Field Fisher Waterhouse

FFW/129/03

GENERAL MEDICAL COUNCIL

-and-

DR BARTON

FTPH TRANSCRIPTS

Field Fisher Waterhouse

GENERAL MEDICAL COUNCIL

-and-

Code A

FTPH TRANSCRIPTS

3 OF 3

4111914 v1

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 29 June 2009

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

Chairman: Code A, LLB JP

Panel Members: Code A

Legal Assessor: Code A

CASE OF:

Code A

(DAY FIFTEEN)

Code A of counsel and Code A of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

Code A and Code A of counsel, instructed by the Medical Defence Union, appeared on behalf of Code A, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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A THE CHAIRMAN: Good morning everyone. Welcome back. I am very pleased to see that the doctor has been able to join us this morning. I hope that is indicative of things having gone well over the weekend.

Code A: I will call Code A

Code A, Affirmed

B (Following introductions by the Chairman)

Examined by Code A

Q I think it is Code A
A That is correct.

C Q I want to ask you a little bit about your professional background and then move on to your work at the Gosport War Memorial Hospital. Are you still a senior staff nurse?
A I am still a senior staff nurse, yes.

Q Where are you working at the moment?
A I am currently working day duty on Collingwood Ward, which was formerly Dryad
D Ward.

Q Before we get to your move to the Gosport War Memorial Hospital, we need to know a little bit about your training as a nurse. I think you qualified as a registered general nurse in 1986.
A That is correct.

E Q At first I think you went off to work in a place called Beechcroft Manor Rest Home. That is in Gosport as well, is that right?
A That is correct.

Q You left there in about 1987 to take up a post at the GWMH (as we have been calling it).
F A Yes.

Q Did you start off at the Redclyffe Annexe?
A I started at the Redclyffe Annexe, yes.

Q The Redclyffe Annexe in the late 1980s, was that at a site distant from the Gosport War Memorial Hospital?
A Yes.
G

Q What sort of patients did you look after there?
A Elderly patients. Continuing care.

Q Does that really mean that they were long-term patients?
A Yes.

H Q Did you work different shifts, but mostly at night?

A I only worked night shifts at the time.

Q The Redclyffe Annexe, I think as you have told us, was a geriatric ward. Were there any other wards at the Redclyffe Annexe, or was it purely for geriatric patients?
A It was just the one ward.

Q Did you have patients there who were in for palliative care?
B A Yes.

Q You did.
A Yes, from as far as I can remember.

Q Did you have a number of patients there who remained there for a very long time?
A Yes.

C

Q Tell us about the position, so far as doctoring at the Redclyffe Annexe, prior to Code A arriving. What was the system prior to the time when you had a clinical assistant?
A Prior to Code A arriving, as far as I can remember, if we needed medical cover of any sort we contacted the patient's own GP.

D Q They would then have to come out to the ward, would they?
A They would come to the ward and they would deal with whatever problems arose.

Q Would that include prescribing?
A Yes.

Q Dealing with pain relief, can you remember in general what sort of pain relief was
E used on the Redclyffe Annexe prior to Code A arriving? Were you dealing with a whole range or what was the position?
A A whole range. From as far as I can remember, it was a whole range.

Q Meaning what?
A Non opioids, mild opioids, right the way through.

F Q Prior to Code A arriving, did you ever deal with syringe drivers?
A I think once. I can recall using a syringe driver once, initially, after I had started working at Redclyffe. I am not sure if it was before Code A arrived or not.

Q All right. Once Code A had started working at the Redclyffe Annexe, can you help us as to whether any changes appeared to be made about the running of the ward?
A Things were more organised. Drug charts were written up. We had someone to call
G upon during the day. Prescriptions were written so that needs were anticipated.

Q What does that mean "prescriptions were written so that needs were anticipated"?
A PRN night sedation. PRN analgesia.

Q Is that something you had had before on the ward?
A Not that I can recall.

H

Q Tell us about the use of syringe drivers. Did that remain the same as it was before, or did it change?
A The use of syringe drivers I think increased.

Q Tell us about that increase, please. How do you remember it happening?
A I am not exactly sure. They seemed to arrive and then we used syringe drivers on a fairly regular basis.

Q Of course a number of different drugs can be used in syringe drivers, as we know. What is your recollection of why syringe drivers were being introduced and what they were being used for?
A From what I can remember, if patients were unable to swallow, we administered their mediation through a syringe driver.

Q What about the use of opiates. Did that remain the same or did that change?
A I think it changed.

Q In what direction did it change?
A We tended to us opiates through the syringe drivers more.

Q Tell us about your dealings with Code A You were working on nights.
A Yes.

Q What time did that mean?
A I started my shift at quarter-past eight in the evening and finished at quarter-to eight in the morning. Code A used to arrive on the ward somewhere just after half-past seven in the morning, so there would be a 15 minute overlap, and she would ask us if we had any concerns about the patients.

Q Did that mean you had direct meetings with Code A?
A Yes, but not always.

Q Who, so far as you were concerned, was the main point of contact within the nursing staff for Code A
A Our ward manager.

Q Who was that?
A Code A

Q So which ward were you once you -----
A Dryad Ward.

Q Let us go back a little bit. Did you deal with Code A back at Redclyffe?
A Yes, I did.

Q Once you moved to the new hospital, you moved to Dryad Ward.
A Yes, that is correct.

Q Still dealing with the Redclyffe Annexe for the moment, before you had moved, does the evidence that you have just given reflect the position there, that you were on nights and you would meet Code A occasionally in the mornings?
A At Redclyffe Annexe we did not see Code A quite as much as we did at the new hospital.

Q But Code A was there.
A Code A was there.

Q And Code A was there.
A Yes.

Q Then when things changed and you moved to the new ward, to Dryad Ward, tell us about your workings there with Code A and Code A. How much interaction did you have with Code A?
A It would be at handover times, so either first thing in the morning, or if she was on a late shift she would handover to us in the evening, or possibly by telephone call.

Q Possibly by telephone call?
A Yes.

Q How would that work?
A If she needed to ask us something, she would phone us at home. But that was very rare.

Q Are we talking about Code A?
A Code A, yes.

Q So if she needed to ask you something – presumably about a particular patient.
A Yes.

Q Tell us about the type of patient you had, once the move took place. You have described the patients at the Redclyffe Annexe. Was there any difference once you got to Dryad Ward?
A Initially there were similar types of patients, but during the course of the time of Dryad Ward, patients changed from continuing care, palliative care, rehabilitation of fractured hip patients.

Q I am sorry, the last ----
A Rehabilitation of patients with fractured hips.

Q Were those patients who required greater care, or greater intervention, as it were?
A Yes.

Q I want to go back to the time just prior to the move.
A Okay.

Q Do you remember that when you were still at the Redclyffe Annexe there had been concerns raised about the use of syringe drivers and about the opiates that were being used?
A Yes.

Q Were you very much a part of those meetings and the concerns being raised?
A Yes.

Q Did you have concerns yourself?
A I did have concerns myself.

Q We will have a look at some documentation in a moment, but do you remember the essence of your concerns?
A I can remember being concerned about how syringe drivers were being used, the amount of training we had received prior to the arrival of the syringe drivers, and training in general.

Q I am going to ask you to take up a bundle marked Panel Bundle 1 and turn to tab 6. Just so that you know, I am not ignoring parts of this. The Panel have already heard evidence from a number of witnesses and we have already looked at some of this documentation, so I am not going to go through it all again.
A Right.

Q I am going to draw your attention to certain aspects where I think you were specifically closely involved. Looking at page 2 for the moment, do you have a document entitled "Summary of meeting held at Redclyffe Annexe 11 July 1991".
A Yes.

Q I think you see your name in the right-hand column of the nurses that attended. Just casting your eye over the list of concerns, we have been through this and so I want to try to avoid going through it again – we can see that the concerns revolved around, first of all, the amount of the use of the diamorphine; the lack of the use of the sliding scale – which I will ask you about; the possibility that patient deaths were being hastened unnecessarily; lack of training; and too high a degree of unresponsiveness. It as all those sorts of areas that were being raised.
A Yes.

Q Did you share those concerns?
A I think I did at the time.

Q What sort of training had you had, first of all, in the use of syringe drivers, and what sort of training did you get in the use of syringe drivers?
A Prior to this meeting?

Q Yes.
A When I had come across the very first syringe driver during my time at Redclyffe Annexe, I explained to the ward manager at the time, [Code A], and she said, "Surely you've come across a syringe driver before." I said, "No, I don't recall using one." So she took me to the patient and said, "It's a pump with a syringe. You won't need to touch it, there's nothing to worry about." That was the extent of my initial training.

Q Did you ever have to load at that time, after that sort of training, a syringe driver yourself?
A No.

Q Did you ever receive more formal training on the use of syringe driver?
A I do not think I did prior to this meeting.

Q Let us just fast forward a moment. Did you subsequently receive training on the use of a syringe driver?
A Yes.

Q What sort of training did you receive?
A The first training I can recall having shortly after the meeting was, I think, a one hour session with a community nurse used to dealing with syringe drivers.

Q And that training consisted of what?
A I think I can recall she brought a syringe driver with her and talked through how to set it up and the purpose of it – as much as you can in one hour.

Q And how many of you were there – can you remember?
A No, I cannot offhand.

Q But more than just you?
A More than just me, yes.

Q So it was really a demonstration of the use of a syringe driver?
A Yes, yes.

Q What other training did you have?
A I cannot remember offhand.

Q What about the use of opiates, the use of the drugs that went into the syringe driver. Did you have any specific training about those?
A I cannot remember any specific training as such, but a number of us took it upon ourselves to do as much research as we could.

Q I think you specifically did some research about syringe drivers?
A I did.

Q We will come onto that. Can I take you, please, to page 6 of this little bundle. You will find the page number in the right hand corner. This is after the meeting in July. We are now into the end of October 1991. We can see the purpose of this visit by Code A Code A, community tutor:

> "The visit was in response to a request by Code A to discuss the issue of anomalies in the administration of drugs."

Do you recall this meeting?
A Yes, I can.

Q What was this all about?
A At the time, I was attending a Care of the Elderly ENB course. As part of that course we had to discuss problems in our work area or things that bothered us. I chose to discuss

pain control. It was a result of this discussion. Apparently a previous member of staff had attended a similar course and had raised similar concerns.

Q And the person who is coming along to give this talk, was that Code A ?
A Yes.

Q I can see that she described as Community Tutor?
A Yes.

Q Can you help us with what that actually means?
A Her involvement with me was as a tutor at the School of Nursing. She actually participated in the Care of the Elderly ENB course.

Q Which you were doing?
A Yes.

Q I see. So she came along, did she, to speak to the nursing staff that we can see at the Redclyffe Annexe?
A Yes.

Q Was that as a result of your request?
A My request and, as I stated, the outcome of a previous discussion.

Q Okay. And then we can see that some problems were identified at the day of the meeting. These were nurses, were they, speaking out?
A Yes.

Q About the problems that they had seen?
A Yes.

Q Were there any members of management at this meeting?
A No.

Q Or Code A or Code A ?
A No.

Q So it is nurses together as it were with the Nurse Tutor?
A Yes. The purpose of the meeting was really to find out what our concerns were and whether there really was a problem.

Q Then we can see the two first matters were raised by Code A ?
A Yes.

Q Then you reported an occasion when a syringe driver had run out before the prescribed time.

> "The staff are concerned that diamorphine is being prescribed indiscriminately without alternative analgesia, night sedation or tranquillisers being considered or prescribed."

Was that at the time a concern that you shared?
A Yes.

Q We have heard quite a lot, as you will appreciate, in this case about the sliding case of analgesia?
A Certainly.

Q Did you know about the sliding scale of analgesia, the concept of it?
A Yes.

Q There is a specific document called the Wessex Protocol. Had you heard of the Wessex Protocol?
A Probably not at the time, but yes, I am aware of it.

Q But you knew the concept of starting at the bottom and moving upwards?
A Yes.

Q Then at paragraph 5 we can see a specific concern raised by you:

"Code A reported that a female patient of 92 years awaiting discharge had i.m."

Is that "intramuscularly"?
A Yes.

Q

"... 10 mg Diamorphine at 10.40 hours on 20.9.91, and a further i.m. 10 mg Diamorphine at 13.00 hours on 20.9.91, administered for either a manual evacuation of faeces or an enema."

And the use of diamorphine concerned you on that occasion?
A Yes.

Q Over the page:

"There are a number of other incidents which are causing the staff concern but photograph the purposes of this report are too many to mention. The staff are willing to discuss these incidents."

Then you were obviously speaking up a bit at this meeting. That is no criticism.
A I think people expressed their concerns. Then, when it was a more formal meeting, as you can appreciate, people go quiet and because I knew Code A it was left to me to do the speaking.

Q It is a bit like asking if there are any questions at the end of a lecture.
A Yes.

Q It is quite difficult to do it, but you knew Code A?
A Yes.

Q And so you felt it easier. Let us have a look at what you raised.

"7. It was reported by Code A that:"

And then you reported the quantities that were being used between certain dates. Then at (b) you said:

"b) .... (24 of the 57 ampoules of Diamorphine 30 mg were administered to one patient, who had no obvious pain...".

Why, so far as you were concerned, was the lack of pain relevant?
A I think I wondered why they were having diamorphine if they did not have pain, or did not appear to have pain.

Q Then:

"c) 8 ampoules of Diamorphine ... were used between [certain dates] (4 of the 8 ... were administered to the patient identified in 7b above ...

Note – This patient had previously been prescribed Oramorph 10 mg ... which was administered regularly commencing on 2 July 1991.

The staff cannot understand why the patient was prescribed Oramorph and Diamorphine.

When the staff questioned the prescription with Sister...".

Would that be Code A?
A Yes.

Q

"... they were informed that the pain had pain. The staff recalled having asked the patient on numerous occasions if he had pain, his normal reply was no."

A That is right.

Q Do you remember this incident?
A Yes, now I have read it.

Q It is a long time ago?
A Yes.

Q Can you just tell us – what was Code A reaction generally if you confronted her or asked her about why patients were on diamorphine?
A At the time the relationship between nights and days what not necessarily at its best. On night staff, there were a few members of staff that had been around for a long, long time and a great deal of new staff, and we did not really know Code A very well, so it was building up a rapport, I suppose.

Q Did you yourself have occasions of speaking to Code A which you can recall and indicating your concerns directly to her?
A I think yes.

Q And do you have a recollection of the sort of reaction that you got back from her?
A I do not think it was the reaction I expected. I do not think it was a very helpful reaction.

Q Then we can see the conclusions where you were concerned about the use of diamorphine indiscriminately and that non-opioids and weaker opioids were not being considered prior to the use of diamorphine. The sliding scale of analgesia comes into play there, does it?
A Yes.

Q I am going to miss out a couple of documents. There is a letter from Code A at page 10 to Code A we know, was the patient care manager. I think Code A Code A was raising your concerns directly with management. I am sorry – back into tab 6, page 10. That is a letter we have looked at. Did you understand Code A was raising your concerns with management?
A Yes.

Q I will not ask you any more about that. Could I ask you to go to page 14, please – same tab. Here is another letter from a nurse representative – somebody called Code A Code A Did you know Code A ?
A Yes.

Q He is described as a "Branch Convenor"?
A Yes.

Q In essence, was he representing the nurses ---
A He was, yes.

Q --- in this exchange. This had now gone up to the District General Manager, Code A Code A This is a letter dated 2 December 1991. Would you look at the second paragraph? He writes:

> "I was contacted by a staff nurse currently employed on night duty in Redclyffe Annexe, her concern was that patients within Redclyffe were being prescribed Diamorphine who she felt did not always require it, the outcome being that the patient died. The drug was always being administered via 'syringe drivers'. It is fair to say that this member of staff was speaking on behalf of a group of her colleagues."

Do you have a recollection as to who that member of staff was?
A I believe it was Code A

Q Again, did you share that concern?
A Yes.

Q Page 16, please. This note refers to a letter from you referring to the meeting that had taken place on 31 October which we have looked at at page 6. Code A is your local manager, the hospital manager. Is that right?
A Yes.

Q

> "May I take this opportunity to once more state that I am happy to discuss any areas of concern that staff may have, in fact I would welcome open discussion, as I feel the only alternative is disruptive criticism which achieves nothing positive and leaves staff feeling frustrated."

Did you have any face to face dealings with Code A?
A Yes, I did.

Q Was she trying to assist, did you feel?
A I did not think she was at the time, no.

Q Why not?
A I can remember one incident. At the time of these meetings, my mother was dying of a brain tumour, which I felt was totally unrelated, but she brought that up and she stated that perhaps my judgments were clouded by my own personal problems.

Q Was your mother on a syringe driver?
A Not at the time, no.

Q Was she receiving opiates?
A Yes. She did later go on to a syringe driver.

Q And it was being suggested that because of that background, as it were ---
A Yes.

Q --- you had these particular concerns?
A Yes.

Q Page 18. I am sorry – that is actually a letter not to yourself but to Code A but there is reference there to a policy being written up. Was a policy ever written up that you can recall?
A I cannot recall a policy, no.

Q Can we go to page 21, please. Another meeting, I think, was set up and you had been sent a memo. The memo is back on page 17, and I am going to try and short-circuit things. You were being invited, I think, by that memo to put your views down in writing. Then, if we go to page 21 we can see that Code A is writing:

> " Due to the lack of response to my memo ... Code A will be unable to comment on specific cases, however, we have arranged a meeting for all members of staff at Redclyffe who have concerns on the prescribing of Diamorphine on ... 17th December ... to discuss the subject in general terms.

A

It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have so I hope everyone will take the opportunity to attend and help resolve this issue."

Then we have the note of the meeting at page 23. By this stage had you expressed such concerns as you could to management?

A Relating to the memo?

B

Q Yes.

A I honestly cannot remember.

Q Just before we come onto this, we are going to see that Code A attended this specific meeting on 17 December. How much discussion, if any, up until this point had you actually had with Code A?

C

A I cannot recall having any discussion with Code A prior to this meeting.

Q May I ask why not? She was coming in. These concerns had started, or at least had been written about, in July 1991. We are now in December 1991. Was there any reason you did not raise them with Code A?

A I think because we did not actually come into contact with her, or very rarely up until that point. Our point of contact would have been Code A or the day nurse in charge?

D

Q So you were dealing with Code A?

A Yes.

Q You described her attitude. Page 23, we can see that you were present at this meeting on 17 December. Let us go down to paragraph 3. We can see that staff were invited to give details –

E

"... of cases they had been concerned over but no information was received; it was therefore decided to talk to staff on the general issue of symptom control...".

I am not going to read through the whole of this. You are welcome to cast your eye over it if you wish to. Page 24 we can see that Code A had presented staff's concerns so that at this stage, Code A was apparently putting forward the concerns the nurses had, and then there is a set of propositions, one to five. Just look through those.

F

A Yes.

Q The Panel have read them through already, and they have had them read through for them, including (4):

"4. What is questioned is the appropriateness of prescribing diamorphine for other symptoms or less obvious pain.

G

5. No one was questioning the amounts of diamorphine or suggesting that doses were inappropriate.

All present agreed with these statements, no other comments were asked to be considered."

H

A At this stage did you still have any concerns about the use of diamorphine and syringe drivers?
A I think one of my main concerns was how staff were actually using the syringe drivers, changing the rates and things.

Q What was that? Can you just explain that a little more?
A I can recall several incidents where the practice was to initiate the syringe driver, start
B the rate higher than necessary for a few hours, then to reduce the rate.

Q Did you ever get a written protocol following all those meetings?
A I cannot recall receiving one, no.

Q How did things move on after December 1991? Did you receive further training?
A I attended lots of training courses. I think anything that was available, I attended.
C
Q Was that of your own volition or was that something arranged by GWMH?
A It was mostly off my own bat.

Q Because you wanted to know more?
A Yes.

D Q Did you receive any formal training about the use of opiates and the quantities of opiates to use?
A Through Gosport War Memorial Hospital?

Q Yes.
A I cannot recall off-hand.

E Q Did you go on any training courses yourself?
A I think I did, yes.

Q Can you recall whether you had any specific further discussion or training either with Code A ?
A No.

F Q You moved, as you have told us, about a year after this to the Dryad ward.
A Yes.

Q Can you help us? Did things change at the Dryad ward, or did your concerns resolve themselves?
A I am not sure if I can say things resolved themselves. I think my understanding was different. By that point I had attended a lot of training sessions and done a lot of reading and
G research.

Q So you knew more about the use of diamorphine and more about the use of syringe drivers?
A I think so, yes.

Q Did your concerns about their use resolve themselves?
H A I cannot recall being as concerned.

Q Can you tell the Panel this? Did things actually change after these meetings so far as you are concerned, or was it your understanding that changed?
A I think mostly my understanding.

Q Did anything change about the actual use of syringe drivers and the use of diamorphine that you can remember?
A The use of syringe drivers possibly changed slightly, certainly at night. Once we were aware of certain protocols and guidelines, we tended to stick to those, recording on charts, regular checks, that type of thing, but this was on a more informal basis.

Q So the record keeping got better, did it?
A Yes.

Q Anything else?
A Not that I can remember.

Q What about the quantities of opiates being used or how quickly they were being used? Did that change or did that remain the same?
A I think it was about the same.

Q So far as the use of opiates is concerned on Dryad ward, you have had your training, such as it is, you have had the meetings, you have moved to Dryad ward. I just want to ask you a little bit about the authority for the use of a syringe driver, the authority for an increase in medication. We have seen through the notes – perhaps I do not need to take you to a specific note, because I expect you will remember – that [Code A] used to pre-prescribe; she used to prescribe a variable dose.
A Yes.

Q Do you recall that happening?
A I can recall that happening, yes.

Q There were variable doses of diamorphine to be administered through a syringe driver.
A Yes.

Q As a member of the night staff, were you ever responsible yourself for setting up a syringe driver, initiating a syringe driver?
A Very rarely.

Q But it did happen?
A Possibly occasionally. I cannot actually recall setting one up.

Q If you had done, that would presumably be with another nurse?
A Yes.

Q Whether you actually set one up or not, can you remember what your understanding was about the authority to set one up? Would you need to go back to the doctor, or would you be able to set one up if it was prescribed?
A Once it was prescribed, if we found it necessary, then we could set it up.

Q The initiation dose would be what to your understanding?
A The lowest dose from the prescription chart.

Q Increases in doses would be dealt with how so far as you were concerned? First of all, did you ever deal with an increase in dose yourself?
A Probably, yes.

Q We will be looking in a moment at some patient notes. Again, so far as you are concerned, what was your understanding of how doses should be increased?
A We had the authority, if the patient we felt was still in pain or discomfort, the prescription was such that we could adjust the dose if we felt it was necessary.

Q If you felt it was necessary?
A Yes.

Q But by how much? If you have a range, say, from 20 to 200, you started off at 20 and you felt that the patient required it, by how much would you feel you would be entitled to increase the dose?
A 5 or 10 mg.

Q 5 or 10 mg?
A I think so.

Q Would you go back to a doctor before increasing it, or not?
A Sometimes.

Q But not always?
A Not always, no.

Q You were interviewed by the police, were you not?
A Yes.

Q And you gave a number of statements also to the police.
A Yes.

Q You said I think all the way through those that you yourself would not give drugs to a patient unless you thought it was appropriate.
A Yes, that is correct.

Q That is part of your duty as a nurse.
A Yes.

Q Can I ask you what you know about conversion rates from oral morphine to subcut diamorphine, or what you knew then?
A I know that the dose of the subcut would have been less than the oral.

Q Do you know how much the dose has to be less to be the equivalent?
A About a third.

A Q Is that knowledge that you had back in the mid to late 1990s?
A That I am not sure.

Q So that may or may not have been part of the special training that you did?
A Exactly.

