain?
A Yes.

Q Why should not the answer be "but, how do you know he is going to be in pain?"
A If I stopped the ---

Q Yes?
A Well, for a start, he would get a very unpleasant withdrawal reaction stopping it. Both the diamorphine and the midazolam if withdrawn, or if you gave an antidote to it, would give very unpleasant pain ---

Q That is a very fair answer but what about reducing the dose so he could lighten up?
A Because we were only just able, from the note that I remember writing in the notes, to control the symptoms that he was having on the level of diamorphine and midazolam he was having at that time. Any lowering of the dosage would have caused him distress and agony.

Q How do you know that?
A I made that clinical judgment. I was looking after him. I felt that that was appropriate for the patient.

Q Is that your philosophy as a doctor or is that a judgment about that patient?
A Do not do harm is my philosophy as a doctor. So anything that involved even the potential for doing that patient harm by reducing the analgesia, I would not agree to.

Q But what about the challenge that there is potential for variability in the opposite direction, that having controlled the cause symptom ---
A But we had not. He was still, in the next clinical entry in the notes, getting pain.

Q But is it not true that you will never know?
A No, and I do not want to know.

Q You do not question that in your own mind at all?
A No, I do not.

Q On the same theme of variability, the same graph of dementia with acute episodes of confusion, would you agree that that is a typical pattern in confused old ladies? They have their days?
A Yes.

Q Sometimes quite violently have their days?
A Yes.

Q And the next day they are all light and smiles?
A You are talking about Mrs Devine?

Q No, I am talking in general.
A You are absolutely correct; in general terms, that can happen, yes.

Q So they have a variability, or they may have a variability?
A They may have a variability superimposed upon a general downhill path.

Q And so when you treat a very acute, and in Mrs Devine's case a very aggressively acute, episode of confusion, there are two alternatives. You went for the fentanyl patch?
A I did.

Q Which, rightly or wrongly – I am not making a judgment on that at the moment – might have been or might not have been the right kind of treatment for confusion, but, nevertheless, you chose for an acute episode a long-acting treatment. Why did you not take the course that you did the next day and give her a single dose of an antipsychotic?
A Because the difference between her behaviour on the two days was chalk and cheese. The previous day, the day she was seen in the afternoon by elderly psychological ---

Q Dr Taylor.
A Dr Taylor – her behaviour was manageable, controllable. She was not in any great distress. She was not being of any great bother to herself or anyone else. The following morning when I came on to the ward, we had an acute psychiatric emergency. Chlorpromazine is not a drug that I would choose to use for anything other than an acute psychiatric emergency. It is an unpleasant drug to use; it is a dirty drug and it was what I had available in the drug cupboard on that day when presented with that problem, but I would not have continued to use it.

Q No, it was a very peculiar, very almost dangerous position.
A Yes.

Q I understand that. There is certainly an analogy with the opiates. Was there not a half-way house? She was spitting out tablets, that is true?
A Yes.

Q But do you have to go from tablets to a quite potent patch?
A Or a syringe driver.

Q Or a syringe driver. Is there nothing in the middle?
A No. Rectal administration?

Q What is to say, for instance, that another oral administration might work like some syrup?
A You could not take the risk that she would spit it all over the nurses and we would be back in the same situation of not being able to control her behaviour, poor soul. She needed relief from her acute anxiety, fear, aggression, all this spectrum of behaviour. In my clinical judgment, it was the best I could come up with on that day and the following day.

Q Two doctors saw her that day: Dr Taylor who --- Let us accept, for the sake of argument, that she was a bit better by the time Dr Taylor saw her, she was not as wandering, as much of a nuisance, because these people can be a nuisance.
A Six or eight hours into the treatment she was much more comfortable and seemed happy, yes.

Q And it may be the treatment or it may be naturally variability. We do not know that.

A A Yes.

Q But she made the judgment: we will take her to Mulberry when there is a bed.
A I did not see her, I did not speak to her that day, but I do not think, from the entry she made in the notes, that she knew about the creatinine and I do not think she realised that Mrs Devine was terminal.

B Q Terminal what?
A She was entering the terminal phase of her life.

Q Terminal phase of what part of her life?
A Because of the combination of the very high creatinine and the deterioration in her dementia, she was going to die very soon.