B Q I want to go on, before we begin looking at specific patients, to ask you about two other areas. The first is the issue of hydration of patients. Again, we have heard lots of evidence about hydration and the use of syringe drivers, but what was your knowledge about its use on Dryad ward? Did you use hydration on Dryad ward?
A Very rarely.

Q What sort of method of hydration would you use on Dryad ward?
A If a patient was unable to drink orally, on very rare occasions it would be
C subcutaneous fluids.

Q So not intravenous?
A No.

Q Subcutaneous?
A Subcutaneous.
D

Q Which means, as we have heard, a low level drip.
A Yes.

Q In what circumstances would you yourself have thought it appropriate to use a subcutaneous drip? Would that have to be prescribed by a doctor or would you be able to set it up on your own?
E A I think in those days it would have been on a doctor's recommendation.

Q So there would have to be a note made that a subcutaneous drip should be set up?
A Yes, from what I can recall.

Q But then you would be able to do that?
A Yes.
F

Q That would involve, we have heard, inserting a small needle into the patient's skin and allowing a slow drip of what? Saline?
A Yes.

Q If a patient was unable to swallow, might that be an indication for a syringe driver to be used?
G A Yes.

Q You have said I think that it would be very rare for hydration to be used, but it was sometimes used, was it, in relation to patients who were on a syringe driver?
A I am pretty certain that I can recall a couple of cases, yes.

Q I want to ask you about some other occasional notes that we have seen and your
H understanding of them. We have seen in some of the notes – not actually from Dryad ward,

but from the Haslar Hospital I think it was – "Not for resuscitation", or "Not for 555". Would you understand what those words mean?
A Yes.

Q "Not for resuscitation" perhaps is fairly obvious.
A Yes.

Q We have also seen expressions such as "Make comfortable" or "TLC".
A Yes.

Q Let us deal with TLC first of all. TLC would mean what to you?
A Tender loving care.

Q What significance would that have for a patient?
A To keep the patient comfortable.

Q Would it be any indication of what sort of state of illness they were in?
A I would assume the patient was probably terminally ill by that point.

Q So effectively for palliative care.
A Yes.

Q "Happy for nursing staff to confirm death". What, if anything, does that mean to you?
A That the patient was terminally ill and, if they died, nursing staff were able to confirm death.

Q So that would be its significance to you; it would indicate that the patient was terminally ill.
A Yes.

Q I am sorry. I began by asking you about "Make comfortable" and I forgot to come back to it. "Make comfortable". What would that signify to you?
A Similar to TLC, I think.

Q So "TLC", "Make comfortable", "Happy for nursing staff to confirm death", in your mind at least were end of life type words?
A Yes.

Q Was there any other notation to indicate to you that a patient was for palliative care and would it ever be written in the notes that you saw "For palliative care only" or whatever might be written?
A Possibly "For palliative care".

Q Do you remember that ever being written?
A I have seen it written, but I cannot recall if it was then or if it has been in more recent years.

Q When the police investigation started, I suspect that word of that raced round the nursing environment fairly fast, did it?
A Yes.

Q You handed your notes about what had gone on in 1991 to somebody called Code A Code A

A Yes.

Q Just tell us, please, why you did that?

A It was as a result of a comment in the CHAI report. It stated that nobody had ever questioned pain control within Gosport War Memorial Hospital.

Q You were concerned about that because?

A A number of staff were concerned, so I felt it was appropriate to take my notes to Code A.

Q I am going to start dealing with various patients. We can deal before we break I think with Patient E, Code A, very quickly. You were interviewed by the police in 2000 about this lady. I am not going to invite anybody to turn up the notes of this patient, because I think your dealings with this patient were extremely limited.

A Yes.

Q In fact, I think according to your interview, you had almost no dealings with her until she died.

A That is correct.

Q Then you were asked to hand a note or a book of some sort to one of the relatives?

A A book, yes, from a relative to a colleague.

Q I may have to come back to Patient E, but for the moment I am going to move on. I think you went through Patient E's notes, did you not, with the police and you did not find any notations.

A No.

Code A: I am going to move on to Code A, who is our Patient F. I do not know, sir, when you want to take our break. This patient will probably take about 10 or 15 minutes, so it might be convenient to have the break now.

THE CHAIRMAN: Very well. We are going to take our break now. The Panel assistant will take you to somewhere where you can get some refreshments. You are on oath – and I will probably remind you of this later – and your oath continues every time we take a break and so it is absolutely essential that you do not talk to anybody about any aspect of this case. Is that clear to you?

A Yes.

THE CHAIRMAN: We will return, ladies and gentlemen, at 10.45.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everyone.

Code A: Sir, I do not know if we are waiting for the doctor. She is not here.

THE CHAIRMAN: I am sorry, there is such a rampart of files, that we cannot see from this end.

Code A: She is not here at the moment, but perhaps we may just continue. She will be here.

Code A, we were about to turn to Code A, Patient F. I think, with one exception, it is fair to say that you do not have an individual recollection of these patients.
A No.

Q So far as Code A is concerned, she is one of those about whom, unfortunately, you have no recollection.
A That is correct.

Q That is no criticism of you; it is all a very long time ago. I only want to ask you very briefly about some entries in her records. Could I ask you to take up bundle F, page 78 – and the page numbers that we are looking for are those with two short lines either side of them. This is not your note at all, but it shows us that this patient was transferred to Dryad Ward – that was your ward ----
A Yes.

Q -- for continuing care. Do you know what the "HPC" notation means?
A I am not sure, no.

Q I am sorry, it is "history of presenting complaint," it is not?
A Yes.

Q Then fracture …
A Neck of femur.

Q Thank you. We can see that she had a Barthel of 6. "Get to know. Gentle rehabilitation. I am happy for nursing staff to confirm death" – which you have indicated to us was an indication of palliative care. A Barthel of 6. We know there is a maximum of 20, but is a Barthel of 6, on Dryad Ward, good, bad or average?
A Average, I would think.

Q It means she can do some things for herself, with assistance.
A Yes.

Q She is not totally in the hands of the staff.
A That is correct.

Q Can we turn to the prescription charts, please, which you will find starting at page 368A. We can see that she has been written up, at page 368B, for Oramorph 10 milligrams and temazepam, and various other drugs at page 368C. At page 368E, she has been written up, under the daily review prescriptions, for diamorphine 20-200 milligrams. Do you see that?
A Yes.

Q How do you interpret that prescription?

A That we could adjust the dose between 20 and 200 milligrams.

Q Depending on what?
A Depending on the patient's need for pain control – if we felt the patient was in discomfort.

Q Would you regard that as a PRN prescription?
B A Yes.

Q Meaning "as required".
A As required, yes.

Q But it is written up in the daily review prescriptions.
A Yes.

C

Q But you would not automatically give that?
A That drug or the dose?

Q You can see: "Diamorphine 20-200 mgs." Who would have written the dates at the top: 19, 20, 21, 22?
A The person who administered the drug.

D

Q And they would be administering it on the basis, would they, of their decision about the patient's need?
A Yes.

Q Would this sort of prescription normally be under a "PRN" heading?
A Yes.

E

Q You have told us, quite rightly, that you would not issue a drug unless you thought it was appropriate.
A That is correct.

Q Before issuing a drug, would you look at the Haslar notes necessarily, or would you be reacting to the patient at that moment?
F A Probably reacting to the patient at that moment in time.

Q I think you were shown a controlled drugs record, but I am going to ask you about one of these entries here. On page 368E, do you see your initials anywhere? We can give you the original, if that helps you. (Original handed to the witness) You can look at the original controlled drug record if you need to, but in your police statement you reveal that 60 milligrams was withdrawn on 21 August at 7.35, and the entry was witnessed by yourself and
G it was given by Code A
A That is correct.

Q I do not suppose you have any independent recollection of that at the moment.
A No.

Q All right. When we look at 21 August, where we see "07.35" that is 60 milligrams
H being given with you being present.

A A Correct.

Q But it has not been initialled by you.
A No.

Q I do not think your initial appears elsewhere on this page, does it?
A No.

B

Q Can you tell us, so far as you are concerned, how this would have worked. Who would have made the decision to increase this patient's prescription by 20 milligrams?
A It would have been a joint decision between myself and Code A

Q And you would be entitled to do that because of what?
A Because we have the leeway in the prescription and we were caring for the patient.

C

Q You told us earlier that your recollection was that any increases would normally be between five and ten milligrams.
A Yes.

Q This is an increase of half again, as it were.
A Twenty.

D

Q From 40 to 60 milligrams.
A Yes.

Q Can you recall anything about the basis for it?
A No, I cannot. I am sorry.

E Q There is a nursing note at page 394 which you might like to go to. If you would look towards the bottom of the page, I do not think the first writing is yours, is it?
A No.

Q 20 August 1998. This is the day before that drug that you have issued. "Condition appears to have deteriorated overnight. Driver recharged ..." You would have had nothing to do with the initiation of the driver.
F A No.

Q Nor the starting dose.
A No.

Q And you cannot tell us why it was initiated.
A Only making assumptions from the records in front of me.

G

Q Diamorphine, we can see 20 milligrams is where it started off, and midazolam 20 milligrams. Then, towards the bottom of the page, do we see "Night"?
A Yes.

Q "General condition continued to deteriorate. Very "bubbly". Suction attempted without success. Position changed frequently ..." Can you read this for us?
H A "Only rousable ..."

Q It has been suggested that is "Code A rousable ..."
A "Code A rousable and distressed when moved. Syringe driver recharged. Diamorphine 60mgs. Midazolam 60 mgs. Hyoscine 800mcg ... Daughter has inquired 08:00 [something] condition".

Q Whose signature is that?
A Code A

Q She was present with you, you have told us.
A Yes.

Q At the withdrawal of the drugs. When we see on the page before, "General condition continues to deteriorate" this is a patient who is on a syringe driver, and there is no note, I do not think, that the patient is being hydrated.
A No.

Q She has been on the syringe driver, as we can see, from 19 August. When you describe that a patient's condition is deteriorating, it may be obvious to you but what does it mean?
A The patient's breathing, perhaps, might have deteriorated. They appear uncomfortable, distressed. Their physical condition and observations would have changed.

Q Their physical condition would have changed.
A Yes.

Q In what way? What would you be looking for?
A Signs of distress and pain.

Q Right.
A Agitation.

Q If there is pain, would you make a note of it normally?
A Usually, yes.

Q "Condition deteriorating" means what? All of those things? Some of those things?
A I think all of those things.

Q If pain is the basis for you increasing a dose, is that something that you would note or you would not normally note?
A I think I would normally note.

Q I am going to ask you to put that file away, please. There is almost no need for you to turn it up, but so far as Patient G is concerned, Code A, who was known as Code A, I think you have signed a note, just to have a very quick look at it, at page 647, and that relates to the patient dying on 26 September.
A Yes.

Q These are clinical notes. You would only put a note into these notes presumably if the patient was dead.

A A Usually, yes.

Q Because they do not form part of the nursing record.
A No, that is correct.

Q We can see previously that the patient had been transferred to Dryad Ward on 21 September. We see the words, "Make comfortable. Give adequate analgesia. I am happy for
B nursing staff to confirm death." How would you read those three comments?
A I would assume that the patient was still in a very poorly state.

Q Presumably, it was as a result of those words, "I am happy for nursing staff to confirm death," that you, together with Code A were able to do what you did.
A Yes, that is correct.

C Q If you could have a very quick look at page 758, please, I want to make sure that we have not missed anything. I do not think that you have initialled any of these.
A No.

Q Okay. You can put bundle G away, please. I want to turn to Code A, our Patient I. At page 164 we can find a drug sheet. You are about to be handed the original drug chart. (Original handed to the witness) This patient had been transferred to Dryad
D Ward on 26 March 1999. We can see at the top of this page that she was prescribed Oramorph. There are four separate prescriptions for Oramorph on this page, but we can see that the first date at the very top is 26 March – yes?
A Yes.

Q I do not think that you can recall this patient specifically, is that right?
A No, I cannot remember her. I am sorry.

E Q I think you have initialled an entry for the administration of Oramorph at 2200 hours. In the second row up from the bottom, do you see Oramorph has been written up? Is that ten milligrams.
A Ten milligrams in five millilitres.

Q 2200 hours would have been written by whom?
F A That is a member of the ward staff's handwriting.

Q That is...?
A It is one of the ward nurse's handwriting.

Q If we look up above that, we can see that there is also Oramorph prescribed, seemingly at the same time, but those are the sorts of daily prescriptions to be given at six
G o'clock, ten o'clock, 1400 hours and 1800 hours, is that right?
A Yes.

Q Again help us with how this works. Is this a PRN prescription or a regular prescription?
A This is a regular prescription.

H Q You would expect those drugs to be given at those times.

A A Yes, that is correct.

Q Not depending upon the nurse's evaluation of pain or anything else.
A No.

Q Is that your initial, at 2200 hours?
A Yes.

B

Q With an "X" next to it? Is that right?
A I think it is a [Code A] rather than an "X".

Q It is a '[Code A]', is it. Right, okay.
A I think that is one of my initials.

C Q That is you? All right. You gave those drugs when? On which day?
A On 26 March 1999 at 2200 hours.

Q And at ---
A And then again on 27 March 2999 at 6 o'clock in the morning.

Q So do we have to go up to the top for that?
D A Yes.

Q And you would have been giving the patient those drugs because they were written up?
A Yes.

Q On 26 March, I just want to understand this. Have you given any drugs in the
E evening of the 26th?
A At 2200 hours?

Q Yes?
A I have given Oramorph.

Q In your statement you also referred to 23.15. I have to confess that I have not been
F able to find that.
A It is probably the same thing.

Q It is probably the same thing?
A The due time for the drug would have been 2200 hours but it was probably administered at 23.15.

G Q Then, on 27 March, as you told us, in the morning, you have given some more drugs - yes?
A Yes.

Q I think you have witnessed [Code A] on 28 March giving her drugs. Would you have had reference to any of the nursing notes at the time that you gave these drugs, or witnessed these drugs being given?
H A I think so, yes.

Q If you go back to page 96, you will find a nursing care plan. If we look at the bottom of that page – I do not think this is your writing, is it? It has a big "84" in bold but it is actually page 96, with two lines either side of it. Do you have that?
A Yes.

Q Is this your writing anywhere?
A No.

Q At the bottom we see 28 March:

"Is having regular Oramorph, but still in pain."

On 28 March:

"Has been vomiting with Oramorph. Advised by Code A to stop Oramorph."

So you would not have stopped the Oramorph unless told to by Code A?
A Unless the patient was vomiting but probably after speaking to Code A or getting authorisation.

Q That is all that I ask you about that patient. We are going to move on to Code A That is file J. Is it fair to say, you do have a little bit of recollection about this gentleman, Code A? Let us get you to the notes first of all.
A Okay.

Q Would you go first of all to pages 171, 174 and 175 you will find the drug charts. Do you remember that this patient was a patient with pressure sores?
A I think I do, yes.

Q And we know that he was admitted to your ward on 23 August 1999. What, if anything, can you remember at the moment about this man's sores?
A If I can recall correctly, I think they were large.

Q And was he a very large man?
A I think he was, yes.

Q Because you were dealing with these patients on night duty, does it follow that the decision to initiate syringe drivers and the decision to initiate opiates was more often made during the day?
A Yes.

Q Does that follow for all of the patients that we have been looking at?
A Yes.

Q So when you would come to a patient at night, they would – if they were going to be on a syringe driver – in general already have been on a syringe driver?
A Yes.

Q And part of your duty would be to continue with that syringe driver and ensure that it was operating correctly?
A Yes, that is correct.

Q I think before we get to a syringe driver with this patient, can we just look at the issue of Oramorph first of all. Then if we go to page 174, I think we can see Oramorph was written up. First of all we are going to look over the page as well. There are more references to Oramorph on the following page. Oramorph was written up on the 26 August. Is that right?
A Yes.

Q And all of these prescriptions are written up by Code A Can we also see that there is a range prescription written up for diamorphine?
A Yes.

Q I just want to understand this. If we go over the page to 175 can we see there is a regular prescription and Oramorph has been written up as well?
A Yes.

Q That is 10 mg in 5 ml. Is that right?
A Yes, that is correct.

Q I just want to deal with what you administered. Do you have the originals? We do not have those. We may have to find that. I am sure we have it somewhere. In your statement you make reference, I think, to witnessing the administration of Oramorph by Code A Code A on 26 August at 22.55?
A Yes.

Q Can you see that entry?
A Yes.

Q Where?
A On 26 August.

Q Yes. At page ---?
A Page 172 . At page -175-.

Q At 175?
A Yes.

Q I see. Is it the second row down?
A Second row down, yes.

Q Was that 20 mg?
A Yes.

Q Then on 27 August have you witness that administration? Again, according to your statement you said "22.15: I have signed that I witnessed the administration of Oramorph. This is from the controlled drugs record."
A Yes.

Q You did not give the drugs yourself, but they were being given?
A Yes.

Q It may be obvious but what is the purpose of giving an extra 20 mg dose, as it were, in the evening?
A The dose in the evening we were given to believe was a stronger dose so that the patient was comfortable throughout the night.

Q Right?
A Because it would have lasted until six o'clock in the morning.

Q Has the same happened on the 28th and the 29th?
A Yes.

Q Just going back to the page before, please, we can see that the syringe driver was started on the 26th, so three days after the patient's admission, at 40 mg diamorphine. Yes?
A Yes.

Q The minimum dose prescribed was 40 mg?
A Yes.

Q And as a nurse would you take it, are you entitled to administer to the patient any less than the minimum dose?
A No.

Q So on 26 August the syringe driver is set up so the patient receives 40 mg over a 24-hour period, together with midazolam. Do we see that?
A Is it actually the 26th, or is it the 30th, which is written below.

Q I am sorry – I think you may be right. It is written up for the 26 August, and then it may be administered on the 30th. Let us just have a look at the original. Can I pass the witness the original? (Document handed to the witness) We know from the nursing notes that the syringe driver was actually commenced at 14.45 in the afternoon of 30 August. It is quite difficult to read the prescription sheet.
A It is, yes.

Q Does it look like the 30th?
A It does look like the 30th.

Q So on the days leading up to the 30th, as you described, on 26, 27, 28 and 29 the patient is on Oramorph with an extra dose given at night?
A Yes.

Q And then the diamorphine is started intravenously ?
A Subcutaneously.

Q Sorry. You are quite right. It is subcutaneously. So far as the initiation of the syringe driver is concerned, as you have indicated, that would be based on the doctor's prescription?
A Yes.

Q And the doctor's assessment?
A Yes.

Q Can we put that away, please. The last patient I want to ask you anything about is, I think, Code A Would you put that file away and turn to patient K, please. Do you have any recollection of Code A ?
A No.

Q Again, I think the only part of her notes that I want you to have a look at please is page 281, and could you keep a finger there, please, and also turn up page 223. Again, this is just to orientate you and just to see if this triggers any memory.
A Okay.

Q So do you have page 223 as, I think, a nursing note – I think the nursing summary of significant events?
A Yes, I do.

Q We can see at the top of the page that this patient was admitted on 21 October with increasing confusion and aggression. At the bottom of the page we see that on 19 November there is a note:

> "Marked deterioration over last 24 hours. Extremely aggressive this a.m. Refusing all help from staff..."

And then she is given chlorpromazine at 8.30 and then, over the page, we see a syringe driver was commenced at 9.25. By 9.25 you would have been well off duty, as it were?
A Yes.

Q But just reading through these notes again, does it bring back to mind the patient at all? During the day, apparently, she was aggressive?
A I think I have some vague recollection of her.

Q But can you tell us what that recollection is?
A I can remember an incident shortly before I went off duty where she was very aggressive, or she became very aggressive.

Q Right. Would you normally have made a note of that?
A Probably, but it might have depended what time it was. I think if ---

Q Would the note have appeared here in the summary?
A It would, if I had made a note.

Q Could you just look through pages 223 and 224 please. I think we have identified all the writing here.
A No entries by me.

Q And if that sort of incident did occur but you did not note it, would you relate it orally to the day staff?
A Yes.

Q But it is the sort of thing that you should have noted if it had happened, or not necessarily?
A I think, if I can remember rightly at the time, although I was based on a ward, I would have been the nurse in charge of the hospital and looking after minor injuries as well, so there would have been another staff nurse actually in charge of the ward who probably would have made notes as such.

Q Or not?
A Or tended to make more of the notes. Yes. Or not.

Q I think so far as this patient is concerned, you witnessed some withdrawals of diamorphine, not administered by you, and so I am not going to ask you about those. I said that was the last patient. I think there may be one more reference to you in the notes of Code A Code A, but it may be that we do not need to turn it up. Would you just give me a moment? Yes. It is Patient L and you, I think, have simply verified her death?
A All right.

Q You can turn it up certainly if you want to remind yourself. It is page 1292, right at the back of the bundle. Do you have that?
A Yes, I have found it.

Q This patient was transferred to Daedalus ward – so not your ward – but nevertheless you have, as I think we can see at the bottom, witnessed the verification of her death. Would that be because, as senior nurse, you would have been called over to do that?
A Yes.

Q But normally you would not be on Daedalus Ward?
A Occasionally, but it was not my regular ward.

Q As we saw when we started with Code A, she was actually also on Daedalus ward, but you performed a specific duty presumably because you were the senior nurse and the patient had died.
A Yes.

Code A Thank you very much. Wait there, please.

Cross-examined by Code A

Q Code A, I am going to ask you some questions on behalf of Code A. If you keep that folder open in front of you and just turn to page 1337, I think there is a note of yours about Code A
A Yes.

Q It is fairly legible, so I do not think I need ask you to read it out. You gave evidence at the inquest, did you not?
A Yes.

Q And I asked you a few questions then.
A Yes.

Q Is it right that Code A, during the time that you had worked on the same patient that she was working with, you thought her to be very conscientious as a doctor?
A Yes, I do, and I did then.

Q She was, so far as you could tell, hard-working?
A Very.

Q And always concerned to do the best for the patients?
A Yes, she was.

Q The staff knew that if Code A needed to be contacted, she could be telephoned.
A Yes.

Q And that was no problem at all.
A No problem at all.

Q You have been asked about a number of specific patients and you have been asked to look at their medical records. These are obviously the patients with whom the Panel are concerned in 1996 and thereafter. Would it be right to say that you would not have given medication to any of those patients unless you, as a nurse, thought it was appropriate?
A Correct.

Q You were in a position, with the patient in front of you, to discuss matters with another qualified nurse.
A Yes.

Q You had had the experience of dealing with that and other patients and you would be able to judge their level of comfort or their level of need for the medication.
A Yes.

Q If you had felt that the medication that was written up for the patient was inappropriate, you would not have given it, would you?
A No, that is correct.

Q That would be your duty as well as what you would want.
A Exactly.

Q Is it right that in the mid to late 1990s, the War Memorial Hospital was taking patients that were often elderly and often had many complicated medical histories.
A That is correct.

Q Did it feel, as a nurse on Dryad ward, that you may be taking patients that other hospitals locally would not have wanted to take?
A Yes, it did.

Q Were the patients often in poor condition when they arrived with you?
A Very poor condition, some of them.

Q Was it obvious, as a nurse, with a number of years experience then, that a lot of the patients who were transferred in the mid to late 1990s were unlikely to leave the War Memorial Hospital?
A Yes, that is correct.

Q Your assessment of a number of the patients was that they were in poor shape; they were towards the very end of their lives.
A Yes, they were.

Q Can I come to the beginning of the 1990s, because that is a time you have been asked a lot of questions about and you have been asked to look at a number of documents. Would it be fair to say that by 1996 and thereafter, any concerns that you might have had in 1991 had been resolved?
A I think so. I cannot remember being concerned at the latter date.

Q You were asked questions by several people at the inquest. Is it right that you said that by 1996, you had no concerns about anything that had affected you earlier on?
A I cannot recall having any concerns.

Q In the early 1990s, right at the beginning, obviously we were dealing with a different ward and what you have told us is that there were some new staff on Redclyffe.
A Yes, there were.

Q There were some staff who had been there for many years.
A Yes, correct.

Q Was there a process going on of the two sets of staff getting to know each other?
A Yes, there was.

Q I think there were some tensions.
A There were.

Q The day staff and the night staff did not always speak with one voice.
A No.

Q On top of that, is it right that the mix of patients that the Redclyffe Annex had been taking had been changing over the last couple of years?
A Yes.

Q Right at the end of the 1980s and beginning of the 1990s, you were getting some patients on to the ward that were really rather poorly.
A Yes, that is correct.

Q I think before that, in the late 1980s, the patients had not needed a great deal of nursing or medical care.
A That is true.

Q As the type of patient changed, you were dealing with more complicated patients and I think the nursing and medical needs of those patients changed as well.
A Yes, that is correct.

Q Was that one of the issues that was arising in 1991?
A I think it was. There were a lot of changes.

Q Not just personnel or the type of patient, but the types of treatment that patients were getting, including giving opiates by syringe driver.
A That is correct.

Q You have told us that your introduction to a syringe driver was by a Code A who basically showed you a syringe driver and told you to get on with it.
A Yes.

Q Did that feel like that was adequate training for someone on the night staff?
A No, it did not.

Q What about your night nursing colleagues? Were they getting any more training in the use of syringe drivers than you?
A I think they had less training.

Q So is this the picture that we should have of 1991 and the events that led up to the meetings that we have seen notes from: that you and your night staff colleagues, with no training at all, were being expected to deal with complicated patients and syringe drivers containing diamorphine?
A Yes.

Q Which you had never really dealt with before, syringe drivers containing that type of drug.
A No, that is true.

Q Was it your understanding then, at the time that concerns were raised, that it should only be patients who had pain that should be put on a syringe driver and diamorphine?
A At the time, yes.

Q At the time. So concerns were raised, as we have seen, essentially by night staff I think.
A Yes.

Q You, Code A
A Yes.

Q Were you the three main people who were raising concerns?
A We were the main people. There were other people that were concerned, but did not want their names involved in anything.

Q A significant part of that was the failure to have provided you with training up to that point.
A Yes.

Q We know that there were meetings at which various members of the administration were present, Code A for one.

A A Yes.

Q We know that a Code A, who was a consultant geriatrician, was present at a meeting and he explained how he wanted his patients to be dealt with.
A Yes.

B Q Were you given the explanation that diamorphine should not just be used for pain, but it had other uses as well?
A I think so, yes.

Q That syringe drivers were extremely useful as a means of ensuring a regular administration of medication to a patient so that their blood levels of the drug did not go up and down.
A Yes.

C Q I think you explained when you were interviewed by the police the benefits of a syringe driver, in that it did not lead to peaks and troughs in the patient.
A Yes.

Q Had you known that before the sort of conversations that were had around 1991?
A I would not have thought so, no.

D Q Is it right that you were told in about 1991 about other uses of diamorphine: for breathlessness or for agitation?
A Yes.

Q Is it right that after those concerns had been raised and explanations had been given, I think you had been told by doctors other than Code A, but by people like Code A as
E well about the benefits of syringe drivers and diamorphine?
A Yes.

Q Is it right that communication between day staff and night staff started to get better?
A I think it did.

Q What you have told us is that you organised courses for yourself to go on.
F A Yes.

Q I do not know. Did the hospital or the administration organise courses for your colleagues, did they have to do it themselves or just rely on a talk from Code A?
A Courses were available usually at QA. They were sometimes advertised and it was up to us whether we applied to attend or not. They were mostly short courses: an hour, a couple of hours at most.

G Q I think by the time 1996 arrived, the time of the patients with which the Panel are dealing, your knowledge was significantly greater.
A Yes.

Q And your understanding of the use of syringe drivers.
A Yes.

H

Q That is how we reached the point that you were comfortable with the doses that you have been taken through by Code A.
A Yes.

Q So again, what had happened in 1991 was perhaps as a result of inadequate training of staff and, because of that, inadequate understanding by night staff.
A Yes.

Q Can I just deal with two other issues? One is hydration. If a patient is right at the end of their life and they are drifting in and out of consciousness, perhaps receiving medication by a syringe driver, but maybe not, is it your understanding that there may be good reasons not to give hydration to a patient?
A I believe that hydration would have been of little benefit at that point.

Q In fact, it can cause problems, can it not?
A Yes.

Q The last issue I ask about is this. You were asked about the entry that there might be in medical records by a doctor, "I am happy for nursing staff to verify death" or something of that nature. You have told us that you understood from that that the patient was very ill, very poorly, or that they may die soon.
A Yes.

Q I think the most important information that a nurse would get before they start the shift is at handover. Would that be right?
A Yes.

Q What has happened before may be irrelevant now; the patient's condition may have changed.
A Yes.

Q And you would expect at handover to be given information about how the patient has been doing over the last shift and is likely to do on the shift you are just about to nurse.
A Yes.

Code A: I am very grateful, Code A Thank you very much.

Re-examined by Code A

Q I only have one matter I want to ask you in re-examination. Going back to the 1991 matters, who was it who explained to you, as it were, that you had had this misunderstanding as a result of which your mind changed and you had a better understanding? Who were you dealing with?
A I cannot recall any one person explaining. I think it was more of a gradual thing, you know, as I gained knowledge.

Q Prior to working at Redclyffe, had you worked in palliative care before?
A Not in a nursing capacity.

Code A: Thank you.

THE CHAIRMAN: We are going to take another break now and resume at 12 o'clock, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. I have asked for the witness not to be called back immediately because what I am about to say really has nothing to do with that witness at all. It is a matter that I am raising at this point simply because we have come to the time when there is a growing sense amongst the members of the Panel absolutely, including myself, that we felt there is a need for us to make this point. We do so, if I may put it this way, with the greatest of respect to fine and senior advocates appearing before us. We do so because we feel that it would be helpful to the advocates to understand what is helpful to the Panel in going about our business.

We fully understand what the rules are concerning the manner in which cross-examinations are to be conducted and when leading questions are permissible and when they are not. So what I am going to say is placed before you as much as anything as an observation. Nobody has to take the slightest bit of notice of what I say, but it is simply this.

Where there are witnesses who are to be cross-examined and those witnesses are in the main, shall we say, not hostile to the cross-examiner, there is a great deal of value for the Panel if the cross-examiner gives that witness as great an opportunity as they might think sensible to answer with their own words. The difficulty with a large amount of leading is that at the end of the day one really hears a great deal from the cross-examiner and very little from the witness, other than to agree. In terms of the impact that that makes on the Panel, I am sure you can understand it is a lot less than it is if we hear the words of the witnesses themselves.

I put this forward at this stage not particularly as a result of the cross-examination of the last witness, but rather because this is a sense that has been growing amongst the Panel for some time now. We take, as I am sure you appreciate, very seriously the need for us to weigh each witness carefully and it is very difficult to do that when a large part of their testimony is really boiling down to agreeing or not agreeing with what is said. So if possible, we would like to hear far more of the individual witness's own words in cross-examination. As I say, it is a matter for all of you whether you go along with that or not. Code A ?

Code A : Sir, thank you for those observations. I make no comment about them. We have heard them, but of course the Panel will understand that with a large number of witnesses, the words being put to them are things they had already themselves said. For example, the last witness gave evidence at the inquest and we have heard that with other witnesses. So that is the case very often; I am not saying in every case, because obviously we have to put our case to a witness. If they agree with it, fine. If they do not, then they will say so.

With a large number of witnesses this is quoting back not counsel's words but what the witness himself or herself has already said. For example, I know that we are going to be getting to one of the consultants before too long, Code A and there is a mass of material where he has already said certain things. I can say now that if they are not elicited in examination-in-chief, I shall obviously be asking him what he said based on what he has already said.

THE CHAIRMAN: That is helpful, Code A. Of course the Panel has already appreciated the fact that a lot of the style of questioning that we have seen does result in the saving of a great deal of time, particularly where people have already said the same thing before, but the point that we really want to get across is that we have not heard that before. It is the lack of spontaneity which, frankly, reduces the impact of evidence that should be impacting on us more than it does in that format. If it means that things go a little bit slower so that, at least in the first instance, a witness is given the opportunity to put it their way, of course there is absolutely the opportunity to come back and say, "On another occasion did you not say such and such ..." This was designed to be helpful because we really do wish to be giving the maximum weight to the words that are spoken to us, and it is merely observation that it is difficult to do so when they come from the mouth of counsel rather than from the witness, even though it may very well originally have come from the witness. If the same question that had been put to the witness on the previous occasion could be put, it might well elicit the same answer, and that would be much fresher and have much greater impact on the Panel than if it came, in the first instance, from the mouth of counsel.

Code A Sir, thank you again for the observation. I simply say two things in response to that. The mere fact that a witness agrees with the way that it is put by counsel should not, with great respect, reduce the impact of the answer. It may be another illustration that it is 100 per cent correct. The other difficulty which we all have to bear in mind as advocates – and we appreciate the difficulties in eliciting evidence sometimes: with some witnesses it is very easy and sometimes it is very difficult – and one of the things which counsel tries to avoid in cross-examination, when one already knows what the witness has said in answer to a question, is asking an open question, getting a slightly different answer, and having to say, "Do you remember on 14 April you said this? Would that be correct?" That is partially what we are trying to avoid.

Sir, I will say no more because I am slowing things down even more as I speak. We will bear in mind what you have said. Thank you.

THE CHAIRMAN: That is very kind. Thank you.

Code A?

Code A: I have no observation to make, sir.

THE CHAIRMAN: Very well. Then we will have the witness back, please. (Pause)

Welcome back, Code A. I am sorry we kept you out for a little while. We were dealing with matters that had absolutely nothing to do with yourself and there was no point in asking you to sit there whilst we did so.

I remind you that you remain on oath. I think I am right in saying that we have now completed questions from the barristers – at least for now –and so we come to the stage where members of the Panel are able to ask questions of you if they have any.

I am going to turn first of all to Code A who is a lay member of the Panel.

A

Questioned by THE PANEL

Code A: Hello. I am really wanting to get an understanding of this aspect from a practical perspective and from the nursing perspective. We have heard a lot of evidence to date about the positive and negative effects of both Oramorph and diamorphine.

A Yes.

B

Q We have also looked at a lot of patients who have been very poorly and deteriorating. I need to understand just a little bit more how you, as a nurse, distinguish within that deterioration what is the contribution of the drugs and what is the failing health of the patient. How do you distinguish which is causing the deterioration? For instance, Oramorph can contribute to sickness and it can contribute to confusion.

A Yes.

C

Q We know that diamorphine can contribute to repression of the systems, et cetera. When you are looking at the deterioration of that patient ----

A Sometimes it can be difficult, but I think mostly it is experience.

Q I think I need a little bit more than that if you can help us.

A It is hard to put into words exactly. I think it would be looking at each individual

D patient, looking at their specific symptoms, looking at the whole picture, the drugs, the patient, their physical condition.

Q Because, you see, I look at some of the notes that we have had and it can tell me that the patient is restless, anxious, agitated, and that is an indication of deterioration.

A Yes.

E

Q And hence a decision to increase the medication.

A Yes.

Q This does not help me to understand how that is different from if it was the medication that was causing that agitation.

A I see.

F

Q I was just trying to get from the nursing perspective your sorting out of the difference.

A I think that is quite difficult. It really is experience, I think.

Q If you cannot help me any more ----

A I am sorry, I am not sure if I can put that into words.

Q I cannot see the safeguards in that, and so that is what I was trying to get out, how it

G might not lead to moving to increase the drugs.

A Yes, certainly, I understand.

Q And yet it might have been the drugs that was causing this to start off with. Saying it is experience does not feel like a big safeguard to me. But maybe you cannot help me.

A I cannot think of a way to explain it. I am sorry.

H

Code A: Okay. Thank you.

THE CHAIRMAN: I am going to turn now to Code A who is a lay member of the Panel.

Code A: Good afternoon. Just to go on from where my colleague has started, you said it is about experience.
A Yes.

Q About the individual patient.
A Yes.

Q Therefore it must be the amount of experience of the individual nurse.
A Yes.

Q You could be in a situation where perhaps a less experienced nurse than yourself is having to make a decision whether or not to increase or decrease the amount of drugs, because they are perhaps reading the signs and symptoms incorrectly.
A That could happen, but often, if that is the case, if I was in that position, I would probably try to find another more senior or experienced member of staff to discuss my concerns with.

Q With the greatest of respect, you are still nursing, I believe.
A Yes.

Q So you have a vast, wide range of experience.
A Yes.

Q And you are able to draw on that experience to say, "I'm not necessarily sure about this."
A Yes.

Q "I need to confer with someone." But 15 years ago, or whatever time it was, you were not as experienced.
A No.

Q Would all your colleagues have thought that in that same respect?
A I like to think so. I think a lot of them would have, yes.

Code A: Thank you very much.

THE CHAIRMAN: Code A is a medical member of the Panel.

Code A: Hello, Code A Just thinking about the drug Kardex, in general, on a drug Kardex there are two kinds of prescription. The first is a PRN prescription.
A Yes.

Q And if it is written up on a particular day, that date is there.
A Yes.

Q To say that it was written up today. How do you know, as a nurse in charge at night, when to give a drug that is written up PRN?
A Do you mean by the chart?

Q The chart is your instruction to give the drug PRN.
A Yes.

Q How do you decide when to give such a drug?
A If we felt the patient needed it by looking at the patient's physical condition.

Q You make a decision based upon the state of the patient.
A Yes.

Q The other kind of prescription is called a regular prescription.
A Yes.

Q Or it was on the drug charts at Gosport. It is written up today, with today's date, regular.
A Yes.

Q When would that drug be given?
A On that day.

Q If it is not given for three days, what can be the explanation for that?
A There could be several explanations. It could be that the patient was unable to take it, or the patient had refused it, or the drug was unavailable.

Q How would we know that?
A Hopefully it would be recorded somewhere.

Q Somewhere in the nursing notes or the medical notes.
A Yes, in the nursing notes.

Q Somebody would have explained why a prescribed drug has not been given.
A Yes.

Q Is that because a prescribed drug on regular prescriptions is an instruction to give?
A Yes.

Q Thank you. That is very helpful because there is just something that is bothering me about one prescription. In a completely different area, cast your mind back to those days in 1991 when you were still at Redclyffe and you and colleagues made what amounted to quite serious criticisms of drugs and the way they were used.
A Yes.

Q I think it is true to say that you stated that you thought that patients had come to harm, or at least one patient had come to harm because of that.
A Yes.

Q So your concerns were very serious.

A A They were at the time, yes.

Q In the first place, did you feel that your concerns were addressed fairly early on in the year?
A No.

Q Can you say how you felt? Do you remember how you felt after the first meeting?
B A Frustrated, I think.

Q Because?
A If I can remember correctly, I think management seemed to be of different beliefs from the rest of us. I am not sure if we were necessarily looking at things from the same angle. We felt frustrated.

C Q What was your angle?
A I wanted to make sure patients were being treated correctly. I wanted to make sure that I knew what I was doing.

Q What do you think their angle was?
A I think they were looking at ... That we were maybe even accusing people of things, that we were just looking and saying, "Well, patients are having too many drugs" without
D looking at the bigger picture.

Q You did not think they really listened very hard.
A No.

Q But it festered.
A Yes.
E

Q And then you made a second complaint.
A Yes.

Q Towards the end of the year. You were asked, "Do you think they took it more seriously the second time?"
A I think they did, yes.
F

Q Indeed, I have forgotten her name, but the matron asked you for specific evidence on particular patients.
A Yes.

Q To back up what you had been saying.
A Yes.
G

Q And nobody replied to that request.
A No.

Q Why do you think that was?
A I honestly cannot remember.

H

Q Was it because you did not have any specific information? I am sorry, that sounds like a criticism. I do not mean it to be a criticism.
A I can remember, at the meeting with Code A, that we were able to access controlled drugs books and to look at records and things, and at a later date when we tried, I do not think we were able to find necessarily what we needed to sort of back up our concerns.

Q Your first approaches were to "management".
A Yes.

Q Is that management or is it nurse management?
A Nurse management.

Q To the people you relate to.
A Yes.

Q Your second complaint was, similarly, to the same people.
A Yes.

Q Then doctors started to be involved in the process, did they not?
A Yes.

Q Was it as easy to make complaint in general? Was it easy to make complaint about things that were going on once there were doctors in the room?
A I think for some people no.

Q Why do you think that is?
A I think people were concerned for themselves, really – how long they would still be in a job, how things would affect them.

Q Why should that be, in 1991?
A I think that is just the air ... That is how it felt at the time. It felt too definite sides: them and us.

Q Sides?
A Yes.

Q But you are looking after the same people: patients.
A I know.

Q Does that mean there is a sense that a nurse would find it very difficult to criticise a doctor?
A Well, to criticise – full stop.

Q Would it not be fair to say that in a way you were criticising your own nurse management by going to them and complaining.
A Yes.

Q That was easier.
A Yes.

Q Why was it more difficult to complain about or to a doctor in 1991?
A I think we always felt doctors were superior and that was just how we felt.

Q Is a doctor's view of a problem more valuable than a nurse's view of a problem?
A Not necessarily.

Q Was there a perception that it might have been in 1999?
A Yes.

Q Would that amount to a fear that a nurse would not be believed but a doctor would?
A Yes, I think so. Yes.

Q Is that a generalisation of what would happen nearly 20 years ago?
A Yes, it would be.

Q In any kind of complaint?
A Well, I can only talk about the complaint I was concerned in. That is how I felt.

Code A: Thank you very much.

THE CHAIRMAN: Code A, it comes to me now. I am also a lay member of the Panel. Code A raised with you an issue about the potential for an error in ascribing observed deterioration in a patient to something other than the effect of the drug or drugs that the patient was taking. I think you said that the best way that you could describe the way in which patients were safeguarded against the risk of a mistake being made in that regard, was the experience of the nursing staff. I am not sure if you did mention also not just their wider experience in nursing but their experience of the patient himself or herself. If you did not, would you accept that experience of that individual patient ---
A Yes.

Q --- is important in that regard?
A Yes, I would.

Q It is right, is it not, that in many instances deterioration will be noted in a patient of whom the nurse has very little experience because they have only recently come onto the ward?
A That is true.

Q In those circumstances the danger and the risk would be much greater than a patient that the nurse had been nursing, perhaps for months?
A That is true.

Q Thank you for that. Following on slightly with a point that was raised by Code A the writing up of a prescription and when one would expect that prescription to have been administered: in your evidence today in respect of Patient I, it was pointed out to you that there was one time at which the prescription was written up for administration, but apparently a different time at which it was actually administered?
A Yes.

Q I think it is clear to all of us how the two can, for the best of reasons, be different. What would assist me, at any rate, is to know what sort of difference would be permissible from the point of view of a nurse signing before they would feel a need to put a note of explanation in? So, for example, if a particular dose is due at, say, 10 a.m. and it is not, for the best of reasons, administered until a later time – we have heard from you that if it were an hour or two hours, even later, it would still get the signature and the tick.
A Yes.

Q How much further would it have to be outside the time before you would expect yourself or a colleague to feel the need to put in a note to the effect, actually this was delivered at a different time?
A I think it would need to be quite a reasonable time outside of the prescribed time.

Q And what would that be, a "reasonable time"? Are we talking three hours, four, five, six?
A Probably less than that. Probably no more than about two hours, perhaps.

Q So up to and including two hours, you would not expect there to be a note, but thereafter you would?
A Yes.

Q And I can absolutely see that in terms of if it is administered late. Are there occasions when it can work the other way and it is administered earlier than the time expected? Say ten o'clock a.m. was the time that it is written up for; would it only ever be potentially late, or could it also potentially be actually administered early?
A Possibly only a few minutes early.

Q Right?
A But it is usually at the exact time, or as close to it.

Q Possibly a few minutes early and possible up to two hours late ---?
A Late.

Q --- after which one would expect, if it were later, that there would be a note indicating the same?
A Yes.

Q That is extremely helpful. Thank you very much indeed. That completes the questions from the Panel. I now am required to ask if there are any questions arising out of the Panel questions that the barristers wish to ask. Code A ?

Code A Just a few, if I may.

Further cross-examined by Code A

Q The patient's condition.
A Yes?

Q You can tell a great deal about a patient just by looking at their skin, can you not?
A Yes.

Q Can you expand that answer for me?
A You can see their colour; you can see whether they are hydrated; whether they are well oxygenated; their nutritional state.

Q What if the skin is breaking down?
A That would show that they were probably under-nourished, that they were generally in a poor condition.

Q If you are looking at a patient and you look at the limbs, arms and legs ---
A Yes.

Q --- can that tell you a great deal about the general health of the patient?
A They could become cyanosed.

Q Blue tinge?
A Blue tinge, yes.

Q Not enough oxygen getting to their ---?
A Not enough oxygen.

Q --- tissues. If you see patients whose limbs are wasted?
A Yes.

Q The word "cachectic" ---
A Yes.

Q --- is sometimes used of patients, I think ---
A Yes.

Q --- towards the ends of their lives if they have had a lengthy decline?
A Yes.

Q Again, if you see a patient who is rather wasted, or very wasted, is that going to tell an experienced nurse a great deal about their recent health, if they have not been eating properly for quite a while?
A Yes. That is how it would be.

Q You are not going to become severely depleted or wasted after being off your food for two days, are you?
A No.

Q Again, if you are nursing a patient it is easy to tell whether there is swelling, whether the patient has temperature?
A Yes.

Q You can see their breathing. You can see how laboured they may be?
A Yes.

Q Just sitting around or lining around?

A Yes.

Q Is it fair to say, you can tell a great deal about a patient's condition just by looking at them?
A That is true.

Q Is it right that with a patient who does not speak to you at all but whom you are nursing, moving in the bed, perhaps changing a dressing or changing something in the bedclothes, you are still able to tell a great deal about their level of agitation and draw inferences about whether they are in pain or not?
A Yes.

Q And would you be aware if a patient was unconscious and unrousable?
A I think so, yes.

Q And should we draw a distinction between a patient who is unconscious and unrousable, and one who is responding, who is clearly in some discomfort when you are nursing them?
A Yes.

Q Can I turn to a second topic. You were asked about 1991.
A Yes.

Q And you were asked about the circumstances in which you raised concerns?
A Yes.

Q What you had told me and told the Panel in your earlier answers was that at the time you were raising concerns, your knowledge was limited as to the use of syringe drivers and the circumstances in which it might be appropriate to use them?
A Yes, that is correct.

Q And you have made it clear that those shortcomings in your knowledge, because you had not been trained, were such that the doctors were giving you far more information?
A Yes.

Q Certainly Code A was?
A Yes.

Q In the last of the meetings that we have heard about?
A Yes, that is true.

Q And were you well aware when you raised your concerns that you needed to have more training? You needed to have more information?
A Yes, we were.

Q Is that part of the reason why you were raising concerns, but not challenging the doctors, because the doctors knew why the drugs were being prescribed?
A Yes.

Q The doctors knew why syringe drivers were being written up?

A Yes, that is probably true.

Q And was it absolutely plain, certainly from Code A, the geriatrician, the consultant, that that was the way he wanted the patients to be treated?
A Yes.

Q And Code A was treating patients in accordance with what Code A was saying was appropriate?
A Yes. That is true.

Q And is it fair to say that the senior nursing staff – sisters – who may have been at the meetings were agreeing with the approach that Code A was advocating?
A Yes.

Code A: I ask this last question, sir, with some trepidation because it does not strictly arise from any questions the Panel have asked. I was going to ask the witness why she says Code A is a good doctor – if that is a fair one to ask.