C Q A creatinine of 300 – terminal?
A It was a very rapid rate of change in this particular lady. She had been running along in a quite stable fashion and it had gone up very quickly. I felt, in my clinical judgment that day, that Mrs Devine was becoming terminally ill and I had to control this psychotic, aggressive, dangerous behaviour. So then I had no choice, if I felt the fentanyl was not controlling the aggression side of it, to go for the midazolam together with an equivalent dose of diamorphine.

D Q Terminal renal failure with a creatinine of 300?
A I know it is not colossally high but that was in a very elderly person with pre-existing renal disease. I felt that she was coming to the end stage.

Q Let us just look at the other side of her, and that is why I said "terminal side of what". The term "terminal dementia" has cropped up.
E A Yes, but her behaviour had deteriorated quite markedly overall during the time she had been with us on the ward, but even more so during those last few days.

Q Terminal dementia as a term, what does that mean, to you?
A It means that some of their more fundamental brain functions are beginning to break down.

F Q But where does the "terminal" come in? It is a worrying word to me, "terminal". I do not quite understand what it means. What does "terminal dementia" mean to you?
A It means that something about the dementia means that she is going to die soon. I do not really understand the psycho-pharmacology of what happens but people do die of dementia and I thought that she was dying.

Q They do die of dementia but sometimes it can be very slow, can it not?
G A And sometimes it then accelerates and becomes very much quicker.

Q What is the scale of dementia? How do you measure it as a clinician?
A The tools that we have are very crude and can only measure cognitive function. We cannot measure what else the brain is controlling, which we know is all the bodily functions.

Q What I am getting to, I suppose, is the suggestion that if you have a mental test score
H of nil, is it not true that you can live for quite a long time?

A A You could.

Q Years?
A Provided the other more basic lower functions in your brain were carrying on in their usual fashion, but once those start to break down, then you are in trouble.

Q Yes, like in at least one of the patients we saw where there was weight loss and loss of
B interest in life – not dementia itself but depression as well. OK. Most of my questions are not really general and they are not really specific patients; they go across the boundary. The other generality that I wanted very briefly to explore is "too ill to move". You could draw all sorts of spectra of "too ill to move" from the sublimely stupid, somebody dying at the roadside is too ill to get to a hospital and that would be completely wrong, to too ill to move in the case of somebody like Mr Packman, or an old lady with a hip problem that has become very complicated. Too ill to move depends upon a balance of risks I think you said.
C A Yes. It is not only would they survive the actual mechanics of the journey but would it be possible to do anything other than palliation when they arrived at the other end of the journey to where you were transferring them.

Q And so if you had firmly in your mind that an orthopaedic procedure was out of the question, you would take that view and say "too ill to move, it is not worth it".
A I would.
D

Q But if it is a matter of making a difference in a life and death decision, that is to say end of life or not end of life, can you explain to me why going down a corridor and lying on a trolley in your own hospital is out of the question because it is too much of an imposition?
A Are you talking about Mrs Spurgeon with what we thought was the infected hip? To be more specific about it, I would only subject a patient in a lot of pain towards the end of their life to that procedure if I felt there was some purpose to it, if there was some reason for
E doing it. Now I did not order that X-ray and I did not have anything to do with whether it was done or not done and whether I felt that it was appropriate to do or not is nothing to do with what my consultant decided to do. I personally would not have put her through that procedure anyway because I would not have felt that a look at the X-ray would alter my management of her at that time.

Q Forgive me coming back to an old theme at that point. What then is the relationship
F between you, your consultant and the patient?
A I am responsible for the day-to-day care of that patient.

Q He wants an X-ray?
A He ordered it. It was booked for the following afternoon. As far as I am aware, it was done. I have no idea.

G Q You did not think it was necessary?
A But I would not have cancelled it and I would not have countermanded it and I would not have hidden it so that he could not see it.

Q And you would not have gone to look for it either?
A No, because I knew he was coming back on the ward round to look at it on the Monday and the nurses would have made it available to him to look at. That was part of their
H duty.

Q I do not want to divert into that area really. Mr Packman: I would like just to pinpoint this, that you had in mind that he had suffered a myocardial infarction?
A I did.

Q And he was grey round the mouth and you were called to see him. You came to see him because he was grey round the mouth; he was not at all well. You thought he was having a heart attack.
A I did.

Q He was 67 and he had all his faculties?
A His chronological age was 67 but his age with regard to his co-morbidities was considerably older than 67 and there was a case of a gentleman that I felt, even if he survived the trauma of a transfer, difficult as that was going to be, the chances of them doing anything definitive for him at the other end, other than pure palliation, were remote.

Q Why would they not give him thrombolysis?
A Because he bled and they had stopped the Clexane to prevent the DVTs because he had had a bleed. I do not think they would have considered him for thrombolysis, even if we had had it available routinely in those days.

Q I think you are absolutely right, but why would they not have given him intensive cardiac care for arrhythmias for 24 hours?
A And then?

Q You tell me what is the mortality rate in the first two hours of the onset of a myocardial infarction?
A It is very, very high and it was going to be even higher for him and putting him in an ambulance and transferring him 10 miles up the road to get to the nearest coronary care unit was probably going to be his last journey.

Q But if you took that view for other patients in the community, you would not send anybody to hospital?
A But I did not take that view for other patients in the community. This was this particular patient in front of me. This was this particular man and his particular problems and his particular co-morbidities. That would be quite different from how I would react to a young, fit, 67 year old marathon runner who collapsed in my surgery and I thought was having a heart attack. The management of him would be totally different, of course, but this man was very seriously ill. He was dying.

Q Was he dying when he came to you?
A Probably.

Q Is that what really made up your mind?
A Yes.

DR SMITH: That is all I have for general questions.

THE CHAIRMAN: I am sorry, did you not have a specific question in relation to ---

DR SMITH: Not with regard to specifics.

THE CHAIRMAN: This refers to an individual patient? In that case, no, I do not because we are on generalities. Dr Barton, I am sure your head is reeling. Mine is. Are you fit to go on for a bit longer before we take our break?

A Thank you.

Q Okay. We are still on general and I am the last of the 'generals'. As you know, I am not a medic. I have been struggling to get some understanding as to the relative positions that appear to have been taken up by Professor Ford and yourself in regards to the way in which patients are to be treated towards the end of their lives. You have spoken to us at the beginning of your testimony about how when you started off at Gosport there was a hospice-style operation underway and you were able to give that hospice-style treatment to those who were terminally ill. I need to understand whether all the answers you were giving to Ms Julien about how you would do things were based on the circumstances in which you found yourself, and whether it would differ if you were in the sorts of circumstances you have told us Professor Ford has the luxury of operating from. Does that make sense?

A I am sure one's whole outlook on palliative care could be very different working in a specialised tertiary unit. He talked about one-to-one nursing care, he talked about hourly observation, he talked about being able to titrate the doses of his opiates. I am sure I could have practised different palliative care under those circumstances, but this was what I had. This was what I had available to me, this was the level of cover that I had, and this was the sort of hospital that we worked in. I had to tailor my palliative care to what I had available.

Q Right. If we look specifically at the two ends of the spectrum of alertness and lack of pain, is your general view that there should always be a total elimination of pain as the prime objective? Or do you allow for in your own thinking a balance, where you might accept that a patient might be willing to accept an element of pain in exchange for an element of alertness?

A I think that would be the ideal: sufficient pain relief, so that when dressings were being done or when basic nursing care was being given that the patient was not suffering.

Q An alertness that would allow ----

A Proper nursing care.

Q Yes. And, also, as a part of the general dying process as one would see in your earlier days of the hospice-type operation, where the terminally ill person is able to spend their last days free of pain or relatively free of pain but able to spend them in a state of consciousness in terms of their enjoyment of their last moments with their families, saying the things that needed to be said and so on.

A That would be a perfect end-of-life palliative care pathway. That would be what you were always aiming for.

Q Thank you. I am pleased to understand that is where you are. In terms of this particular hospital at these particular times with these particular patients, what Professor Ford appeared to be saying was that by reason of the prescriptions that you wrote up and that the nurses administered, patients were not given the opportunity of alertness that they should have had and which you indicate in the ideal world you would wish them to have too.

A I think that he cannot make that judgment (a) with the benefit of hindsight and (b) because my notes were so inadequate and the nursing notes were on occasions equally

A sketchy. I think it is very difficult, looking back at that remove of time, to be able to say, "Did they achieve on that unit what they were aiming with each of these patients?" and my suggestion would be that, mostly, yes we did. We gave patients comfort and dignity and relief from some of their more distressing symptoms and we did our best to make sure they were as alert as we could keep them at the same time.