THE CHAIRMAN: It certainly was a fair one to ask at the appropriate time, but I do not suppose Code A is going to take particular objection to it. He is indicating not, so if you feel a burning desire to ask it, please do so.

Code A: I do feel a burning desire to ask it in the light of observations that have been made. (To the witness) You thought Code A conscientious?
A Yes, I do.

Q That was my word, and you agreed with me?
A Yes. That is true.

Q I put it to you that Code A wanted the best for her patients?
A Yes, she did.

Q And you agreed?
A I did, yes.

Q I want you to tell us why you thought that?
A She was always helpful. My experience from seeing Code A at work, she always appeared to do the best for her patients, whatever that might be. She strived to give them the best care.

Code A: I am grateful. Thank you very much.

THE CHAIRMAN: Code A

Further re-examined by Code A

Q You have just been asked about Code A
A Yes.

Q And Code A was here consultant on Redclyffe?

A He would have been based at QA.

Q He was at QA, was he?
A Yes.

Q At the time when Code A was on Redclyffe?
A Yes.

B

Q What was Code A approach to diamorphine? To the use of diamorphine?
A I honestly cannot remember.

Q You were asked by Code A, and also by the Chairman, about being able to tell the state of the patient requires, first of all, a good knowledge of nursing?
A Yes.

C

Q And good experience, but also good knowledge of the patient?
A Yes.

Q And a good knowledge of the patient, is that something that is built up over a period of time?
A Usually, yes.

D

Q When a patient first comes into your hospital, sometimes they are in a slightly bewildered state, as it were, to be in a new environment?
A That is true, they could be.

Q And so to get to grips with that patient's needs, and how they responded in different ways, would it take perhaps a little while to get to know that patient after they had
E transferred?
A Yes, it would.

Q But you were asked by Code A, and you agree with him, that you could tell a great deal from just looking at the patient?
A Yes, that is true.

F

Q And you used the example of looking at the patient's skin?
A Yes.

Q And you spoke specifically about oxygen and cyanosis?
A Yes.

Q And also breathing becoming laboured?
G A Yes.

Q Were you saying that those are indications for patients' deterioration?
A Yes.

Q And do you remember, you were asked by Code A on the Panel, who was asking you about how you distinguish between what is the drugs, what is being caused by the drugs,
H and what is being caused by the illness?

A A Yes.

Q Just looking at the question of the skin and cyanosis and laboured breathing, can that be a symptom of either the use of opiates or illness?
A I would think illness.

Q You think illness?
B A Yes.

Q Why? You do not think morphine has an effect on laboured breathing?
A It does. It does.

Q So why would you put, for instance, cyanosis or laboured breathing, down to illness rather than diamorphine?
C A I do not know.

Q You do not know? And you also spoke about hydration?
A Yes.

Q And a lack of hydration ---
A Yes.
D

Q --- might be an indication of the patient worsening?
A Yes.

Q Getting iller? Is that what you meant?
A Yes.

E Q Would that be written down in the notes as "patient deteriorating"?
A Probably, yes.

Q If you are not hydrating the patient because they are on a syringe driver, again how do you distinguish between the lack of hydration because there are on a syringe driver and the patient is just getting iller?
A It would be difficult.
F

Q It would be difficult what – to distinguish?
A I think so, yes.

Q Just one last thing. You mentioned, and I may have misheard you, but I just want to make sure that we have asked you everything that we should. You were being asked by Code A Code A about the 1991 complaint and you said that you thought that they took it more
G seriously the second time, so the back end of the year?
A Yes.

Q But at one stage I thought I heard you say that you were not able to find the records to back up your concerns. Did you say that?
A I did say that, yes.

H Q What were you talking about?

A I can remember at some point during my concerns with colleagues looking for controlled drug books and looking for back-up records, and being unable to find them. I cannot recall exactly when but I can recall that happening.

Q During this period?
A Yes.

B Q It may be that somebody else was looking at them as a result of concerns?
A Could well have been.

Q You do not know why they were not there.?
A No.

Q You have also been asked by Code A about the relationship between nurses and
C doctors and how easy it was for people to make a complaint. Did you at any stage feel that you, or any of your colleagues, were actually being regarded as trouble makers, or anything like that?
A Yes, I think I do.

Q Why did you think that?
A I suppose the attitude of our ward manager towards us.
D

Q Was that during the first part of the complaining process, or the second part ---
A Both.

Q --- or throughout? Sorry?
A Throughout, but mostly the first part.

E Code A That is very helpful. Thank you.

THE CHAIRMAN: Thank you very much, Code A that brings you to the end of your testimony. We are extremely grateful to you for coming to assist us today. It is only through the presence of witnesses such as yourself that a Panel is able to build up a clearer picture of what happened, very often months, even years in the past. We cannot do it without people like yourself coming, and I want you to know that we are extremely grateful
F to you for coming to assist us today. You are now free to leave. Thank you very much.

THE WITNESS: Thank you.

(The witness withdrew)

G THE CHAIRMAN: Code A unless there are any short matters that we can usefully deal with now, I propose that we take an early lunch, and start fully at quarter to two.

Code A Yes, certainly. The next witness is Code A I do not think she will be all afternoon.

THE CHAIRMAN: Thank you very much indeed. Quarter to two then, please, ladies and gentlemen.
H

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. I think the witness is being called for, Code A

Code A Affirmed

(Following introductions by the Chairman)

Examined by Code A

Q Is it Code A?
A Correct.

Q Are you still employed by the Hampshire Partnership Trust?
A Correct, yes.

Q Could you tell us your position there, please? Are you still a consultant in old age?
A I am a consultant in old age psychiatry.

Q Which hospital are you attached to now?
A I am based at Moorgreen Hospital in Southampton.

Q I think obviously you went through your general training and then you began specialising in psychiatry in the mid 1980s.
A Yes. I did my basic medical training, then general practice training, then psychiatry training.

Q I think from 1992 until 2002, were you working as a consultant in old age psychiatry in the Gosport catchment area.
A Correct.

Q Between 1992 and 1995, you were based at Knowle Hospital.
A Yes.

Q Then I think did you move to Mulberry ward at the GWMH?
A Correct.

Q Just tell us a bit about Mulberry Ward. It is within the main hospital, but it is on the first floor.
A It has moved at the moment, but it was on the first floor and Mulberry ward was divided into an organic assessment unit – so that is primarily for people who have dementia – and into a functional unit, which was Mulberry A.

Q When did the move come about? When did you move to the Mulberry?
A We moved in 1995, sort of June/July. Somewhere around that sort of time.

Q Apart from working on Mulberry ward, did you also do some work at the Phoenix Day Unit?

A A The Phoenix Day Hospital was a day therapy unit for people with mental health problems over 65.

Q Was that down on the ground floor?
A That was on the ground floor.

Q In fact, it is next to Dryad, I think, but there is a sealed door, as it were, between the
B two.
A That is correct, yes.

Q We have also heard about the Dolphin Day Hospital.
A Correct.

Q Did you have much dealings with the people in that hospital?
C A From time to time I would go to Dolphin Day Hospital and would meet up with Code A, with whom we sometimes shared the care of patients, and we would see them jointly together.

Q Was that as an outpatient?
A That would be as an outpatient, yes.

D Q So far as Mulberry ward is concerned, how often would you actually attend Mulberry ward and do a session?
A I would do a session once a week, which would generally be for two or three hours, which was a ward round, and on Friday afternoon I may or may not go to the ward, particularly if there were patients of concern, and just check that there were not any issues that the junior doctors or the nursing staff had any concerns about.

E Q So when you were not at Mulberry ward, where were you?
A I had an office in the Gosport War Memorial. I still at that point I think had patients up at Knowle on the continuing care ward and I did a lot of community work and clinic work outside of Gosport War Memorial.

Q So it is not that you were attached to a different hospital?
A No.
F

Q This was your base.
A That was my base, yes.

Q I want to ask you about two patients that we have been dealing with in this case. I appreciate you have re-read your statements I think.
A Correct. I have, yes.
G

Q I do not know if you have re-read the notes, but do you have some recollection of these patients?
A I have some recollection of Code A I have, I am afraid, a very vague recollection of Code A

Q I am just going to ask you to give us a brief resumé, as it were, with reference to the
H notes, which I hope will assist you. If you look to your left, I hope you will see a file marked

A Patient A. If you take that file and turn first to page 37. Can I explain that I am not going to ask you to read through the whole of the very extensive notes that I think you made, which will be a relief to you, me and the Panel, but I am just going to ask you to give us a thumbnail sketch. Is it fair to say that you had been looking after Code A I think since 1992?
A Correct.

Q He had suffered for a very long time from something you describe in your statement
B as a chronic resistive depression.
A Correct.

Q A chronic resistive depression is what?
A It is a chronic depressive disorder which responds poorly to treatment and, as a consequence, he was very debilitated by his chronic depressive illness, such that he lacked motivation and drive; his mood was persistently low and he really did very little.

C

Q Can you help us, with a patient like this, with that sort of depression, is that anything to do with organic changes in the brain, or is it something quite different?
A It can be, but for Code A, I do not think – my recollection is that that was not the case. He had been chronically depressed for some years. Depression is a common illness, but at the severe end, for someone like Code A, there is a significant risk of having a chronic depressive illness that does not respond to treatment and I believe that he fell into that
D category. But you are correct in saying that there is a sense that cerebrovascular disease can prevent someone with a depressive illness from getting better.

Q If it is organic, presumably it is progressive as well?
A Correct.

Q In relation to this note that we see at page 37, is this your note?
E A No. That is Code A note. She would have done the admission clerking.

Q We can see a quarter of the way down the page, "[diagnosis] chronic resistant depression". Then we can see something about his history, "Feeling very low, inwardly tearful".
A I think it means "increasingly tearful".

F Q Again, just skipping forward, if we go to page 48, we see in September 1995, "Informal admission by Code A."
A That means arranged by me or facilitated by me.

Q "Chronically depressed gentleman." At the bottom of the page, under "Past Presenting History", we see, "Chronic depression since ?" and is it SOS?
A I think it is "50s".

G

Q I have consistently misread that. " ... 50s when attempted suicide ..."
A Yes.

Q Then over the page, we can see a list of the drugs that he was on.
A Correct.

H Q We can see diazepam. I am looking for any analgesics.

A A He is not on any on that list.

Q The diazepam, will that have a sedative effect though?
A It could be quite sedative, yes.

Q Could I ask you to go, please, to page 54 onwards, which I think deals with his inpatient treatment during this period.
B A Yes.

Q Was he under your care in September 1995?
A Yes, he was.

Q It may be obvious from what you have said, but what were you trying to treat him for?
A Trying to improve his mood.
C
Q If we go to page 55, for instance, we can see on 18 October 1995:

"Ward round, Code A
Eating well
Seems better + brighter – wife has
noticed the improvement
D Receiving visitors."

Then, "[Therefore] no ECT". Is that electro convulsive therapy>?
A Correct.

Q Which is sometimes used still I think for depression.
A Yes, it is still used.
E
Q We will find a letter at page 57. This is written by Code A, who was your registrar.
A Correct. Well, SHO.

Q She describes herself as your registrar.
A In that case, she may be a registrar. The titles of junior doctors change over the years.
F Her role was as a junior doctor, so do not let us get pedantic.

Q Again, we can see that it reflects that the patient was admitted on 14 September.
A Correct.

Q And discharged on 24 October. Where was he? Which hospital does that mean he was at?
G A The admission was to Mulberry Ward at Gosport War Memorial.

Q We can see, just reading the first few lines:

"This 71 year old gentleman was admitted informally by Code A complaining of an exacerbation of his chronically depressed mood."

H A Yes.

Q Over the page, we see under his mental state examination that he had been very flat and his concentration was very poor. He said if the opportunity to die came along, he would be glad to accept it. Then again over the page, just skipping quickly through, on page 49, under "Treatment and Prognosis", the last four lines:

> "Code A mood did in fact improve quite a bit during admission and he seemed to have more energy and to become more sociable with both patients and visitors. Therefore he was discharged back to his rest home and will be followed up as a day patient attending the ward on Thursdays."

His rest home, I think was that the Hazeldene Rest Home?
A That is correct, yes.

Q This was a patient who certainly on occasion was capable of getting a bit better.
A Yes, and sometimes a change of environment for someone like Code A was enough to enable that to happen.

Q Sadly, if we can move on to page 63 – this is effectively a month and a half after his discharge – he is back in for an informal admission. Again, an informal admission to where?
A To Mulberry ward.

Q We can see the presenting complaint, "Everything's horrible". Then the following words are:

> "From [Rest Home]
> verbally aggressive to wife + staff
> staying in bed all day
> not mobilising
> constipated
> not eating well
> sleep 'alright'
> No DVM"

What is DVM?
A Diurnal variation in mood.

Q Meaning?
A Diurnal variation in mood is one of the symptoms that you can get with depression, where you feel pretty dreadful in the morning, but by the end of the day your mood has improved and day in, day out, it would present like that. But he did not have that.

Q Then:

> "Feels bad all the time.
> Hopeless + suicidal"

A Correct.

Q Moving on quickly, can we take, please to page 126. This is on 13 December 1995 and there is a reference here to past psychiatric or medical history, Parkinson's disease. Is that a diagnosis that you made?
A No. I cannot recollect that, to be honest, at all.

Q Then we can see:

"REASON FOR ADMISSION TO HOSPITAL The rest home cannot cope with him, he has put himself to bed and refuses to get up. He has become both physically and verbally aggressive towards staff at the rest home. Lack of energy and self motivation."

I think he then remained in hospital for quite some time over the Christmas period.
A Correct.

Q Can I take you, please, to page 68, which deals with his moving on from your care. That date at page 68 I think is 4 January 1996.
A It is 4 January 1996.

Q Is this your note?
A No, that is Code A note.

Q I am sorry, it is, indeed, Code A note. It is entitled "ELDERLY MEDICINE" and says, "Thank you [something] ..."
A It says: "Thank you. Frail 82 year old man."

Q "Frail 82 year old man with:

(1) chronic resistant depression – very withdrawn completely dependent – Barthel 0.
(2) Catheter – by-passing
(3) Ulceration (superficial) of left buttock and hip."

Then is it:

(4) hypoproteinaemic."
A Correct.

Q Meaning, what?
A That means that the albumen and the protein in his blood were low – almost certainly related to poor dietary intake.

Q Can we look at what is suggested below. I appreciate this is not your note but this is, I think, while he is still at your hospital.
A Yes. It was some suggestions as to how we might help Code A who was very unwell at that time.

Q Was Code A a geriatrician consultant?
A Code A was a consultant geriatrician.

Q He suggests high protein drips, bladder wash-outs times two per week.
A That says "[something] tulle to buttock ulcers" and I guess that is a specific dressing that the nurses would know about.

Q Then:

"I'd be happy to take him over to a long-stay bed at GWMH. I feel his rest home place can now be given up as he's unlikely to return there."
A Correct.

Q We know, I think, that he transferred to Dryad on 25 January 1996.
A Correct.

Q Can you just deal with this position when he left your hospital?
A Left Mulberry, do you mean?

Q I beg your pardon. You are quite right, left Mulberry Ward.
A When Code A left the ward and went to the long-stay ward, to Dryad, his physical health had become the major concern, and although his mental health was definitely an issue, his physical health had deteriorated significantly. The priority at that time was to address his physical health problems rather than his mental health problems.

Q His physical health problems, as described in that note, were his ulceration.
A His ulceration.

Q He had had a chest infection since his admission to Mulberry Ward which he had had physio for, two courses of antibiotics. It has added to his physical frailty overall and he was really very frail. By that, I mean generally frail and very poorly. He as not getting out of bed. He was entirely dependent on nursing staff, so despite the best efforts of the nurses, et cetera, we really had not made any headway with him at all.

Q The suggestion of high protein drinks, bladder wash-outs, et cetera, the purpose of them would be?
A He had been catheterised, my recollection is, not long before that, because he had gone into retention one night – I think between Christmas and New Year, maybe longer, but it was during his admission – and what was happening was that the urine was by-passing the catheter and coming down the urethra, out of his penis, outside the catheter rather than in the catheter. I am not a physician but I would imagine that is because the catheter was blocked, therefore the washouts were to try to improve the flow of the catheter functioning.

Q And the high protein drinks?
A To try to help with his poor dietary intake and increase his albumen and protein and his general health.

Q Once he had transferred to Dryad, did you have further dealings with him?
A I did not have further dealings with him.

Q You deal with this on the last page of you statement from my learned friend. Did you have patients dying on Mulberry Ward?

A Yes, would did have patients who dies on Mulberry Ward, more likely to be on the organic unit rather than on the functional unit.

Q If there are concerns that someone's physical health is so poor that there is a possibility of them dying, do you have a process you go through?
A We asked Code A who was our patch geriatrician, to come and assess them and help to make a decision what was the best treatment and intervention for that person.

Q So that would not be your decision. Would that be a joint decision with Code A
A It would be a decision of Code A If she discussed it with me, then it would be clearly a joint decision – there was jointness to it, I guess. It was not always formally a joint decision.

Q Could we put that file away and turn to the file of Code A, file G. At page 112, first of all, please, there is a letter from Code A dealing with the patient's admission to Mulberry Ward. He was admitted on 21 July as an informal admission.
A Correct.

Q Of 1998. Do you have any recollection of this patient now?
A I am very sorry but I do not have an enormous recollection of him. I have some recollection and the recollection is more about a series – I suppose of a process – rather than remembering Code A himself.

Q Let us see if this triggers any memory. If you go to page 465, I think you will see a discharge summary. You are shown, I think, as the named consultant.
A Correct.

Q Admission date 21 July 1998.
A Yes.

Q From Alverstoke House. Was that a -----
A Alverstoke House was a nursing home in Gosport.

Q "Reasons for admission:

Code A had been attending the Phoenix Day Hospital since June 1998 and was well known to Code A. She had reviewed at Alverstoke House prior to admission where he was presenting with low mood, especially in the evenings and with disturbed nights sleep. He expressed feelings of worthlessness and hopelessness regarding his future but denied any suicidal thoughts. He was commenced on Sertraline 50mgs mane but his mood decreased."

Sertraline does what?
A Sertraline is an antidepressant.

Q The note continues:

"Alverstoke House found him difficult to manage. He was therefore transferred to Mulberry Ward A ward for assessment."

A Mulberry Ward A. Mulberry Ward was split into A and B. A being the functional unit.

Q Underneath, we see "Diagnosis:

"(1) Parkinson's disease + dementia.

(2) Depressive episode

(3) Mylodysplasia."

A Mylodysplasia is a function of blood and bone marrow, where you have poor production of some blood cells. I believe that was – I would have to look – platelets and white cells.

Q "PROGRESS AND TREATMENT

PSYCHOLOGICAL – he was low in mood and irritable on admission he was very distressed by his lack of mobility and independence as his Parkinson's disease worsened. He was reviewed by Code A ... for his Parkinson's medication. His sertraline was stopped and he was commenced on mirtazapine."

A Mirtazapine is another antidepressant.

Q Then:

"His behaviour at times was very difficult and he was often rude to the nurses. He was very demanding of the nurses' time and preoccupied with his medication regime. Carbamazepine was introduced."

Physical – he had regular reviews by Code A for his Parkinson's."

Parkinson's was not something that you would be directly dealing with.

A No, generally not.

Q Do you recall this admission to Mulberry Ward?

A I recall some of it. It is just that it is not as clear as Code A, who I had known very well.

Q Just dealing with this admission to Mulberry Ward, if we go to page 72, I think we will find a note of yours. Again, I am not going to spend very long on this. Do we see an entry for 24 July.

A Yes.

Q Is that you?

A That is me writing, yes.

Q You can hopefully read it to us.

A I can. It says:

A

"Seen on ward. Depressed. Tearful. Talks about wife and alienation from step children. Irritable. Difficulties with placement. Start mirtazepine 30 mgs at night."

The asterisk is to say:

"Check full blood count next week and weekly."

B Given his mylodysplasia, I felt it was important that we kept an eye on that.

Q If we leaf through the following pages, again I am not going to alight on any of them for very long, the following page records an incident on 25 July at 2300 hours:

"Had got himself out of his chair and crawled on all fours to his bedroom, did not want to sit in a chair, would not use frame to walk or attempt to weight bear."

C

Was he quite a difficult patient?
A He was not an easy man, I think, for the nurses to manage.

Q At the bottom of the page:

"Code A managed to attend to this own personal hygiene. He became quite rude and abusive to a member of staff early am. Spoken to Code A about his rudeness did apologies to member of staff ..."

D

At this stage were his mental faculties there, as it were, or impaired? How would you put it?
A I cannot comment on whether his faculties in terms of his memory and that level of functioning and self-awareness were totally there. I really cannot comment. I would say that clearly he had periods where he was frustrated and his behaviour was difficult, but behaviour and having your faculties do not always match.

E

Q We can all be rude.
A We can all be rude, but I cannot tell you whether this man was just always rude or his behaviour was part and parcel of his psychological make-up, his mental state, him being depressed. He had Parkinson's, which he found difficult because it made him dependent on other people. With Parkinson's you do get fluctuating physical states because of medication. Having seen the notes and from my personal recollection of this man, it would be difficult to say it was either one or the other and more likely to be a combination of his person and his illnesses.

F

Q Can we skip on, please, to page 88. I am obviously dealing on only with very short aspects of this statement. We see a note that may be by Code A on 19 August 1998: "Discussed with Code A ..."
A Yes.

G

Q I think this revolved around the problem that Code A was agitated and unsettled at night.
A Yes. Also, there is a comment about having hallucinations and being paranoid as well, and risperidone is an antipsychotic medication and would be used for the treatment of hallucinations and paranoid delusions.

H

A Q Finally in relation to this submission, could we go to page 93. Does your writing appear on this page?
A No.

Q This is asking you to help us with the history of this patient. Right at the end, we can see that he was due for discharge to the Thalassa Nursing Home. He was quite anxious and fluids were encouraged. Urinary output good. If he was fit enough to discharge to the
B Thalassa Nursing Home, does that tell us anything about his state of health?
A It would suggest that the challenges for the nursing homes had been his behaviour, which could well have been part and parcel of his low mood, and that behaviour must have been settled enough for him to move back into a nursing home environment.

Q I should have taken you to this earlier, but right at the beginning of his admission, I think you had written a note?
C A Yes.

Q It is page 116.
A Yes. I have to confess, I am somewhat embarrassed by this note because I did not read it, and it was dictated and signed without me seeing it, and it is not the sort of language I would normally use.

D Q I was going to ask you.
A Because that is not what I would normally send out.

Q Very well.
A Clearly, given the tone of the letter, things had not been easy.

Q No. But that, of course, was prior to his admission?
E A That was prior to the admission.

Q And when you refer – and I am sorry if it slightly embarrasses you ---
A That is all right.

Q --- but when you refer to a patient as being "a bit of a saga"?
A Yes. I think it was the whole... My recollection was that Code A had
F somehow managed to come from one nursing home, probably another nursing home, and he was not settling. I think he had actually turned up just with the social worker hoping, I think I am correct in saying, that the situation would be resolved. I believe that is what led to his admission.

Q Then he gets through with the admission?
A Uh-huh.
G
Q Which we have looked at?
A Yes.

Q He is released back, as it were, to the Thalassa. Could we go to page 100, this was cc'd to you.
A From Code A
H

A Q The psychiatric nurse?
A Correct.

Q

"Code A has settled well into Thalassa Nursing Home. There have been no real management or behavioural problems. He can be awkward at times but mostly he is pleasant and compliant. His mood seems good. I plan to review him in one
B month."

We know that in fact, I think three days later he was actually transferred to Dryad. The reason for that we find at page 458. That is that unfortunately he developed a large necrotic sacral ulcer. This was cc'd to you again, as we can see at the bottom.
A Yes.

C Q We can see from the third line:

"His Parkinson's disease doesn't seem any worse and mentally he was less depressed but continues to be very frail."

He was really being admitted for treatment for his sacral ulcer.
A Correct.
D

Q Can we take it that you had no further dealing with him?
A I had no further dealing with Code A

Code A Thank you very much. Will you wait there, please.

Cross-examined by Code A
E

Q I am going to ask you questions on behalf of Code A Can I just ask about Parkinson's disease and whether it is a disease that can itself lead to death?
A Yes.

Q If a patient were to die – a patient who had Parkinson's disease – what would be the mode of death? Would they be bed-bound?
F A Certainly bed-bound, yes. With Parkinson's disease it is a fairly prolonged chronic disease, very debilitating, gradually deteriorating and, in general, people become entirely bed-bound and entirely dependent for activities of daily living on nurses and other carers who may be looking after them. There may be difficulty with eating and drinking because of problems with swallowing and may spend many months or years in bed prior to this happening.

G Q If someone did develop bedsores, as we know Code A did in the nursing home before he was sent into hospital at the War Memorial, are there likely to be difficulties in dealing with the pressure sores because of inadequate nutrition because of the Parkinson's, or might there be such problems?
A I would imagine there are going to be enormous problems treating bedsores. They are very difficult to treat. It is a very lengthy process and, in addition, if you have someone who could be bed-bound then, as a matter of turning them, keeping them off the sacral area, I have
H

A to confess I am no expert in managing bedsores, but it would strike me that that is a very difficult... Sorry. Can you just repeat the question. I have got lost on my....

Q I was just asking about inadequate nutrition.
A Sorry.

Q Problems because of the Parkinson's, whether that was likely or whether it could lead
B to problems in dealing with the bedsores?
A The Parkinson's, purely by the consequences of physical immobility, the stiffness, difficulty moving someone, is going to make it difficult, and someone would need regular turning and it would take a very long time – months if not years – to treat that sort of level of bedsore. In terms of maintaining nutrition, that is going to be very difficult because someone would have difficulties in swallowing and taking adequate nutrition and may lose weight. That would not be uncommon for someone to lose weight with Parkinson's.

C
Q We have seen through the correspondence that you have been referred to that Code A
Code A had lost quite a lot of weight?
A Correct.

Q In the correspondence we have seen the consultant was remarking on that?
A Uh-huh.

D
Q Yes?
A Sorry. Yes.

Q Can I ask you about a creatinine figure?
A Yes.

E Q You shudder! If you prefer me not to, I will not.
A Try me out!

Q You have been referred to page 465.
A Yes.

Q The creatinine is over 301.
F
Q Yes.
A And his urea of 28.

Q Tell us what creatinine is?
A Oh, goodness me! Creatinine is a chemical in the bloodstream that reflects renal function.
G
Q Right. If creatinine is significantly elevated?
A That suggests poor renal function.

Q I understand. Renal – relating to the kidneys?
A Sorry. Kidney function. Thank you.

H

Q I am not going to ask you what a normal range would be for a male or a female unless you know?
A No, but it is less than that. Just over 100 or something along that.

Q Yes, that is very significantly elevated, 301?
A Yes.

Q And is an indicator of poor renal function?
A Correct.

Q Put the notes away now. I am not going to ask you any more questions about that. I am going to ask you about your knowledge of Code A
A Okay.

Q What the Panel know, I think, is that she took up a clinical assistant's job at the Gosport War Memorial Hospital in about 1988. Did you know her before that time?
A 1988? Sorry, I am just trying to think and place myself in time. Our paths may have crossed but I cannot think that I actually knew her before 1988.

Q I think it is right that you will have shared patients?
A Yes, we will have shared patients.

Q At the War Memorial Hospital?
A At the War Memorial Hospital.

Q And would you have had discussions or contacts with Code A about patients who were treated at the War Memorial Hospital?
A Yes.

Q When you were both working there?
A Correct. We would have done.

Q And have you also, as a consultant, dealt with patients of Code A for whom she was the general practitioner?
A Correct. I would have done that as well.

Q And in that role would you have seen referrals by Code A
A Yes, I would.

Q And possibly have had discussions over the telephone or face to face about patients?
A I think fairly regular discussions with Code A I did a clinic in her surgery and regularly met Code A and other GPs of that practice every month.

Q Although you cannot give us the year when you first came across her, have you had sufficient time to form a view of her skills and abilities as a doctor?
A Yes.

Q Tell us what you think of her?
A My opinion is that Code A has always been a really very accomplished doctor. She has in terms of managing her patients always for my service made very timely referrals, very

A appropriate referrals. She has asked pertinent questions about intervention and care. Like any consultant/GP interface there was always discussion about what would be an appropriate course of action. I know that I have had discussions with Code A on occasion when we did not always see eye to eye, but she has changed her views, changed her opinion, and we worked on together with patients, but in a very positive fashion. Certainly, within her practice she was the most psychologically minded and able of the GPs.

B Q Tell us what you mean by "psychologically minded"?
A Able to see that people had a psychological component to illness, and understood people as individuals rather than, I suppose, just bodies to do something to. She was very aware of people as individuals. She was quick to pick up on depression and was generally timely with interventions. In terms of our interface at Gosport War Memorial we shared many patients, even before the move to Dryad on Redclyffe Ward, which then became my continuing care unit. The referrals made by Code A to myself on Dryad or Redclyffe ward C – I cannot think of an inappropriate referral. Obviously it is difficult to search the total memory bank, but I cannot recall anything that was not appropriate for my assessment or my intervention, or for my team's intervention. We worked very hard on some really challenging cases. She was very pro-active at getting people home and certainly Code A was very supportive of those management plans on Dryad ward. I think we achieved very many successful discharges home, or to residential or nursing home care.

D Q Perhaps it is time for a question.
A Sorry. Yes. Does that ---

Q It is all right. What would you say about her level of commitment towards patient care?
A She was phenomenally committed. She was always in there first thing, even before me, so she was in there first thing and I knew that I could catch her first thing in the morning E when I arrived. If there were problems, all the nurses had to do was to call her, and I knew that she would turn up. So if I had a problem with somebody, or we had agreed to meet she would come in. She was very committed to providing the care on Dryad ward.

Code A: Thank you very much.

THE CHAIRMAN: It means we have come to the stage when members of the Panel may F have questions of you. I will look to see if any do. Yes. Code A is a medical member of the Panel.

Questioned by THE PANEL

Code A: I am a physician. Can we go back to creatinine.
A Ah!
G
Q Your reaction was...
A Yes, go on. It still is.

Q It is not a viva.
A No.

H Q Just a flavour, if you would.

A A Okay, fine.

Q Because Code A did bring it up.
A Yes.

Q A level of 301 is raised?
A It is raised. He also has a raised urea, has he not, of 28.

B

Q Can you think of any reasons why a creatinine may be higher than it normally is in a patient?
A He could be dehydrated.

Q Any other reasons?
A Some renal impairment. Probably medications.

C

Q Could infection cause it to be high?
A Okay. Infection – I am sure you are right.

Q So a creatinine of 301 may be a temporary thing. It may get better than that.
A Okay.

D Q Would you agree with that? In some cases, a raised creatinine may go down with some treatment of some conditions?
A Correct.

Q And, secondly, is a level of creatinine of 300 something that you would equate with near death?
A No.

E

Q No? Anywhere near death?
A Do you know, I just do not quite know actually so I would prefer to say I would not be one hundred per cent certain.

Q I only ask these questions because the rest of the Panel are lay.
A No, sure. That is very reasonable.

F

Q That is very helpful. In a similar vein this gentleman had pretty bad bedsores, sacral sores?
A Correct.

Q From immobility from Parkinson's disease. A month before that he had not been as ill. You had felt he was well enough to go back to a rest home, a nursing home. Again, with
G Parkinson's and immobility, the fact that you develop bedsores: what in your opinion would that equate to? Is that a situation which may be easily remediable in some people?
A I am sorry. The thoughts that go through my mind are that he is spending a lot of time in bed, and either not moving or not being moved.

Q But may the situation improve under certain circumstances?
A Improved nursing care could improve it.

H

Q And ---
A I am sorry. I am not quite....

Q Okay. We will leave it there because that is sufficient for the question I am asking. With Parkinson's, may immobility sometimes improve as well?
A Yes.

Q Sorry – mobility improve.
A Mobility can improve.

Q In general terms, then, faced with a patient with a known background like this man, who develops a sacral sore and immobility and a raised creatinine – I am sorry, it does sound like a viva and I do not mean it to be.
A It is like a viva.

Q I am very sorry. Speaking as a physician – you speaking as a physician – what would be the general principles of management of his physical problems if you are faced with a man on your doorstep like that?
A Let us make an assessment to start with, if there is any underlying cause for this, or deterioration. Then it is about management of his Parkinson's, his bedsore and his mobility.

Q So it is "make an assessment"?
A Yes.

Q Get to know the patient?
A Yes.

Q Their problems, and see if there is a way through?
A Correct.

Q Having said all that, is it reasonable to sum up that you would not – let me put the word "necessarily" in if you like – you would not necessarily think that this was an end of life situation?
A It is bedsores, Parkinson's and poor mobility and a creatinine of 301 paint part of a picture, do they not? Part of the assessment is to get the whole picture. I do not know what the rest of the whole picture is or was. I know his mood is good.

Q Let me crystallise it into this then. In such a situation there is potentially for improvement?
A Uh-huh.

Q Yes?
A Yes. Sorry, sorry. Yes.

Q But there is also potential for no improvement or, indeed, deterioration?
A Correct.

Code A It is something you need to assess. Thank you very much.

THE CHAIRMAN: Doctor, I am not a medical member, as will probably become apparent. We have heard a great deal about getting the whole picture and, of course, a lot of that has to do with when you take that picture.
A Yes.

Q We have heard a great deal about deterioration. We have heard a great deal about the effects that different medications can have on physical and mental status, and their ability to sometimes mask what one might call a true picture.
A Uh-hum.

Q Indeed, you have told us today about the effect of medication that can be had with a patient suffering from Parkinson's. You indicated there was a fluctuation in their physical status.
A Yes.

Q We have also heard a great deal of evidence from others about the effect that a transfer can have on a patient, both physically and mentally, and not necessarily a transfer between hospitals; even a transfer between wards.
A Yes.

Q In the whole business of assessing the true picture, can you give us any assistance in broad terms, appreciating that every patient is an individual, of what one should be looking at in terms of the passage of time between the moment of arrival after transfer, before you can be making the sort of assessment that is going to have an impact on your decisions in terms of the long-term for the patient?
A Okay. As you rightly say, each person is very individual and not specifically talking about the two patients we are talking about today, I suppose assessment can be very short. If someone comes in, you may have known them from the past, you have known them from the day hospital, and it is very clear that they have deteriorated significantly and that assessment takes place very quickly. It may be that the underlying reasons for the deterioration are crystal clear and you can make decisions there and then. Generally it takes a bit longer than that and it may be several days. For some people, if I think about [Code A] who was transferred from a residential home, for it to be crystal clear to us what was happening took a week to be clear whether he was going to get better and improve or not, for example. For some people, it takes longer than that. It is dependent on the rest home, the nursing home, the information you receive from them, the information you receive from families, how they respond to the new environment, whether they feel confident and comfortable in that environment to appreciate the process of assessment and if you have a patient who readily engages with that assessment process, then again it is so much the quicker. Does that help you?

Q That assists greatly, but just in respect of the last point, of course lack of engagement or otherwise may itself be a feature of, shall we call it the transfer effect.
A Correct.

Q So it is a matter of building in margins of safety, I guess. At which point might it become safe? I appreciate that initial assessment is vital, but that is merely for your immediate management of a patient, is it not?
A Correct, yes.

Q But suppose it is a ward where, for example, there is routinely a decision that will be made for patients whom it is assessed are coming into that end of life stage and they may be put on to a course of treatment that of necessity is a one-way street and a short street at that. What I am looking for is any guidance that you can give us as to the sort of timescale on average that one would expect to elapse before that sort of decision is made to ensure that there is no great risk of a patient being put into that final phase when in fact some of the symptoms of deterioration that they are manifesting are either as a result of the transfer mode or indeed fluctuations that may occur because of the use of certain medications or simply the side effects that might occur as a result of the use of certain medications. Maybe there is not a guideline that you can give us, but if you can, it would help me enormously.

A I am just taking a little time to think out an answer, because clearly if it was an easy answer, you would be there a long time ago. I think if you are embarking on a course of treatment, then clearly that has to be well thought through and whatever the course of treatment, it needs clear thought given as to why you are undertaking that treatment and what it is for. I think the timeframe to embark on these, as you have alluded to before, is very much about individual patient decisions, rather than a timeframe by which every patient is treated, because that would be very non-personalised, would it not, and you would feel you were just were not valued as an individual. To be honest, I really could not give you a timeframe in which you make these decisions, but when someone comes into hospital, you do have to make a decision about their treatment plan. Often prior to admission, there would have been some treatment plan alluded to. For example, for Code A and Code A Code A had already come – I am sorry, not Code A. I beg his pardon. For Code A had already come up with a treatment plan which was for us to use on Mulberry and I would imagine that would continue to be used on Dryad ward. So there are treatment plans that should be set up at the beginning and may precede a patient into hospital. But embarking on – I forget the words you used to describe it – a one-way street of treatment, which suggests a sort of an end point that is terminal, those decisions are not I would say something that you make instantly when someone comes into hospital, unless there was good reason to do so. I cannot define "unless there is good reason to do so", but it may be that there are circumstances where that may be the case.

Q Would it follow that if the patient were to be admitted on to the ward on the basis of pre-planning which indicated, for example, that the patient was for rehabilitation, those sorts of circumstances would make it on the face of it inconsistent, if there were a rapid assessment culminating in that patient being put on to a course of treatment that completely contradicted that for which they came in, for example, rehabilitation they are coming in for, but very swiftly being put on to an end of life course of treatment that would only have one outcome.

A It sounds far too straightforward to say yes, you would surmise that would be the right outcome, that if you are coming in for rehab, you are not put on sort of end of life pathway unless circumstances have changed.

THE CHAIRMAN: That is very helpful. I appreciate those were very difficult questions to try to answer, but it certainly assists me as a non-medic. We have reached the point now where the Panel have asked their questions and it is open to the advocates themselves to ask questions which arise out of the questions asked by the Panel. I am going to ask Code A if he has any questions arising.

Further cross-examined by Code A

Q Coming back to Code A, if you would. You checked yourself. You said Code A had been assessed by Code A and you stopped yourself from saying that Code A had been as well. If you look at page ---
A You are right. I beg your pardon. You are absolutely correct. I did not mean to contradict myself.

Q --- 644. When Code A asked you questions, he stopped the chronology on 18 September and told you that three days later, Code A was to be admitted to the War Memorial Hospital.
A Yes.

Q What we know is that on 21 September, he was assessed at the Dolphin Day Hospital, which is part of the War Memorial complex, assessed by Code A and we have her assessment there. At the bottom of page 644, we have six numbered points. To the left of the number 1, we have a triangle, which is medial shorthand for "diagnosis".
A Yes.

Q I do not think I need to take you through them, but it is clear that Code A has written up a plan. That is the first word she has written on the next page, page 645, and she sets out five numbered points. Again, the detail of them perhaps does not matter. She is suggesting that Oramorph should be prescribed as required, if he is in pain. She has assessed the extent of the pressure sore on the previous page and at the end of her note, she has written, "Prognosis poor".
A Yes.

Q We can turn over two pages to page 647, where we will see that Code A underneath a photograph of the sacral sore, has made an entry that Code A is to be transferred to Dryad ward.
A Yes.

Q In those circumstances, would you expect the clinical assistant to pay high regard to the plan drawn up by the consultant arranging for the admission?
A Yes. If it were my clinical assistant, I would expect them to follow the plan.

Q You were asked questions by the Panel about pathways that patients might be placed on and you were asked if, say, a patient was admitted to the ward for rehabilitation, whether rehabilitation is what they should get by way of treatment.
A Yes.

Q We have to assume for these purposes that rehabilitation is realistic as a basis for admitting a patient to the ward, rather than something written on a piece of paper.
A Correct.

Q Any doctor, on seeing a patient, either at the time of admission or just after, would you expect them to undertake an assessment both of the history and of the patient's then condition. Yes?
A Yes.

A Q You were asked questions about pathways for patients. Do you really need to assess the patient yourself in order to be able to decide what is appropriate for this patient at this point in time?
A Sorry, when you say "you", are you talking about ---

Q For you or for anyone to make a decision appropriate for this patient, do you need to be able to review not just the history, but the present position?
B A I think what I replied to the Chairman was that if there was an intention to rehabilitate, then you would assume that someone would be going into the unit to be rehabilitated, but situations change and I very clearly said that. That is the plan, but when someone gets to the ward, that is not always how the situation is. Does that answer your question?

Q It does mostly. The way in which one might know that the situation had changed is
C because the doctor and/or nursing staff are continuously assessing the patient.
A Yes. You make an assessment, which I think I said should be taking place.

Code A: Thank you.

Re-examined by Code A

D Q I have only one matter to ask you about. I just wanted to try and follow what you just said. I am not going to ask you about creatinine.
A No, please do not ask me about creatinine!

Q Still with Code A, page 645 of file G, is that the plan set out by Code A for this patient?
A I believe that to be correct.
E

Q Then you said – I just tried to note it quickly: "I would expect a clinical assistant to pay high regard to the plan set out by the consultant."
A What you are saying is, I am contradicting myself, I think.

Q No, I am not suggesting anything.
A All I am saying is that if, as a consultant, you make a plan for a patient you have seen
F in the community and then they are admitted to a ward, a clinical assistant or a junior doctor, you would expect them to follow the plan. But part of the junior doctor's role or the clinical assistant's role is to make an assessment of that patient when they come into hospital. If there is a significant difference, then you have to look and change the plan. You cannot stick with the plan regardless.

Q I entirely understand that. If there is a significant difference between what you read
G as the consultant's plan and what your assessment of the patient is, would you in normal circumstances make any note about that?
A I would expect my junior doctor to make a note about that. What you are saying is, if I thought there was going to be a significant difference ---

Q If you read a consultant's plan for a particular patient, the patient gets wheeled round to you and you take a look at that patient and think, "Hold on. This is an end of life patient",
H would you make a note about that and the reasons for your decision?

A A I would expect my junior doctor to do that. If I am the consultant and I make a plan and then, when the patient gets wheeled round to my junior doctor for admission, they think, "What's up here? Things are not quite what they seem to be", I would expect them to think about the plan and either contact me or do something about it and not necessarily follow the plan.

Q This patient on page 645 who is being assessed on 21 September is where?
B A From what I understand, this person is in Dolphin Day Hospital, having come in from the nursing home. When Code A has written her comment, I cannot tell you.

Q I think it is accepted that when Code A saw the patient, the patient was still in Dolphin Day. That is what is being suggested.

Code A Code A knows what Code A said to the police.
C

Code A Let us imagine that for the moment. The patient has not even been moved yet. The patient is still lying in the same ward where the consultant has just assessed him. The consultant has suggested that the patient is for a high protein diet and Oramorph if in pain. You, as the clinical assistant, go and see that same patient and you make a decision at that time to put the patient on a syringe driver on that day, on 21 September. Is that something you would communicate to the consultant?
D A Generally. I have slightly lost track of where you have gone with your thinking and your position.

Q It is your evidence that matters, not my thinking.
A It is how the evidence has been presented.

Q If we go to page 758, which is the drug record, on 21 September, the same date as that
E assessment by Code A, this patient is put on a syringe driver by Code A
A Okay.

Q Would you expect Code A to communicate that to Code A why her assessment was seemingly rather different?
A I am sorry, I am just looking for .... (Pause)

F Code A I am sorry to interrupt, but I wonder if it would be fair for Code A if Code A were to take the witness through the history of what happened that day. We can start at page 754.

Code A I am sorry, I am simply picking up on the examination by Code A. He was asking this witness questions and the witness said, "I would expect a clinical assistant to pay high regard to the plan drawn up by the consultant." That is all that I was asking about.
G A Yes. I am sorry, I got slightly sidetracked. I did not quite hear everything you were talking about, and it sounded like you were talking to yourself and Code A and not to me.

Q No, I am asking you questions.
A I thought you were having another discussion.

H

Q I am sorry. That is my fault. I am asking you questions. I was asking you if the clinical assistant comes to a different view, first of all would you expect them to make a note about it or not?
A I would expect if they come to a different decision that there is some recording and some discussion.

Q And the discussion would be with whom?
A With either a senior doctor or myself.

Code A Thank you.

THE CHAIRMAN: Thank you, Code A

Thank you, doctor, very much indeed. That completes your testimony. We are extremely grateful to you for coming to assist us today. It is always very difficult for a panel in these sorts of situations to try to get a true picture of what happened, very often months and, indeed, years ago, and we really do rely upon witnesses such as yourself coming to assist us. In that regard, you really have been of great assistance and you go with our thanks. Thank you.

(The witness withdrew)

Code A That is the last live evidence that we have. We might finally make an attempt at some reading this afternoon. I wonder if the Panel might like a short break. There is about 30 minutes of reading to do.

THE CHAIRMAN: We will take a short break. We will return at 25 minutes past the hour.

(After a short break)

THE CHAIRMAN: Welcome back everyone.

Code A Sir, could we start with some housekeeping. The first piece of paper we want to give you is the death certificate for Code A which we have not had until now. At file E there is an empty tab, and perhaps that could be filed there. We are not going to give it a different C number. (Documents distributed and inserted in bundle E)

THE CHAIRMAN: For the record, the Panel have received the death certificate in the case of Patient Code A and we have added it to the patient bundle behind the appropriate tab.

Code A Thank you very much. There is also one for Code A, bundle E. (Documents distributed and inserted in bundle E) There is a document after the death certificate which is the birth certificate. The reason for that is that the death certificate appears to reveal the wrong date of birth by a day. It was 29 December 1909 and it is shown in the death certificate as 28 December. I do not expect much turns on it, but that is why you have a copy of both.

THE CHAIRMAN: Thank you very much. Both of those documents have been received by the Panel and placed into bundle C behind the appropriate tab.

A

Code A: I am now going to read the statement of Code A which is a statement read by agreement, I believe.

Code A Yes.

B Code A: This is the statement of Code A

STATEMENTS OF Code A READ

She describes herself as a care manager in social services. She made a number of statements to the police, the first of which is dated 10 November 2005. She says,

> "I am currently employed as a care manager in relation to social and home care for the
C elderly at Fareham Social Services.
>
> I was an E grade staff nurse in the NHS."

She gives her nursing and midwifery number.

I have just realised that we do not have a copy for the stenographer. I am sorry, and we will
D provide one post event, as it were.

THE CHAIRMAN: Whilst you have interrupted yourself, can I just confirm that this statement has been admitted on the basis that the defence are content for you to read it but they do not accept the contents as being fair.

Code A Sir, I think this one is accepted.

E

Code A Sir, I think in this case there is no difficulty about the content. I do not think any issue is taken with what I understand is going to be an edited version simply to cut out irrelevancies.

THE CHAIRMAN: That which we hear is accepted by the defence as being undisputed fact. Thank you.

F

Code A It is not a matter of contention.

THE CHAIRMAN: Thank you.

Code A She says,

G

> "Between May 1976 and May 1979 I trained as a student nurse. I worked at both St Mary's Hospital and the Royal Hospital in Portsmouth."

She says that she qualified as a State Registered Nurse in May 1979 and that she worked on a female geriatric ward. She deals with her midwifery training in 1981.

H

A

"During the period 1983 to 1986 I worked part time as a staff nurse on night duty at both Thalassa and Bury Lodge Nursing Homes for the elderly in Gosport. I initially worked two nights per week."

She then speaks about running her own business between 1986 and 1990. She came back to nursing in 1991.