Q As you say, the lack of notes and the sheer distance in time make it difficult both for
B Professor Ford to advance his view and also for you to unhappily advance your view.
A Certainly.

Q Had you the notes, you would be able to look, find it, and say, "It is very clearly there." One of the things that he was talking about was the view he had that you were going too quickly on to the syringe driver and Dr Smith has talked with you briefly about the alternatives between the time when, let us say, the oramorph option ceased to be viable
C because a patient could not swallow and the kind when you chose to go on to the driver. The question that he was asking you was why not for a time have PRN, for example, diamorphine injections. From the point of view of the nurses, first of all, would that have been particularly difficult to achieve?
A In that you have to have two trained nurses to remove from the cupboard and sign to administer each dose to that patient every four hours, it would take two of your trained staff away from the ward for that length of time, and they had 22 other patients to look after and
D the phone ringing and all the other admin. But that is not a good argument. That is not the argument you make for the patient. The argument for the patient would be that you would get peaks and troughs in their pain relief and they would already be starting to suffer pain at the point when you decided you must go to the cupboard and get them another injection, because they are going down all the time and then you put in another peak.

Q I understand that very clearly and I can see from a long-term point of view that that
E would be highly inappropriate.
A Yes.

Q But when we are looking at the perspective which he appeared to be advancing, that we need to find out what is the appropriate level of opiate to be giving to this patient, so that when one does perhaps move into the syringe driver situation you have it right ----
A Yes, but you have put that patient through 48/72 hours of comfort/discomfort,
F comfort/discomfort in order to find yourself a level at which you are going to set the syringe driver.

Q If it takes that long. Presumably it might equally ----
A When you saw the sort of doses that some of these patients needed, you would need to escalate the injections quite quickly or you would take a long time to find out what your steady state was going to be, and I think that for some of these patients that sort of coming in
G and out of pain would be unacceptable – to me.

Q Yes. To you.
A Yes.

Q In many cases it would not be possible to ask the patient, but in evaluating that as a potential route, assuming that it was something on which a patient or indeed their close
H family would have views, would you seek those views or would you feel that ---

A My priority was totally to the patient and the comfort of the patient. I would not be looking at the views of ----

Q Of family?
A Of family.

Q Very well. But dealing with the patient, I think we have agreed that there might be occasions when a patient would be prepared to accept some level of pain in exchange for relief from drowsiness.
A I think that would be acceptable with the consent, the full consent of the patient, and with the option that if that became too unpleasant and uncomfortable for them then you could move on to subcutaneous analgesia. It is the patient who is always at the forefront of your decision making.

Q So far as the suggestions from Professor Ford that by going into the driver scenario you also ran the risk of masking the true causes of matters such as agitation and restlessness: as you have pointed out, they might very well be simply a part of that terminal process, but as he pointed out, they might also be as a direct result of the prescription of the particular medication at that level.
A You always have to accept when using these drugs that there is the double effect. But if you start from the initial premise that these patients were dying and that was the process that was going on, then it was perfectly acceptable to give sufficient doses of the drugs to control their distressing symptoms and accept that controlling those symptoms might in some way shorten their life.

Q The suggestion as I understood it from Professor Ford was that there might be occasions when the distressing symptom was not present until the high level of a particular drug or combination of drugs had been administered and that you were not then in a position, to use your word, to "untangle" whether that symptom had been caused by the drug itself or by the inevitable terminal process.
A I think that would be very difficult to entangle, again, without the patient in front of you in the clinical situation. I do not think you could do it with the benefit of hindsight.

Q If the process were slowed down, so that instead of going directly from, say, the Oramorph – which then becomes impossible – onto the syringe driver, you employed that middle stage which he appeared to be advocating, do you think that might have made any difference towards not having what might ultimately be an entanglement?
A No. I do not because I think the entanglement is largely caused by the process of dying. I do not think that titrating the drugs, as he suggested, would have made any difference to that at all.

Q That is very helpful to me. We have come to the end of the general questions. I wonder if this would be a convenient moment for you to take a break and I will then ask the Panel if they have any specific patient questions to put to you.
A Thank you.

THE CHAIRMAN: Fifteen minutes, please, ladies and gentlemen.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Doctor, have you managed to get some refreshments?
A Thank you.

Q You feel okay to "chonk" on for a bit longer.
A Thank you.

THE CHAIRMAN: Very well. We will turn now to questions from the Panel with regard to specific patients. I will just mention the patient's letter and invite questions, and then go on through in that way.

First of all does anybody have any questions related to Patient A? Patient B? Patient C? Patient D? Patient E? Patient F? Patient G? Patient H?

Dr Smith.

DR SMITH: Dr Barton, Patient H is Mr Wilson. You felt that he had heart failure. He was the man who had gained a considerable amount of fluid. Fourteen kilograms, I think it was.
A Eleven kilograms.

Q You said he was verging on the edge of heart failure and that when he became "bubbly" that was a sign of heart failure.
A He was examined, was he not, by one of my partners?

Q Yes.
A Who described him as "bubbly". I imagine that when his chest was examined he had creps at both bases, which is what he described as "bubbly".

DR SMITH: You are quite right, it was another doctor who examined him. I will leave that.

THE CHAIRMAN: Very well. Patient I? Patient J? Patient K?

Dr Smith.

DR SMITH: And this is the last you will hear from me!
A Elsie Devine.

Q Elsie Devine – so graphically described by one of the nurses. I want to contextualise by taking you through fentanyl and chlorpromazine again. It is not a criticism of using a fentanyl patch, it is not a criticism of using chlorpromazine in an acute, very aggressive, very dramatic episode; it is to contextualise what happens. We have heard about the fentanyl patch. We have heard from the extensive drug company manual on it. It was put on on the previous day to what we are calling "the episode," on the 19th, the Thursday, and by the time 7.30 came around – that was when all the drama was going – it had been on for 24 hours or so. It was removed at 12.30.
A Yes.

Q I had to go back on the evidence to prove that to myself and it is indeed on a prescription on page 279, "Removed at 12.30," and I think it is Sister Hamblin's signature.
A Yes.

Q In talking you through it, Mr Kark put it to you – and I am not sure if it was from the *BNF* or that manual – that there may in the elderly be reduced clearance or prolonged half-life and the elderly may be more sensitive. You pointed out that that was in the context of an intravenous study.
A Yes.

Q First of all, I wonder if you can explain this. Having achieved a certain blood level, does it matter which way the drug has got into you what happens to the half-life?
A No. But the reason for stopping the fentanyl and starting the subcutaneous analgesia was that patently the fentanyl was not controlling her distress and aggression and agitation.

Q I accept that that was your reasoning behind that.
A I could have continued with the fentanyl and I could have left the patch on, but I would have still been looking at using a syringe driver to give her the necessary relief from the restlessness and the agitation and the fear.

Q I am not looking as to reasons or motives for using it.
A All right.

Q It is just contextualising the whole scenario that we have a drug which has a long half-life, and indeed it was not taken up until some hours after chlorpromazine.
A I think the calculation was that she would have received an extra 10 mg of diamorphine during that time.

Q Indeed the 17 hours that it takes to clear may well be longer than that.
A Yes.

Q Then chlorpromazine and that is why I have asked if I can use these photocopies of the *BNF*. It is the relevant *BNF* of 1997 and I want to take you to page 163 in the top right-hand corner. It is where chlorpromazine is described, halfway down on the right-hand side.
A Yes.

Q It talks about cautions in cardiovascular and cerebrovascular disease, and then, four lines down, in renal impairment.
A Yes.

Q It says, "caution in the elderly".
A Yes.

Q Right down at the bottom, its side effects include drowsiness, and then over the page, on page 164, about five lines down on the left-hand side, respiratory depression.
A Yes.

Q Under "Dose", albeit it says "*by mouth*" a few lines down it says: "ELDERLY third to half adult dose."
A Yes.

Q Would you agree, if it is not a specific about any other way of giving it, that it is a caution.

A A Yes.

Q About the drug.
A Yes.

Q Then: "*By deep intramuscular injection,* 25-50 mg every 6-8 hours."
A Yes. 25-50 mg and she was only ever going to get the one.