B

I am skipping parts. I know my learned friend and I have agreed, but I think he will agree that we can précis this. She says:

"In September 1991 I rejoined the NHS as a D grade Registered General Nurse (RGN) working part time at the Redcliffe Annexe in the Avenue, Gosport. This was a long stay unit for the elderly (patients over the age of 65 years). I have re-registered with the United Kingdom Central Council for Nursing, Midwifery and Health

C

Visiting.

In my time at the Redcliffe Annexe I was working with ..."

and she names Code A and Code A, who she describes as the Ward Manager.

D

"As a D Grade I was a junior Staff Nurse and as such I always worked with a Senior Staff Nurse.

I received no training in the use of IV drugs and I did not administer these.

I do not recall the term the Wessex Protocols.

E

With regards to the use of a syringe driver, I am aware that it can only be used on the authority of a prescription written by a Doctor. The use of which is only authorised after discussions amongst the medical team and the nursing staff have reviewed the patient's pain relief/control and the analgesic ladder had been followed; ie, beginning with simple paracetamol, distalgesics, co-dydramol, a codeine based analgesic, and then morphiates would be the next consideration.

F

Once the authority for a syringe driver was given; ie, it was written on the prescription chart and normally in the clinical notes, there should also be an entry in the nursing notes which would state what controlled drugs were to be administered to a patient and what quantity and dosage. The period of time the dosage was to be administered was usually over a 24 hour period.

G

These drugs would be taken from the secure drugs cupboard after the amount/dosage of the drug was checked against the prescription sheet. The appropriate amount withdrawn would be then recorded in the controlled drugs book, which should be witnessed by the two nurses who had withdrawn the drugs.

The drug solution containing the prescribed drug(s) was made up in sterilised water.

H

In the case where it was a mixture of drugs, then the compatibility of drugs would be checked in the British National Formulary (BNF). On occasions the pharmacist would be contacted for advice.

Once satisfied that the drugs compatibility was correct then the driver would be taken to the patient, where a further check would be made to ensure it was the correct patient.

A small butterfly needle would have been inserted below skin level (subcutaneous) and the syringe driver applied, which delivers a set quantity of drugs over a 24-hour period.

With regard to training it was purely on a one-to-one basis and on the job learning. We were given handouts and there may have been a course, I am unsure.

My understanding of the term the named nurse is that this person is responsible for the care of the patients allocated to them. The relatives of that patient would also speak to them if the named nurse was on duty.

The time and date of all entries would vary from patient to patient; they may be completed at the time, but normally completed at the end of the shift.

My shifts were from 0730 to 1330 and from 1230 to 2100 hours.

The Redcliffe Annexe closed and all patients and staff transferred to a new ward at Gosport War Memorial Hospital known as Dryad Ward. At this time I was an E Grade Staff Nurse.

My responsibilities at this time were deputising in the absence of the senior staff nurse or ward manager, supervising staff and delegating work loads. Also assessing, implementing and evaluating individual patient's care. Further to this I would accompany doctors and consultants on their ward rounds. I would also order drugs and arrange for their safe storage and then dispense safely to the patients.

The ward rounds were completed before surgery by the GPs, usually between 0730 and 0800 hours. These would consist of a meeting between them and the staff and opinions from us sought and the GP would visit the patient if necessary.

The consultants rounds would usually be once a week and would take all morning, and all patients would be visited by them.

The following terms can be written in the nursing notes.

ANC means All Nursing Care and means all care that is required for the individual patient, in relation to care plans such as Hygiene, Nutrition etc.

TLC means Tender Loving Care, which in my opinion indicates that the patient is in the terminal stages of life and should be treated with dignity and respect.

'I am happy for staff to verify death', would be written by a Doctor and means that the patient is expected to die in the near future. To verify death then two trained members of staff would check the patient for vital signs, (there was a policy to follow for this) and as such the eyes would be checked for pupil reaction, along with the pulse and the heart. The patient may also be pinched to see if pain registers.

I have been asked about Code A, a nurse at GWMH, expressing her concerns regarding syringe drivers to me. I cannot recall any conversation with Code A regarding this topic at all.

I was on Dryad ward from September 1997 to October 1998 and in that time I believe I worked with Code A for approximately 6 months before I left.

If there had been any such conversation with Code A I think I would have documented this and spoken to other members of staff. I don't recall doing either of these."

She then makes a statement dealing primarily with Patient A, Code A. It is dated 25 October 2004. She repeats, frankly, a vast amount of the same material. Then she says – and for my learned friends I am now on page 4, half way down:

"I have been asked to detail my involvement in the case and treatment of patient Code A."

He is now Patient A. She refers to a photocopy of the nursing notes. She confirms that she has written the following entry for 21 January 1996. I am going to give the references for the purposes of the transcript. If you want to look them up then, of course, I will pause but she actually reveals what she says in her notes in any event. It is our page 212 of Patient A. She says:

"I can confirm that I have written the following entry for the 21/1/1996 (21/01/96).

Condition remains unchanged, Code A phoned, driver recharged at 1745 Diamorphine 120mgs, Midazolam 80mgs, Hyoscine 1200 micro grams, Nozinan 100 mgs, one syringe running at 50mms per 24 hours the other at 58 mms..."

That must be "mls", I think.

"... appears comfortable."

It actually says "mm" which is millimetres but I am not sure that makes sense.

"This entry has been signed by me."

She says:

"Firstly I do not recollect this patient Code A or remember the subsequent care given.

A

With regards to the above entry the patient's condition has not changed during my shift. Code A has phoned because she is obviously aware that Code A is very poorly, ie, prognosis is poor.

The syringe driver has been set up and commenced prior to my shift. I have recharged the syringe driver as per the prescription chart written by Code A clearly shows that this doseage and mixture of drugs can be administered to the

B patient.

However if as trained nurses we felt that the amount of drugs was no longer required, ie, there were signs of improvement then I would not administer these drugs. I would firstly phone the doctor on duty for advice.

In my experience contacting a doctor for advice in these circumstances was a rare

C experience.

With reference to the different rates that I have recorded – both syringe drivers were set to run over a 24 hour period.

With reference to where I have written 'appears comfortable' I understand this to mean that there were no obvious signs of pain or discomfort.

D

I have written under the initial entry on page 29…"

for us it is page 212 –

"2015 no change in condition – which is self explanatory.

E To summarise the patient Code A at this stage was obviously very poorly, the family were aware of his condition. That during my shift the patient's condition had not changed."

She then talks about witnessing withdrawals from the drugs record which I think we both agree we do not need to go through.

F I then turn to her statement dated 11 January 2005. This is for Patient Code A and that is your file F, so we are dealing with Code A. She again reveals her training. She says that when she was at the Redclyffe Annexe she was a D grade as a junior staff. This is just addition to the preface that she gave in the first statement. She says:

"During this initial period that I was working at the Redcliffe Annex I updated my knowledge concerning nursing and healthcare by reading the Nursing Standard and

G Nursing Times.

Although I know I received training in connection with the use of syringe drivers I cannot remember the dates or where this training took place. However I would not have been allowed to use or set up a syringe driver without the appropriate training.

I cannot specifically remember using syringe drivers at the Redcliffe Annex."

H

Can I just look to my learned friends and see if they want page 3, which is in different wording, but I think is much the same sort of material. I am sorry. Yes. I am going to move on. I will give my learned friends an opportunity of having a look at that if they want any of it. I am obviously very happy to read it, but I am going to move on. Thank you. Page 4. There she says:

> "I have been asked to detail my involvement with the patient Code A ... who was admitted to Dryad Ward on 18/08/1998.
>
> I do not remember the patient Code A or any treatment administered to this lady."

She looks at the drug charts. For us it would be page 368E. She says:

> "I did not administer any drugs to Code A on the 19/081998. I believe I was off duty that day. I can confirm that I have made one entry for 3 drugs dated 20/08/1998 @ 0915 where I recorded that I have administered 20 mgs of Diamorphine, 20mgs of Midazolam and 400 mcg of Hyoscine.
>
> These drugs and their quantities were prescribed by Code A who was the ward doctor for Dryad Ward at that time.
>
> On examining the nursing summary, page 394 ..., I would have checked the patient notes for the previous day where it was noted that the patient Code A was anxious and in pain, a syringe driver had subsequently been commenced.
>
> On the 20/08/1998 there would have been a verbal handover from the night duty staff informing myself and other staff commencing duty that day how each patient had progressed during the night.
>
> In the case of Code A it appeared that her condition was deteriorating and that she was still in pain.
>
> The dosage for Diamorphine and Midazolam remained the same. However 400mcgs of Hyoscine was introduced into the syringe driver at this time.
>
> I can confirm that I wrote the following entry..."

This is our page 394.

> ".... on 20/8/1998 (12.08.1998) at 1215, condition appears to have deteriorated over night. Driver recharged, 1010 – Diamorphine 20mgs, Midazolam 20mgs, Hyoscine 400mcgs. Family informed of condition, daughter present at time of report."

I am just asking Code A to check something.

> "With regards to this entry it would appear that I have phoned the family to inform them of Code A deterioration in health. I would have almost certainly informed them at the same time that I had administered another drug (in this case Hyoscine) and explained to the family the reason why another drug had been introduced."

A It was just slightly confusing. The note is made at 1215 but the note that the driver was recharged does show that it was recharged at 1010. She says:

> Hyoscine is normally administered to a patient when they produce excessive excretions, eg, saliva and phlegm and they find it difficult to clear these secretions.
>
> Hyoscine helps to reduce excess secretions. It also acts as an antiemetic, ie, it reduces
B the feeling of nausea.
>
> It is worth noting that a common side effect of Diamorphine when administered is nausea.
>
> I am unable to state when these drugs were prescribed by Code A as there is no date to indicate when the entry was made on the prescription chart.
C
>
> I must add that prior to administering the Hyoscine the dosage would be discussed between myself and the other trained nurse where it would be decided to administer what we felt was appropriate within the prescribed guidelines as set out by Code A
>
> My understanding with regards to any controlled drug which was to be prescribed to a patient would be recorded on the prescription drug chart and recorded in the Drs notes
D by the prescribing doctor. Firstly I would only check the drug chart when administering drugs.
>
> I did not as a matter of course check the entries made by the prescribing doctor in the doctors notes. In the case where it was a doctors signature that I didn't recognise then I would check the doctors notes.
>
> E I have checked the doctors notes in relation to the patient Code A and cannot find any reference to drugs or the reason for prescribing drugs within the doctors notes."

Those you would find at page 78.

> "These drugs would only have been prescribed if Code A felt it was appropriate to do so.
F
> The normal procedure for disposing of unused syringe driver controlled drugs was that they would be disposed of by two trained nursing staff. This procedure is done when it is felt that the dosage needs to be increased or amended prior to the syringe driver finishing within that 24 hr period.
>
> The same applies when a patient dies prior to the syringe driver finishing."
G

She talks about being shown the drug register book but in fact we are trying to stay with our prescription charts, and the relevant document would be 368E. She says:

> "... I can confirm that I have made the following entry [in the drug register book]:
>
> 20/8/1998 (20.08/1998) 0915, Code A, 20mg...
H

A

This entry shows that I have administered the drug, that it was witnessed by S/N [Staff Nurse] Code A

I have made no other entries …

…

B

I can confirm that I withdrew the drug Diamorphine out from the dangerous drugs cupboard at 0915 …. which is verified by my entry …

…. I have shown that the syringe driver containing the Diamorphine, Midazolam and Hyoscine was recharged at 1010, 20/8/98 (20/08/1998).

C

I cannot recollect the reason for the delay between withdrawing at 0915 and administering at 1010 … There are numerous distractions on the ward especially as I was senior nurse in charge.

I am inclined to say that it is possible that the time recorded in the nursing notes is incorrect and that I actually administered it at 0915."

D

She then deals with her entry at page 395 on 21 August 1998 at 1855:

". condition continued to deteriorate slowly, all care continued. Family present all afternoon and present when Code A passed away at 1825.

This entry is self explanatory...".

E

She also deals with the note that she makes about the patient dying which perhaps I do not need to go through.

Patient G: again, there is a lot of preamble which I am not going to deal with. I am turning now to page 3 of 5.

F

"I have been asked today about entries in the medical records of Code A …"

This is our file G. She makes reference to page 831.

"The three entries dated 26th September 1998 were written by me.

Code A wrote the prescription on the form of Diamorphine, Hyoscine and Midazolam.

G

All three of these drugs were put into the syringe driver by me.

The syringe driver was already in place and I would have recharged it for twenty four hours over the 26th September, through to the 27th.

H

A syringe driver is a mechanical device normally placed in the stomach. It is batter powered and functions as a device to administer a regular dose of pain relief over a twenty four hour period.

By this date I was an E Grade RGN, a Senior Staff Nurse and was fully trained in the use of syringe drivers.

I can say by reading page 831 that Code A prescribed for Code A parameters of 40 to 200mg of Diamorphine, 800 micrograms to 2g Hyoscine ..."

I do not think it can be that much –

" .. and 20 to 200mg of Midazolam, all to be given over a twenty-four hour period.

I can say that at 1150 hrs on 26th September 1998 I mixed 80mg of Diamorphine, mixed with water, 1,200 micrograms of Hyoscine and 100mg of Midazolam. They were all compatible to go into a syringe driver.

This was all in accordance with standard medical practice.

As a Senior Staff Nurse I would stand in for the Ward Manager or the more Senior Staff Nurse above me in the ward. I was in effect in charge of the running of the ward and this would include the administration of medication to patients.

Each of the above entries was initialled by me."

Then she confirms the notes made by her on 25 and 26 September at page 863. I will deal simply with that made on 26 September, if I may. The rest speak for themselves in any event:

"'Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. Mouth care given. Driver recharged at 1150. Diamorphine 80mg, Hyoscine 1200 micrograms, Midazolam 100mgs. No phone call from the family this am. Code A phoned to enquire on condition.'

All medication given to Code A was within those parameters set by Code A."

Then she says this:

"Any increases in the administration of medication would be discussed between the doctor, if available, and the senior nurse. If the doctor was not available the decision, based on staff experience and qualifications, as well as the patient's condition, would be determined by the two trained staff on duty."

She describes again how to use a syringe driver. Then:

"Further to the above I can confirm that the notes referred to by me ..."

She is referring to the recharging of the syringe driver, which we have just dealt with –

A

"I have also been asked why the diamorphine was increased to 80mg on 26/9/98 and who made the decision to increase the dosage. I assume the increased dosage was because of increased pain and the decision would normally have been the doctors, although if the doctor were not available two trained members of staff who knew the patient could have made the decision, provided it was within prescribed parameters, which it was. This increase would have been over a twenty four period and is not
B excessive."

That deals with the statement of Code A

Code A: Sir, lastly two statements from Code A dealing with patient G, Code A. This I think – I will be corrected if I am wrong – is a statement that is being read on the basis that it is accepted the witness is unavailable and the statement could
C be read, but it is not agreed evidence.

Code A: I confirm that.

Code A: Dealing with Patient G, firstly the statement of 18 October 2005, Ingrid Lloyd sets out her background:

D STATEMENT OF Code A, Read

"Between 1989 and 1992 I did my Nurse training at St Mary's Hospital Paddington and at Southbank Polytechnic London where I completed by Registered Nurse and HND Nursing training."

E She then goes through her employment after that, saying:

"Between 1996 and 1999 I was a night Staff Nurse D Grade on Dryad ward at Gosport War Memorial Hospital where I was in charge of the ward in the absence of a senior member of staff.

F .... my responsibilities included the administration of drugs, patient care and supervising patient care.

My line manager at the time was Code A

I did not receive training/certification in the administration of IV drugs.

G I received mandatory training in the community regarding the setting up of syringe drivers; I believe this was at the Countess of Mountbatten Hospital. I received no certificate.

I have not heard of the term, the Wessex Protocols. I do however have a good knowledge of the analgesic ladder regarding pain relief.

H The named nurse is a term that is not used on night duty, but it is the nurse who is responsible for the planning, administering and implementing a patient's care plans."

She says:

"The term TLC, 'tender loving care' I am familiar with. This would indicate to me that this patient was getting towards the end of their life, and there was likely to be no rescue efforts to resuscitate them.

The term 'I am happy for staff to verify death' I am familiar with, and understand it to mean that death was expected, and that there would be no need for a doctor to be called out during the night if the patient passed away. In a larger hospital this would not occur because there would always be a doctor on duty. GWMH is basically a half way house between a larger hospital and a patient's home.

Ward rounds were not conducted during a night duty.

I have been asked to detail my involvement in the care and treatment of a patient on Dryad ward named Code A ... I have no recollection of this patient ... but I can state that on page 756 of the nursing notes which is a form 'Exceptions to Prescribed Orders' I have written ..."

This is page 756 of the nursing notes –

" ... at 2200 on 21/9/98 that Co-Proxamol, Sinemet CR and Senna were not given, the reason being that the patient was sedated. This means that the Co-Proxamol was not given because the patient was sedated on the syringe driver and the Sinemet and Senna would to be appropriate also due to sedation.

On page 758 of the notes is a prescription chart written up by Code A. This was for a variable dose (20-200mg) of Diamorphine and a variable dose (20-80mg) of Midazolam. I have written on 21/9/98 at 2310hrs that I have administered 20mgs of Diamorphine and 20mgs of Midazolam ... I would think that I set up the syringe driver, but Code A and I would have given it together.

On page 861 of the notes which is a patient summary regarding Code A, I have written on 21/9/98, 'Remained agitated until approx 2030. Syringe driver commenced as requested. Diamorphine 20mgs, Midazolam 20mgs at 2300. Peaceful following.' I have signed this entry.

Diamorphine used in a syringe driver is a faster way of relieving pain than drugs taken orally. The syringe driver administers drugs subcutaneously ... and may be used if the patient is comatose, or absorption of oral drugs was impossible i.e. if the patient had difficulty swallowing, or if the patient had a slow metabolism.

In my experience, and with regard to recent research based evidence I have read, Diamorphine in a syringe driver is an excellent method of pain relief. In a variable dose prescribed of between 20 to 200mgs, the 20mgs administered was the lowest possible dose that could be given over a 24 hour period.

Midazolam is a sedative.

Sinemet is used for Parkinson's.

Senna is a laxative.

The exceptions to prescribed orders was documented at 2200 on 21/9/98 in full expectation that a syringe driver was to be commenced at the earliest opportunity consisting of both Diamorphine and Midazolam which would negate the need for the other analgesic."

That is the end of her first statement. She has then made a supplementary statement dated 30 November 2005, in which she says:

"I have been asked to clarify the following points: with regard to the syringe driver my entry of the 21/9/98 ..."

This is the note on page 861 –

" ... with regard to the syringe driver my entry of the 21/9/98 is followed by an entry dated 22/9/98 made by Code A. However this is a retrospective entry. I was aware from the verbal handover which took place at about 2015 hours on 21/9/98 that the incidents that are mentioned in Code A note had already taken place. It was with this knowledge that together with Code A it was agreed that a syringe driver should commence. This was done so that Code A remained in a pain free and peaceful state.

Although I have stated in the notes that Code A 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 Code A wasn't available until this time as she had other duties to attend to as the night nurse in charge.

The purpose of the syringe driver was to enable a pain free and peaceful state for Code A. With regard to who authorised the syringe driver this was a decision made by three trained nurses including myself, Code A and Code A The drugs were prescribed to be given at our discretion.

The term 'as requested' would suggest that I had had a conversation with another member of staff, possibly Code A, however as I do not recall this I can't make further comment.

I wish to clarify the issue with regard to the Co-proxamol. In my previous statement I have said it was not given because the patient was sedated on a syringe driver. This is not correct. Firstly Code A was not sedated. The reason the Co-proxamol was not given was because I was acting with the full expectation that a syringe driver was to be commenced at the earliest opportunity."

That is the end of those statements.

THE CHAIRMAN: Thank you very much indeed. We are almost within the time, but not quite. Thank you.

Code A: Just in terms of progress, we are I think very much on track on the reviewed the timetable. Tomorrow morning, we have Code A, who is an orthopaedic consultant. I do not think he will be very long. We then have Code A, and I expect that he will be a relatively lengthy witness. He may finish tomorrow, he may not. Then on Wednesday we have Code A and Code A, who is one of the managers now at the Trust, and Code A, about whom we have heard. Then on Thursday we hope to start with Code A. As I flagged up last week, that will slightly depend on us having had the expert's report. If we have not had the expert's report in good time, we will have to ask for an adjournment.

Code A: Sir, may I just indicate one thing which may slightly affect that timetable? You may recall some time ago, I think it was you who asked, as a result of comments made by us, about the two sides getting together to try and produce a kind of comprehensive chronology and history.

A lot of work has been done on that I know by Code A and Code A has been kind enough to work through it. Whether we absolutely reach a final agreed version – it is not a question of dispute about facts; it may be a question of disagreement as to quite what goes in it in terms of how full it should be – but I can see we may be asking perhaps for half a day just to make sure that is straight, because I personally think very strongly, and I think Code A agrees, that for the Panel's assistance as well as for our assistance, when listening to Code A evidence, it is going to be pretty useful to have a history set out. It may prevent the Panel having to constantly look at entries.

It is bound to happen. Code A is bound to have to look at entries on the individual files but I think in the long run it may save time. I just mention that as a possibility. We are doing our best to see that it is all settled before we get to Code A.

THE CHAIRMAN: Thank you very much indeed, Code A. Anything that can be done to make things smooth and easy for the Panel is always going to be very welcome.

We will rise now and we will meet tomorrow at 9.30 am.

(Adjourned until Tuesday 30 June 2009 at 9.30 am)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 30 June 2009

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

Chairman: Code A, LLB JP

Panel Members: Code A

Legal Assessor: Code A

CASE OF:

Code A

(DAY SIXTEEN)

Code A of counsel and Code A of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

Code A QC and Code A of counsel, instructed by the Medical Defence Union, appeared on behalf of Code A, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning everybody. Code A a quick bit of housekeeping, if I may. This Friday a member of the Panel needs to be away by about 3.30 in the afternoon. If there is any danger of that impacting negatively on the schedule, then the Panel would be perfectly prepared to sit longer hours in the run up to, and I will be guided by you as to when and if that is required.

Code A: First of all, I am sure in terms of overall impact that is not going to have a significant effect at all. It is a timely point at which to mention next week and Code A Code A Today we have a fairly full schedule. Code A is going to be calling the first witness Code A, and I may slip out of the room at that time while that is done. Then we are going to be hearing from Code A is a fairly substantial witness. You will recall that he was one of the consultants. Then tomorrow we may still have Code A to finish. I do not know how long we will be with him. Then we have got Code A and others. Now, so far as Thursday is concerned, we certainly may start Code A on Thursday, but you have heard Code A suggestion, which I fully support. Code A has done a huge amount of work on the chronologies and the defence are going through those at the moment. They have done some of them but not all of them, and are adding some details, I think, to those they have seen. Next week we have one, as I understand it, non-sitting day, which is Wednesday, because we are being moved out of here because it is required, I think, for a Council meeting. Then I ought to mention that Thursday, my current instructions are that Code A is not available. He has some prior commitment. I have known about that for some time and perhaps I should have revealed that earlier. I am sure there will be other things that we can do and read, but we are losing two days in the middle of next week. Code A is available, I think, until Monday the 13th. So we have got Friday, Monday and Tuesday of next week, Friday the following week and Monday the week after that, so we have got five full days to deal with Code A evidence, and, although he is a very substantial witness, I am reasonably confident that we will be able to finish in that period.

Code A: May I just mention one other thing which may affect the order of events. At some stage before Code A gives his evidence my learned friend I know is going to put in evidence the statements made by Code A, which include a general statement of her position and individual statements with regard to each one of the patients. I am not suggesting that he calls a policeman, or whoever received the statements, to read them all out, but it is going to be very important for the Panel, before hearing Code A, to have in mind the content of Code A statements, because, apart from anything else, I shall be putting certain matters from them to him. He, of course, has read them all, but I just think we ought to allow, in terms of the timetabling, for that to take place. It is not a matter of a half hour read.

THE CHAIRMAN: You are absolutely right, Code A. One of the unusual features of this case so far has been that we have not had the sort of gaps that often occur and which enable a Panel to keep up with its reading. I know there is a general feeling that we would welcome some reading time, just keeping up with the transcripts themselves. Normally, Code A, it has to be said that GMC scheduling is not as efficient as yours has been, and your team are to be congratulated on that because you have kept it coming with no real gaps.

Code A: Well, perhaps there is advantage to inefficiency sometimes.

THE CHAIRMAN: Sometimes.

A Code A: One of our difficulties is that because we have known of Code A time slots, as it were, we have had to keep things moving to get to the point where we can call him. Thereafter, I suspect, we can if necessary slow down a little because we still have a long time before the scheduled end of the case, but we will just have to deal with Code A Code A as best we can. I entirely accept Code A point. You will need, I would suspect, at least half a day realistically reading Code A statements.

B THE CHAIRMAN: It sound as though towards the end of this week that time is going to be available to us. Even if we were to start the Professor a little later, at least we would be properly prepared for him, and I think Code A is absolutely right, we need to be in a state of readiness or else the first wave washes over us and we have not really taken it on board in the way we should, if I can mix the metaphor.

Code A: I accept that.

C

THE CHAIRMAN: Good. Thank you. So, Code A, you have a witness.

Code A: Sir, I do. Just before he is called, could I hand out, please, copies of the revised chronology for Patient I, Code A, which is the patient the next witness deals with. (Same handed)

D THE CHAIRMAN: Code A, we will just add these to the patient bundle without the need to give it a separate exhibit number. It will simply go in at the beginning of the bundle.

Code A: Thank you. This is the revised and agreed version which sets out almost all, if not all, of the relevant entries from the notes.

E THE CHAIRMAN: I can see you really have done a great deal of work and we are most grateful for that. Thank you.

Code A: Certainly, sir. The next witness is Code A, who is a consultant orthopaedic surgeon, who reviewed the notes relating to Code A and provided an opinion. He did not deal with her himself. What I was going to suggest is that maybe the most efficient way of dealing with this is for he and I, and therefore the Panel, to go through this document briefly when he is called and familiarise the Panel with it in that way, rather than giving time at the outset for the Panel to just review it.

F THE CHAIRMAN: We are in your hands absolutely.

Code A: Thank you very much. Could I just explain something about the chronologies in terms of the colour coding. The colour coding has only been used in terms of the drugs prescribed and administered. For example, if one looks at page 12 at the top, one can see that there is an entry on page 12 relating to Oramorph and co-dydramol. Entries in red relate to prescriptions and entries in blue relate to drugs administered. So that is designed to be helpful. Could I call then, please, Code A

G

H

Code A Sworn
Examined by Code A

(Following introductions by the chairman)

Q Is your name Code A
A It is.

Q Is it Code A
A Code A

Q You are a consultant orthopaedic surgeon at the Royal Preston Hospital?
A I am.

Q You have been in that post since 1999, is that right?
A Yes.

Q Just a little more about your background: you qualified originally from Oriel College, Oxford, is that right, in 1980?
A Yes.

Q Where did you do your further medical training, please?
A St Bartholomew's Hospital Medical College in London until 1988.

Q What qualification do you hold, please?
A An MA, MBBS, FRCS and the FRCS Orthopaedics.

Q So a Fellow of the Royal College of Surgeons for Orthopaedics?
A Yes, two Fellowships: one is the standard Fellowship, and then there is the intercollegiate Fellowship, which is taken at the end of training.

Q You did your basic surgical training at St Mary's Hospital in London?
A Yes.

Q Then moved on for higher surgical training to the Hammersmith and Charing Cross Hospitals?
A I did.

Q Then, as you say, you have been a consultant surgeon, orthopaedic surgeon, in Preston from 1999?
A Yes.

Q Is it right, Code A, that you were asked in 2006 by the Hampshire Police to provide an expert report into the care provided, from an orthopaedic point of view, in relation to Code A?
A Yes.

Q You produced a report dated 22 January 2006, having been provided with the medical records and reviewed them, is that right?
A Yes.

Q Would you find it helpful in giving your evidence to the Panel to be able to refer to your report?
A Yes.

Code A There is no objection.

Code A: Sir, I am sure that for large parts of Code A evidence he will not need to do that, but there may very well be points where it would be helpful, so I am grateful for that.

THE CHAIRMAN: In the absence of objection from the defence I see no difficulty with that.

Code A: Thank you. Code A, you have also been provided this morning with a chronology, have you not, about what happened in relation to Code A?
A Yes.

Q Have you had some time to look through that?
A I have.

Q For your benefit the Panel also have that, and what we will do in a moment is just to go through it to look at the relevant entries from your point of view.
A Okay.

Q You were asked in 2006 to consider a number of different issues, some of which are relevant for us and some of which less so, but so the Panel are clear on the exercise that you have performed were you asked to address, first of all, whether or not Code A suffered after her admission to the Haslar Hospital in this case from something called compartment syndrome?
A I was.

Q As a result of the operation that took place to her fractured neck of femur?
A Yes.

Q That was an issue that really related to her treatment at the Haslar Hospital?
A Yes.

Q Could you just help the Panel immediately with what compartment syndrome is?
A Compartment syndrome is a condition which arises most commonly after trauma or surgery. The segments of a limb are bound within a tight containing structure called fascia, which binds the soft tissues and the bones together under the skin. If you develop swelling within that tight fascia, then the pressure within that area builds. If the pressure builds sufficiently, then the return of blood from that segment of the body is obstructed. As a consequence, the blood coming in is also secondarily obstructed at the point of the micro circulation, which is where the blood vessels become very small. If that happens, then the tissues in that area lose their oxygen supply and the cells will swell. This worsens the

problem because it increases the pressure in the compartment. If left untreated this condition can lead to muscle and nerve death within the compartment and loss of function in the limb, or compartment of the limb. I hope that is reasonably clear.

Q I suspect it is. You make your point in your report in terms of why this really is an issue that is more relevant to the treatment at the Haslar Hospital. This is something that would arise in reasonably short order after an operation?
A Either after trauma or after an operation, yes.

Q And so for the Panel's benefit, it is not such an issue when we come to her treatment at the second hospital, the Gosport War Memorial Hospital?
A The issue would have been only the sequelae of a compartment syndrome rather than the diagnosis of the compartment syndrome itself.

Q Very well. By that point the damage from compartment syndrome is done?
A Is done.

Q Also for the Panel's benefit, I think it is right to say that from your analysis of the notes, you are unable to say that this patient did have compartment syndrome but it was a possible diagnosis?
A Yes.

Q You were also asked, though, to consider other issues. Firstly whether in your view it would have been reasonable to expect a doctor – one of the doctors who were treating this lady – to refer her for further orthopaedic review after her operation in the light of the symptoms that she showed?
A Yes. I was.

Q You were asked to comment on the possibility that the pain that Code A suffered was due to any reversible post-operative complication?
A Yes.

Q And you were also asked to comment on the antibiotics that were used to treat Code A and whether they were sufficient in your view?
A Yes.

Q Those are issues which are relevant to both hospitals but certainly relevant to the treatment at the Gosport War Memorial Hospital. When you were looking at the records of Code A to inform you in making your report, is it right that you were concerned particularly to see, first of all, the details of the operation she went through and then also signs of further pain, discomfort, swelling – matters of that nature – after the operation?
A Yes.

Q What I will ask you if we can do is to go through this chronology now, to just look at the relevant points. There may be one or two moments while I just ask for your comments and refer you to your report. To run through the most relevant points from the chronology, we can see from the first page and the first entry that it was on 19 March 1999 that Code A was admitted to the Royal Haslar Hospital following a fall. It caused a right subtrochanteric femur fracture.

A We know, moving on to page 3 – do you have page 3 of the chronology?
A Yes.

Q At the top of page 3 we see that surgery was carried out. This was the next day, the 20th, under spinal anaesthetic with the insertion of a right dynamic hip screw. There was a blood transfusion that was given. Then there was a post-operative review that day by a senior house officer that there was a lot of ooze from the wound, that the thigh was about two times
B the size of the left thigh, and there was an issue of whether there was a haematoma, and the patient was complaining of discomfort in the leg and pain on palpation. I think you made a point in your report, that it was quite a complicated fracture and quite a complicated operation that this lady underwent?
A Do you wish me to expand?

Q Please, yes.
C A In the scheme of fractures around the neck of the femur, which is the hip, the subtrochanteric fracture is probably the most difficult of the three sub-types to deal with. It is difficult to reduce. It is difficult to fix and the fixation has a higher propensity to fail than standard fractures.

Q This may be relevant to the point we will come onto, but when you say "a propensity to fail," what does "fail" mean in this context?
D A Failure would usually involve some breakdown in the interface between the implant and the bone, so that the plate may pull away from the side of the bone to which it is fixed. May I stand up?

Q Yes, if you are more comfortable, I am sure. (The witness did so)
A It is fixed down the side of the femur here (indicating) and then there is a screw that passes up into the hip bone itself, so the plate can either pull off in *this* direction (indicating),
E or alternatively the screw can cut out through the femur superiorally, going towards the head. So those are the two commonest modes of failure. (The witness sat down)

Q So literally the fixation between the bones is ---
A It either pulls away from the bone, or it cuts through the bone.

Q That will have inevitable consequences in terms of pain and mobility?
F A Yes.

Q Moving on, we can see that on this day – the day of the surgery, at the bottom of the page – paracetamol was administered and also morphine for pain relief?
A Yes.

Q Unsurprising on the day of operation?
G A Perfectly standard.

Q Moving over to page 4, it is now 21 March. The first entry deals with the morning: "Seen by doctor today" – the X-ray was checked and was okay.

"Code A able now to get into chair. Please give morphine before moving Code A – a lot of pain on movement."
H

A We can see at the bottom of the page that again morphine was being administered that day. Again, this is the day after surgery. Would that level of pain be unusual?
A That would not be unusual.

Q You make a point in your report about the reference to an X-ray being checked and being okay. First of all, in terms of the fixation, in terms of the surgery, what does that reference tell us about at that stage?
B A It states that the doctor reviewing the X-ray was satisfied both with the position of the implant construct on the bone and also with the position that the bone had been put into, which is termed its reduction. So the bone had been satisfactorily straightened and fixed.

Q You make a point in your report about this being on your analysis of the notes, the only reference to an X-ray actually being checked in relation to this patient?
A Yes. There were no X-ray reports and I did not have the opportunity of reviewing any
C X-rays personally.

Q The Panel will know that there is later at Gosport War Memorial Hospital a request by a Code A for another X-ray to take place, but on your analysis of the notes that does not seem to have been followed up. Is that right
A I could not find a record of that X-ray having been taken or reviewed.

D Q Moving on with the notes, in the middle of that page, page 4, I would just point out that the last three lines of that entry say that the right hip is painful +++, no ooze, but thigh enlarged, possible bleed into thigh but no evidence of hypovolaemia. The hip was still painful but that was not very surprising given how recent the operation was?
A It is not surprising. If you read the contents of my report, I was concerned that the issue of compartment syndrome was raised but not acted upon.

E Q This is relevant to the criticism that arose in your report of the treatment at the Haslar?
A Yes.

Q That this should have put people in mind of ---?
A Compartment syndrome.

Q Very well. Particularly in light of the pain and the swelling that was occurring?
F A Yes, and in the light that one doctor had actually made that diagnosis.

Q Yes. That is a note that has not been included in the chronology because it is not so relevant from our point of view but it features in the notes from the Haslar. Moving on to page 5, the next day, 22 March 1999, in the middle of the page, the second entry:

> "Sat out by physios. Drinking and eating much better today. Oral fluids pushed."

G

And it is paracetamol that is being administered that day.

The next page, 23 March, a couple of lines down, a.m. –

> "Moved patient to chair with 2 assistances. Patient has difficulty and pain ++ with mobility."

H

A Then the last couple of lines at 19.53:

> "Transferral and mobilising not well. No ooze on wound on hip."

Still it is just paracetamol being administered.

We move on over the page to the next day, the 24th. There is a review by Code A
B consultant, who also saw the patient at the Gosport War Memorial Hospital. Code A pointed out:

> "Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful."

He wanted to be reassured that all was well from an orthopaedic viewpoint. He was saying if
C it was, he was happy for transfer to take place to the second hospital.

If we move on over the page, again just paracetamol that day that was being administered. The next day, the 25th, there is a note on the ward round that the right leg had increased swelling, the skin was fragile. A haematoma had developed and broken down.

Go over the page, please, to the top of the page. This is the last day the patient was at the
D Haslar Hospital. From the nursing notes, the patient was mobilised to the commode with two staff. The last line there is that she was very reluctant to mobilise. "Needs encouragement." Still just paracetamol being given though.

Then it was the next day, the 26th, that we can see that the transferral took place to Dryad Ward at the Gosport War Memorial Hospital. There is a note in the transfer letter there saying that the patient was now –

E

> "... mobile from bed to chair with 2 nurses and can walk short distances with a zimmer frame."

It also pointed out that the right lower leg was very swollen and there was a small break in the skin. The only medication is analgesia PRN. On the 26th she was transferred.

F Going over the page to page 10, that day three was a review by Code A noted effectively she was not weight bearing, and that there was a plan to sort out analgesia. In the second entry on that page from the nursing notes, it is pointed out that transfer had been difficult since admission.

> "Complained of a lot of pain for which she is receiving Oramorph regularly now, with effect."

G

The legs are swollen. The last few entries relate to the night time:

> "Requires much assistance with mobility at moment due to pain/discomfort. Oramorph ... given...".

Over the page:

H

A

"Oramorph given for pain in hip
Experiencing a lot of pain on movement"

We can see from the entries relating to the drugs that were given that there were four doses of Oramorph given that day.

Over the page to page 12, the 27th, Oramorph continued and also co-dydramol prescribed and
B the nursing notes states:

"Is having regular Oramorph but still in pain.
... In some pain, needs 2 nurses to transfer at present."

The next day, the 28th, Oramorph and co-dydramol both given. Moving through the next few pages quite quickly, page 13 on the 29th March, co-dydramol only given.

C

On the 30th, over the page to page 14, again co-dydramol given. In the nursing care plan it is observed that both wounds are redressed.

"Steri-strips from surgery removed. One small area near top oozing slightly...".

The next day, the 31st, Oramorph given again, a small dose and co-dydramol and MST – so
D slow release morphine – then prescribed for the first time and two doses administered.

We go over the page to page 15. At the top there is a nursing entry that the patient was now commenced on the MST.

"Walked with the physiotherapist this a.m. but in a lot of pain."

E

The next day, 1st April, the second entry is from the nursing care plan. There was a wound in the right hip oozing large amounts of serous fluid and some blood, and a hole was noted in the wound. Still having pain on movement.

You made a comment in your report about what this sort of oozing of serous fluid might indicate. Can you help us with that, please?
A I will just refer to my report.

F

Q It is page 11 of your report, just a few lines down from the top.
A Sorry – just to check. Leaking from a wound at this time following surgery would suggest that there was either a clot that had formed within the leg – and I differentiate this from a venous thrombosis. It is a different kind of thing. This is a post-surgical collection of blood. What happens is that over the course of a number of days after surgery it will liquefy, and then it will drain through if there is a patency in the wound. The alternative is that there
G was an infection on the implant and that this was discharge from that infection.

Q You have described that as a potential deep infection?
A Deep infection.

Q Because not just on the surface of the wound but actually inside?
A Inside, presumably right down to the level of the implant.

H

Q Just moving on, it was the most that was given that day, on 1 April. Then going over the page to page 16 on the 2nd, the next day, again MST given, and on the 3rd. There is a nursing entry for the 3rd, that the patient was still continuing to complain of pain on movement. Then on the 4th, there is a nursing entry that the wound on the right hip was oozing serous fluid and blood, as before, it would seem. MST was again administered.

Going over the page to the 5th, again MST administered. Then the next day, the 6th, there was a review by Code A That entry in itself is not particularly relevant to us, other than that the MST dose was increased to 20 mg. The next entry relates to swabs being taken from the suture line on the right hip and the right calf. Then there is a microbiology report coming back. The fact that swabs were taken would indicate that that was action being taken in respect of the potential infection. Is that right?
A Yes. It would suggest that there was suspicion of an infection.

Q The microbiology report is our page 57. It might be helpful to look at it briefly. Next to you there are a number of files on your left. Can you take out the file marked "I" – which is different from the filed marked "1".
A Yes.

Q Would you turn to page 57. The pagination that we are using is the one at the very bottom of the page with a dash either side. That is the microbiology report. That seems to have been the result of these swabs being taken. Does that seem to make sense to you?
A That would fit. Date received, 6th of the 4th.

Q So that would fit?
A Yes.

Q Date reported, 9th of the 4th. Does that mean the date that this report was actually made?
A The date that the microbiologist made the report was the 9th of the 4th.

Q Can you help us with the infection that was found? You made a point in your report about whether this would be considered a particularly serious or dangerous infection.
A There are two organisms. May I just check my report on that?

Q Of course.
A One is staphylococcus aureus and one is staphylococcus epidermidis. Staphylococcus aureus is a typical pathogen for causing wound infection. Staphylococcus epidermidis is usually a skin commensal, as the name suggests, on the epidermis. A commensal is an organism that lives ordinarily on the surface of the skin without causing problems. It is of theoretical importance in orthopaedic implants, but here, no sensitivities have been given for it. The sensitivities for staphylococcus are typical: flucloxacillin, erythromycin and, quite surprisingly, penicillin, because staphylococcus aureus is not usually sensitive.

Q In fact, when you reviewed the issue of whether the treatment for infection that was given at the Gosport War Memorial Hospital and whether the drugs that were used were satisfactory from your point of view, your conclusion was that it may not have been the perfect solution, but that it was satisfactory from your point of view; it was not something you would criticise. So we may not need to go into that.

A I am sorry, this is why I was looking through my report. I think they commenced on ciprofloxacin, metronidazole, which is a reasonable best guess, because the patient was incontinent of urine, although not of faeces as far as I am aware. So it was a reasonable best guess.

Q If we go over the page in our chronology to page 18, we can see these drugs being commenced. On page 18, the first entry there is the drugs that were given on the 6th, but on the 7th we can see there is an entry that the fracture site was red and inflamed, she was seen by Code A and that those two antibiotic drugs were commenced: metronidazole and ciprofloxacin.
A Yes.

Q Ultimately, when you were giving your opinion on the prescription of those antibiotics, it was your view that that was a satisfactory approach?
A I think I also said, however, that the antibiotics should have been changed on receipt of the report.

Q Can you help us with why that is?
A The organism staphylococcus aureus is not sensitive at all to metronidazole. The antibiotic ciprofloxacin is a broad spectrum antibiotic which is less effective against staphylococcus aureus than antibiotics such as flucloxacillin and erythromycin, both of which are very good anti-staphylococcal agents.

Q We have seen that the report was only made on the 9th.
A Yes.

Q Just moving on to finish the relevant entries from the chronology, on the 7th, the last entry is a review by Code A That is the consultant who had seen the patient prior to her transfer to the Gosport War Memorial Hospital, and his entry was that the patient was still in a lot of pain and very apprehensive. He has said:

> "For x-ray Right hip as movement still quite painful – also, about 2" shortening Right leg."

You referred to this earlier in your evidence in relation to there being a further request for an x-ray. You dealt with this at page 10 of your report. From the note about the movement still being painful and the shortening of the right leg, what concerns would that raise?
A My concern would be, given that picture, that the implant had failed.

Q Is the level of pain that the patient had been in which was registered in the notes and which seemed to be continuing after the operation and in the second hospital, and the difficulties in mobilisation, would that be normal if the fixation was working properly?
A In a sound fixation and in the absence of other complications, you would expect the analgesic requirement to diminish and the ability to mobilise to improve steadily until an end point is reached.

Q So what concerns would have been raised by continuing pain and lack of mobilisation?
A In the first few days after surgery, there was the concern of a compartment syndrome causing pain in the thigh. Compartment syndrome is a very painful condition. After 48 to 72

A hours, the pain of compartment syndrome recedes and the likelihood of that being a reasonable cause for her pain recedes at that point. From then on, really at no time does she demonstrate improvement in terms of her general levels of pain as far as I can establish. There is a brief period while she is at Gosport when her analgesic requirements come down to a paracetamol requirement, but it is always documented in the case records that it is painful for her to mobilise.

B Q What concerns does that raise?
A That would worry me that the implant fixation was not adequate.

Q Is this entry by Code A about the shortening of the right leg further evidence of that?
A It is quite strong evidence of that. The hip should not be short by that degree. That is about 5 centimetres. That is a long way short.

C Q By this stage, some two or so weeks or a little bit more after the operation that this patient underwent, would it be common or uncommon for the patient still to be requiring morphine?
A That would be very uncommon in my experience in the context of an adequate fixation.

D Q Moving over the page in the chronology, on page 19 we can see that on that day, when the review by Code A took place, again MST was given and on the 8th MST was given again. He records:

"Wound oozing slightly overnight. Redness at edges of wound subsiding."

On the 9th, MST was given again and it was recorded by the nurses:

E "To remain on bed rest until Code A sees the x-ray of hip."

As you said before, I think there is no sign in the notes that that x-ray was done or reviewed by anyone.
A I could not find a record of the x-ray having been taken. It would be logged initially in the x-ray department, but there was certainly no report.

F Q Over the page to page 20, on the 10th MST was given again and in the nursing notes it is recorded:

"Very poor night. Appears to be leaning to left ... Stitch line inflamed and hard area. [Complaining of] pain on movement and around stitch line. Oramorph 5 mg given at 07.15 hrs."

G For the Panel's benefit, I should point out now that that 0715 entry would in fact be on the next morning. If it is helpful to write that in, it would in fact be on the morning of the 11th, because this is an overnight entry. Then moving on to 11 April, in the first entry there is another reference to pain on movement and Oramorph being given at 0715. She was complaining of tenderness around the wound, there is a review by Code A, it seems, a reference to the condition of the patient deteriorating and:

H "The patient denies pain when left alone, but complaining when moved at all."

Then there is a note there that the patient may be commenced on a syringe driver and that is what took place the following day. I think for our purposes at the moment, those are the relevant notes we need to look at. As we have gone through, we have already commented on a number of the significant points, but if I could just move on to the opinion that you express having looked at the records. I think it is right to say that when you set out your view in your report, you have made some points about ways in which you were hampered initially and it is right to say that you felt you were hampered by not having had sight of any relevant radiographs of radiologist's reports. So x-ray reports.

A Or preferably x-rays.

Q Or x-rays themselves. But you did of course take account of the fact that there was the initial reference to the x-rays being okay and then the fact that later at the Gosport War Memorial Hospital, although there was reference to the fact that an x-ray should be carried out, there was then no further reference to it.

A Yes.

Q You also felt limited in what you could say because of the fact that there was no post mortem examination.

A Yes.

Q Therefore is it right that in looking at what the diagnostic possibilities were, you could only give possibilities, rather than firm conclusions.

A A range of possibilities.

Q But you were able at page 14 to set out what in your view that range of diagnostic possibilities was. There are three I think. Can you just help us with what those were?

A They were an untreated compartment syndrome, a failure of the operative fracture fixation and a deep tissue infection or abscess formation.

Q You went into some depth in your report about compartment syndrome and about the failings at the Haslar Hospital.

A There is a much better definition of compartment syndrome there than I gave half an hour ago.

Q That may be the case, although for my part it was sufficient for us and in fact, as it is not a criticism that you would level at the Gosport War Memorial Hospital in any way, I am not proposing to ask you more about that. From the bottom of page 17 of your report, in the final paragraph, you did have some conclusions that may be relevant for us. What is your opinion in terms of whether it would have been reasonable for any of the doctors who were looking after this patient to have considered the issue of the failure of the fixation of the fracture?