B

Q Yes. I absolutely do not criticise your giving it. I absolutely do not criticise that. If you go back to page 161, which is behind that frontage piece, here is advice on anti-psychotic drugs from the Royal College of Psychiatrists. Number 2 says:

> "Bear in mind risk factors, including obesity – particular caution is indicated in older patients especially those over 70."

C

This lady was that group, I think.
A Yes.

Q Then if you go further down:

> "Important: When prescribing an antipsychotic … on an emergency basis, the [IM] dose should be lower than the corresponding oral dose … particularly if the patient is very active …"

D

This patient was very active; her muscles were really active.
A Yes.

Q Then:

E

> "(increased blood flow to muscle considerably increases the rate of absorption)."

All that is to contextualise. You said in your evidence that you thought that by lunchtime it would have been wearing off.
A Yes.

F

Q Do you think that is right, in the light of that information?
A You are suggesting that, perhaps, I was being a bit optimistic by the rate at which it would wear off? So supposing you said four o'clock, having given it at eight – eight hours later - by which time the level of the midazolam would be slowly increasing and the level of the diamorphine and the fentanyl crossing over, so that, hopefully, she would have a level of comfort and relief from her symptoms.

G

Q What I am putting to you is: with this retrospectoscope, the fentanyl is at its peak but Chlorpromazine in this old lady is probably at a higher level than you may have suggested in your evidence.
A Yes.

Q Is that fair to say?
A Yes.

H

A Q She has had a start dose of opiate, and she is now on a syringe driver.
A Yes.

Q With the retrospectoscope ----
A Would I have given 25mg?

Q No, I am going one stage further than that: would you reconsider whether you thought
B that the drugs contributed to her demise?
A I would not reconsider that the drugs contributed to her demise. I consider that she needed each of those drugs to control the severe distress and agitation and discomfort she was in, and that they were all appropriate.

Q At the risk of repeating myself from my earlier discussion with you, you have no doubts that that might have been a single, acute outburst which might have been controlled ----
C A It was an acute, single outburst but it was superimposed on a gradual level of behavioural change and a rapid change in renal function. So the downward slope was well under way.

DR SMITH: That is all I wanted to ask you. Thank you.

THE CHAIRMAN: Very quickly, on Patient K: why not then keep her on the fentanyl?
A And then put up a syringe driver?
D

Q With just midazolam.
A Yes.

Q And the answer is?
A It was possible to do that but it seemed rather inappropriate to be running a fentanyl patch for three days and monitoring a syringe driver as well. It was much easier to combine
E the two at an equivalent dose in the syringe driver to make monitoring much more easy.

Q But it means a risk because you are now having to remove the fentanyl patch and start the diamorphine with the resultant potential for difficulty.
A Yes, but I knew that the rate of decline of the level of fentanyl was over a period of 24 hours, and I knew that the level of the diamorphine in the syringe driver was going to gradually build up. I was confident that there would be a reasonable cross-over point, which
F would not give her any distress.

THE CHAIRMAN: Thank you. Now it is Patient L. Does anybody have any questions on Patient L? No. That concludes questions from the Panel. It is twenty-past four. I do not know whether counsel would wish to go on and ask any questions they may have arising out of the Panel's questions, or whether there are going to be so many that they will require further time. We are in your hands. Mr Kark?
G

MR KARK: I do have questions and I could certainly start, but I cannot tell you, at the moment, how long I am going to be, I am afraid.

THE CHAIRMAN: So you might not finish today?

MR KARK: I might not finish today.
H

MR LANGDALE: Can I invite Mr Kark to make himself very popular and suggest that he starts on Monday? It will not mean Dr Barton is unnecessarily kept in the witness box over the weekend because I have a number of questions – not very many but enough to mean that between the two of us she would not finish at a sensible time today.

THE CHAIRMAN: Mr Kark, how does popularity sit with you?

MR KARK: I am always seeking popularity. I am very happy to start on Monday.

THE CHAIRMAN: Very well. We will break now. Thank you very much indeed. Doctor, I think, it is probably best to give you a chance to recharge your batteries after what must have been quite an intense afternoon for you. So Monday it is, ladies and gentlemen. We are starting, as normal, at 9.30 on the Monday, but bearing in mind that on the Tuesday we will be starting at 11.30. Thank you very much indeed.

(The Panel adjourned until 9.30 am on Monday 27 July 2009)