A The fact that she remained in pain throughout the entire episode. I could understand her not being able to mobilise because of general debility – it is not uncommon in patients with femoral fractures of this kind – but for mobilisation to be painful and to continue to be painful and to fail to improve would have concerned me, certainly by the end of the first week.

Q So after that and whilst she was in the Gosport War Memorial Hospital, what is your view on whether consideration should have been given to that?

A A It is consistently mentioned in the nursing records and in the medical records that she finds it painful to mobilise. Now, that really should not be happening at that point and the correct thing to do at that point would be to put her on to bed rest, take an x-ray and check that the implant fixation is sound.

Q Is that something that you suggest would be an appropriate course of action for just an orthopaedic doctor or for any doctor having the care of this lady?

B A I train non-orthopaedic, non-surgical doctors at a very junior level: first and second year post qualification, and I would expect any of them to execute that course of action.

Q Would that course of action have been confirmed as necessary by the review by Code A in terms of the shortening of the leg?

A It appears that – one can only surmise, but he makes the comment that the leg is shortened and requests the x-ray. So it would seem that it was fairly much in the fore of his

C thinking.

Q In terms of the treatment for a possible deep infection at the Gosport War Memorial Hospital, what was your opinion on ultimately whether the treatment given was appropriate or not?

A My conclusion was that the choice of antibiotics given at the beginning was reasonable, given the context of the patient as far as I could understand it from the case

D records. I would have reviewed the antibiotic medication on receipt of the microbiology report and at that time stopped the metronidozole and started flucloxacillin, but continued with the ciprafloxacillin.

Q You make a point in your report about appropriate secondary investigation.

A Yes. If the possibility of a deep infection or abscess were entertained, then the best investigation would be an ultrasound scan of the thigh.

E

Q Who would that be referring to?

A The actual ultrasound would be done by a radiologist, but it would be requested by a doctor. May I expand on that a little?

Q Yes, of course.

A I think that that is something that might not fall within the scope of a non-orthopaedic

F doctor.

Q In terms of evaluating it?

A Evaluating and recognising that it might come back to an orthopaedic opinion before an ultrasound would be requested. So it might have to come back to orthopaedics and at that point I imagine that investigation would have been requested.

G Q That rather leads on to the next question, which is whether it would have been reasonable to expect a doctor at the Gosport War Memorial Hospital to have referred this patient back for an orthopaedic review in light of the symptoms that she was displaying?

A Yes, I think that would have been the reasonable course of action.

Q You commented in your report, and it is the bottom of page 18 and then on to page 19, about whether these possible diagnoses were reversible. Can you help us with that?

H A Do you want me to comment on the compartment syndrome?

Q No, not for my purposes.
A The failure of the implant fixation is reversible. It is reversible by revision surgery. It is not common, but there are standard procedures in place for that. The deep infection is reversible as long as the infection does not get completely set on the implant. The difficulty with implants is that they do not allow blood into them, unfortunately, so you can very rarely completely eradicate an infection from an implant. You can keep it under control. So it is reversible to that extent.

Q In terms of controlling somebody's pain, or improving their mobility, is that something that can therefore be helped in that regard?
A Yes. There is a spectrum of infection from the more superficial and less serious infections which can be dealt with by antibiotic treatment, either by tablet form or intravenously, or if infection has become serious, or if abscesses develop, then surgical treatment of an infection may be necessary.

Q On page 20, your second paragraph on page 20, you make some conclusions about treatment at the Gosport War Memorial Hospital. Could you help the Panel with your view on what diagnoses there should have been, whether they are differential diagnoses or not, and what action should have been taken?
A The two possibilities that I reached for a differential diagnoses were that the implant had failed or that she had an uncontrolled infection, or indeed possibly both, which I do not state explicitly. I said that as a consequence it would have been prudent for further orthopaedic opinion to be sought.

Q Further investigation to have been carried out?
A Further investigation by way of a plain X-ray or an ultrasound of the thigh.

Code A Yes. Very well. Those are all my questions, thank you, but there will be some more.

THE CHAIRMAN: I think we have reached the point, Code A at which we will give the witness a break. You have been on the stand for an hour.
A Have I?

THE CHAIRMAN: It sometimes passes very fast, does it not? I will try and break at about this sort of interval, but I should tell you that if at any time you feel in need of a break you only have to say so and we will adapt to your comfort and convenience, but for now you remain on oath, the Panel assistant will take you somewhere where you can get some refreshment, and we will return at 5 minutes to 11, please. Thank you. I should say please do not discuss the case with anybody. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Code A, I stopped you before you could start.

Cross-examined by Code A

Q You are refreshed now, Code A, so you are ready to deal with me. I have not got many questions, but can we just go back over the history for this lady.
A Yes.

Q She broke her hip on 19 March. We see that on the front page of the chronology. We know that by the 24th, this is page 7, and we see the date on the previous page (page 6) the date is given as the 24th, there is a ward round at the Haslar Hospital and a Code A is being suggested as someone who can undertake an assessment. We have Code A assessment over the page at page 7, and then Code A assessment. So this is five days after her fall.
A Yes.

Q Code A we have already noted, and it is recorded in the entry on page 7, that he is asking for reassurance that all is well from an orthopaedic viewpoint; if all is well, then he would be happy for her to be transferred to the Gosport War Memorial Hospital. Your point, I think, is that this lady was not properly investigated whilst she was at the Haslar.
A In the context of what, the implant---

Q Well, I think the way you have put it in your report, which the Panel do not have, you say that it is of grave concern that no further action seems to have been taken in relation to the diagnosis of compartment syndrome, looking at page 19.
A Yes. In relation to the diagnosis of compartment syndrome?

Q Yes.
A That is why I asked in what context. Yes.

Q You say:

"In my opinion this lady had a significant bleed into her thigh in the early stages post-operatively" -

we are talking about the few days after the operation.
A Yes.

Q "and the possibility of compartment syndrome was raised. Once the diagnosis of a compartment syndrome had been considered" - in other words raised – "then it is of grave concern" – your words – "that no further action seems to have been taken in relation to this potentially serious diagnosis."

The suggestion I have made is that this lady was not investigated as thoroughly as she could or should have been at the Haslar Hospital.
A She probably did not even need to be investigated further. To explain the management of compartment syndrome---

Q Right.
A ---it is a clinical diagnosis. Really, almost once the possibility has been raised that a patient has compartment syndrome, then there is an obligation to act upon it.

Q What you have said in your report is that you would expect a basic level surgical doctor, junior doctor, to be able to make the diagnosis.
A Yes.

Q But that a GP perhaps would not be in that position?
A A general practitioner might not be in that position.

Q The time that that should have been considered properly was when Code A was at the Haslar Hospital?
A Yes.

Q It is not apparent that it was.
A That would appear to have been the case, I agree.

Q Again, Code A indicates that he was seeking reassurance that everything was well orthopaedically. It was not in your view?
A That was at five days after the surgery. The issue of the compartment syndrome was a few days before that, if I could just refer back to the chronology.

Q Please do.
A Yes, it was the 21st, which is sort of 48 hours post-admission and 24 hours post-operatively approximately. That is when the issue of compartment syndrome was raised.

Q Right.
A The issues related to compartment syndrome would probably have blown over by four or five days after the surgery.

Q Okay.
A That episode would have been completed and the damage done.

Q Okay. You also say, and I am just going on in your report:

> "Code A early failure to mobilise and the pain that she described consistently on moving her injured leg should have given the doctors caring for her at Haslar sufficient reason to consider appropriate investigation by way of a further plain x-ray of the hip and thigh."

A Yes, I think that is fair.

Q "This would have eliminated the possibility of fixation failure."
A Yes, at that point.

Q You say:

> "It seems from the medical record that these issues occurred prior to transfer to the Gosport War Memorial Hospital."

That, it would appear, was not really done.
A Yes, that would appear to be.

Q Does it follow that if you had been treating this lady you would not have been in a position to give Code A the reassurance he was seeking?
A I do not think I would.

Q Now, would it be your view that this lady was transferred out of the Haslar Hospital before properly she was ready for it?
A I would say that she was.

Q Yes. Once she arrived at the Gosport War Memorial Hospital, it is clear that this lady was still reluctant to mobilise and in a great deal of pain.
A Yes.

Q We know that she was given medication for the pain and swabs were taken. We have indications of that on the notes. If you turn, please, to page 17 of the summary, we see in the nursing care plan that swabs were taken. We have got indications in the medical records that those were sent off for analysis. If I can invite you to turn to the medical records for this patient, Patient I, if you still have them, and if I can invite you to turn to page 59 we will see that this is one report, and from the bottom left hand corner we see that this is a wound swab from the calf.
A Yes.

Q It is collected on 6 April 99, so that ties in with the date that we have just looked at on the chart. We will see, as we look along the bottom line, it is reported on 8 April, and we see a stamp when it is received on the ward. That would be typical, I think, a stamp or a date to be written on?
A Either when it is received or when it has been reviewed. It depends on the practice.

Q You would expect a doctor, when they review a result such as this, to initial it or sign it to say that they have seen it?
A Yes.

Q The Panel will hear in due course that that is Code A initials, which she entered. We see that it comes back, or is seen on the 9th. This is headed "Provisional Report!" We see that the culture result shows that staphylococcus aureus is isolated but that sensitivity tests were to follow; staphylococcus epidermidis again isolated. I think we have to look at the preceding page, page 57, to see when those sensitivity tests were reported. It took an extra day for that to be reported. The stamp at the bottom of the sheet, the date reported is 9 April.
A Yes.

Q The Panel will hear, I think, that the weekend (Saturday and Sunday) was 10 and 11 April. Signed by Code A and it is stamped as seen or received on the ward on 12 April, so a Monday?
A Yes.

Q What you have told us was that the antibiotics introduced by Code A, we have them on the summary at page 18, you have told us that those antibiotics – metronidazole and suprox we have called it on the summary – those were a good best guess at that stage.
A Yes.

Q We know, because we have just seen the results, that the swabs have not been reported on by 7 April.
A Yes.

Q We will see from the next entry down that:

"Commenced antibiotics as hip wound may be infected."

That was the view, I think, at that stage?
A Yes.

Q These antibiotics were brought in to deal with the infection that was probably there, but had not been identified.
A Yes.

Q What you have told us is that it might have been appropriate to review the antibiotics once the results had come in.
A Yes.

Q We know that was by 12 April. I think if one follows through the chronology, we will see that on page 20, on the night of Saturday, 10 April, it looks as if this lady had a stroke.
A I cannot comment on that.

Q All right. Her condition was very poorly on the 11th. The entry that we have in the summary, relating to page 134, suggests that she was seen by Code A I am going to invite you and the Panel to turn up page 134, because it may be that the entry needs a bit of explaining.
A This is still in file I?

Q It is still in file I. There are two page numbers at the bottom of page 134. The other number is in a rather fatter pen, 107.
A Got it.

Q What we see for 11 April 99 in this nursing summary document is an entry which would appear to be written after 7.10 p.m., because it starts by relating something that happened in the evening on that Sunday night. The inference I suggest to be drawn is that this is an entry made by night staff, and we will see the very end of what the night staff entry is, the very last thing they write is "Seen by Code A ". I do not know that you can comment on it, Code A , but I am going to suggest that that was Code A seeing the patient first thing on the Monday morning. It is the last thing that the night staff saw at the end of their shift. Again, we have to go back to page 57 because we know that the pathology report was seen or arrived on the ward on 12 April, and that is when Code A signed it.
A Yes.

Q You have told us that it would have been appropriate to alter the antibiotics once that report had come in, and I think what we see is that the consultant Code A is reviewing the patient again on that day, page 136, just after the 134 that you were looking at, yes, but I think what we have is a full clinical picture of this lady, that she is in a very poor condition, and I think it may be you would agree that the orthopaedic considerations were not at the front of the consultant's mind?

A That might be reasonable, but again it is difficult for me to comment without---

Q I understand. So far as an X-ray is concerned, you have said that an X-ray was clearly sought. If we look back at the summary, page 18, swabs had been taken on 6 April. The summary, page 18, deals with the day after that. We see the entry in the clinical notes. Code A, the consultant, has ordered an X-ray. If we are able to go back to page 134 of the notes, we see in a little more detail as to when the X-ray was actually booked for.

A Yes, I have that.

Q It is just about a third of the way down the page. It is the entry for 7 April. It reads:

"[Seen by] Code A For X-ray tomorrow at 15.00 hours".

A Yes.

Q Obviously the 8th. But you have not seen an X-ray that relates to the X-ray that was booked. If we go back to the summary, page 19, if you would, the bottom of the page, we see entries indicating Code A wanted the patient to stay on bed rest until he saw an X-ray of the hip. You told us that was the way in which you would want to see the patient managed?

A Yes.

Q Off her legs?

A Yes.

Q Until the X-ray was undertaken and reviewed?

A Yes.

Q That clearly was the plan. That was a Friday. Code A was due to come in on the Monday for a ward round and we know that he did by Monday the 12th. Again, it may be that the X-ray was not in the forefront of the mind, given this lady's condition. She was to die that night.

A We do not actually know whether the X-ray was taken.

Q We have not seen an X-ray in the records.

A So we do not know whether the X-ray was actually taken.

Q No. I think that notes that we have do not indicate that it was or was not taken, or if it was not, why it was not. Can I ask, if this lady was to be reviewed by an orthopaedic surgeon, you would anticipate in a community hospital she would have to be transferred back to a hospital such as the Haslar?

A I do not know what the local arrangements are at the Haslar. There are two ways of doing this.

Q One way is to ask a surgeon to come in?

A Yes.

Q What I am going to suggest is that in practice she would have had to be transferred?

A What – as an inpatient?

Q That surgeons from the Haslar would not have wished to come over to the Gosport War Memorial Hospital to review a patient.
A Then she could have been seen as an outpatient or in an outpatient clinic.

Q I understand. At the time that would have been on 12 April?
A There is ample opportunity before that for her to be seen. This process began long before the end of April.

Q I understand. 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 go revision surgery.

Q Yes?
A And had she passed that assessment, which is usually done by the anaesthetist who is schedule 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 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.

Q I understand. It is well recognised that general anaesthetic itself carries risks?
A It is.

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.

Q Under anaesthesia?
A Yes.

Q The patient has to be fit enough to undergo it?
A Yes.

Q And be able to come round afterward?
A Yes.

Code A: Thank you very much.

Re-examined by Code A

Q Code A there are just two matters. Forgive me if they seem obvious, but I just want to clarify them. The first is that you agreed with the suggestion that in your view the transfer from Haslar Hospital to the Gosport War Memorial Hospital took place too soon?
A In my opinion.

Q Because there were other things, other investigations, that you thought should have taken place there first?
A Looking at the case file in its entirety, it looks as though that is the case.

Q The question is therefore – and forgive me, as I say, if it is obvious – with that fact in any way remove the need for later doctors to consider an orthopaedic referral?
A No.

Q The second point is simply this; you were explaining to Code A a moment ago that there was ample opportunity before 12 April for the orthopaedic referral to happen, and that the process started long before then. Could you just explain what you meant by that?
A Again, on my review of the case records, problems with mobilisation were present from the day that she was transferred which was the 26th, I think she was eventually transferred over. The 26th March.

Q Yes.
A There is assessment on the 24th and she was transferred on the 26th. Right the way up to the weekend immediately before she died. At any time there the consideration ought to have been given that there was something amiss.

Code A: Thank you. Those are the matters I wanted to clarify.

THE CHAIRMAN: Thank you very much indeed. Code A we have reached the stage I mentioned at an earlier point this morning. The barristers have completed their questions and it is now open for members of the Panel to ask questions of you, if they have any. I am going to turn now to see if we do have questions. Yes. Code A is a medical member of the Panel.

Questioned by THE PANEL

Code A I am a physician. Just thinking about your evaluation of this lady at the beginning of her third week, the 15th day – this is 9 April. This is about the staph aureus swabs coming back and she is described as ill and not drinking. "Irritable. Leave me alone." From what you know of this lady, can you thinking for the lay members of this Panel, of any possible medical causes for that condition?
A As far as I understand from the documentation prior to her fracture she was independent, living alone and mobilising without assistance. She was not on any medications as far as I am aware. So her pre-morbid state was reasonable. It is very difficult to say but it would fairly exclude, say, any dementing process for example. She presents as somebody who might have a derangement of her electrolytes. Most commonly in my experience the derangement of her electrolytes or an infection would cause similar features as you describe.

Q Indeed, one of your concerns is that she may have had a deep infection in the machinery that is in there?
A That is right, yes.

Q Forgive the physician's view of your world. Such an infection can be severe, can it not?
A It can.

Q And cause very important systematic effects on the patient, on the whole patient?
A Yes. It is well recognised as a cause of alteration in demeanour. I am struggling for the right word. Confusion. That is the word. It can cause confusion.

Q What I am coming round to and asking is, as an orthopaedic surgeon with such an ill, old lady is the situation irremediable?
A What?

Q If it is an infection.
A What? The condition of upset that she had?

Q Yes.
A No. It is absolutely remediable. You run a standard set of tests, a standard set of sources of infection are looked at, including the wound, the urine, if necessary the chest. The chest is listened to – not necessarily X-rayed – but there is a standard set of things that you do in those circumstances.

Q At this late stage when she is really ill?
A Well, yes. I would. I have done that, yes.

Q Going back to what Code A was asking you about, operating on frail old ladies, is it not a kind of dictum in your world that if you do not operate on some people they die, so it is worth operating on them on the chance that they may survive.
A This is part of the reason we set the bar so low for the threshold for proceeding to surgical fixation. It is recognised that fracture of the femur represents a biological state as well as a pure fracture. Some of what we do is actually to a degree palliative but it is well recognised that if we do not operate on people with hip fractures and get them fixed and mobilised, then it shortens their life expectancy.

Q Would you expect a physician to have that similar view as a general physician?
A It has been a dictum for 25-odd, 30 years now, so...

Q Would you expect a general practitioner to understand that?
A I have to say, I probably would these days because... I probably would. I think it is that well known.

Q Would you expect nursing staff, whose job it is to receive patients from an orthopaedic unit, to know that?
A I would expect them to know. In the rehabilitation unit I would expect them to know that.

Q If there was proper liaison between the two units?

A A Yes.

Q And the scene was set for safety?
A If they are regularly receiving patients, then they ought to be aware of that.

Q In your opinion should this lady have died in Gosport War Memorial Hospital?
A It is very difficult for me to answer that.

B

Q In your opinion might she have had a better chance if she had been reviewed by an orthopaedic surgeon?
A I think she would have had a better chance had she been reviewed.

Q And that such a review is not a difficult thing to arrange, one way or another?
A No. It is fairly standard for patients to be sent to rehabilitation units and then sent back if there is something amiss.

C

Code A Thank you very much.

THE CHAIRMAN: Code A is a lay member of the Panel.

Code A What I am trying to clarify is, if you can, what weighting you would give to the fact that in your opinion she was transferred too early and the seeming lack of review. What had a great impact, if that is a fair question?

D

A The answer to that depends on me surmising that her fixation had failed. Had her fixation not failed, then it is difficult to say whether it would have had an effect or not. If the fixation had failed, then I think it would have been picked up earlier at the Haslar Hospital. Does that help?

E

Q Yes. It would have been picked up earlier, and so the outcome would have possibly been ---
A Earlier intervention.

Q Resulting in ---
A Resulting in the fracture healing and her being able to mobilise.

F

Code A Thank you.

THE CHAIRMAN: Code A is a lay member of the Panel.

Code A Code A I am not certain whether this is going to be really significant or not. There is something I did not quite understand. When you were talking about the microbiology report you said, or I understood you to say, the drugs were reasonable best guess, and I understood you to say "particularly as the lady was incontinent"?

G

A Yes. My best guess as an orthopaedic consultant would have been an anti-staphylococcal agent. I would have used a flucloxacillin and erythromycin or something similar.

Q As a lay person, could you break that down so that I can understand?

H

A The bugs that were growing the staphylococcus and different bugs are sensitive to different types of antibiotics, so one antibiotic is particularly good at treating one bug, fairly good at treating another and no good at all at treating another.

Q Right?
A So the commonest infection that occurs in orthopaedics by a street is staphylococcus infection. It is your number one suspect. If I was doing something on an empirical basis – best guess basis – I would have an anti-staphylococcal agent in there like flucloxacillin, which is probably the best. The antibiotics that were chosen: one is ciprofloxacin, which is a very broad spectrum. It will pick off a lot of bugs, but its direct action against staphylococcus is not as good as flucloxacillin. The other antibiotic that was chosen was metronidazole, and metronidazole is good against what are called gram negative bacteria, which are things that are found in the earth or in faeces, for example. So if a patient were faecally incontinent, then they might contaminate a hip wound, it being close enough proximately. So it was reasonable for those two antibiotics to be chosen.

Q But how would it have been different if the person had not been incontinent?
A I do not think there was ever... I did not find anything in the record that she was faecally incontinent.

Q No. That is right. I think there is a slight anxiety for me that this elderly lady had not been incontinent and then had gradually become, or there were indications of incontinence. I was trying to work out in my own mind, is that because this lady was actually incontinent, or is it because of the poor mobility and the worries, et cetera, of actually getting out of bed, because there was not previously ---
A Incontinent of urine.

Q --- incontinence of urine. Yes – incontinence of urine.
A It is quite common following hip surgery. Quite common.

Q So when you talk about incontinence, I have to link that to the faecal incontinence, not the urine incontinence?
A Excuse me. As far as the metronidazole is concerned, that is anti-faecal so in my book it is anti-faecal prophylaxis.

Q So the incontinence that we are saying may not necessarily be a sign of deterioration of the patient per se, but rather the incontinence of the urine, or can be a symptom of the fact that they are less mobile because of the pain?
A It is a transient feature commonly of people who have hip fracture.

Code A: Thank you. That has helped me to understand that.

THE CHAIRMAN: It is just me now, Code A I am also a lay member of the Panel. Can I ask you to address your minds to the time when this patient was first admitted to Gosport and, in particular, was assessed by Code A There is reference to it in the schedule on page 10 referring to the clinical notes on page 27 in the bundle, although they are quite helpfully produced for us in the first column in the schedule if you have difficulty in reading the handwriting in the bundle.
A Yes, I have those records.

Q Given what you have already told us about your misgivings as to the status of the patient at the time that she was transferred and the fact that in your view this should have been spotted at Haslar, I need to ask you specifically about the assessment that took place when she arrived in Gosport. From what you can see of the notes and what you know that the patient would have been exhibiting by way of symptoms at the time that she would have arrived, are you able to make any comment on the adequacy of the assessment that was made on her at that time?

A It seems a fairly sparse assessment at first glance. There is not an examination of the wound, for example, there is not an examination of – it is stated that she is not weight-bearing and that is the only assessment of the hip fracture that I can see in that record. Other than that, it does not appear that the patient's hips or legs have been examined.

Q Do I take it that is something you would regard as essential for the discharge of one's duty of proper assessment or not?

A Well, she has been transferred to a rehabilitation hospital. That is the difficulty I have with answering that, because I do not operate in that sphere. I operate in the sphere of orthopaedic acute admissions. That is probably a question that should be asked of a consultant who has a special interest in the care of the medical elderly.

Q The adequacy of the assessment is a specific question that this Panel is going to have to decide at some point in the future. If you do not feel that you are the appropriate person to comment on that, then I will not press you further on that point.

A This assessment was made in the rehabilitation unit, so I think it is probably not appropriate for me to comment on that.

Q Can I ask you a more general point from your experience of hospitals and records? You appeared to be expressing some surprise or perhaps concern that so far as the x-ray which had been ordered was concerned, there was no apparent note one way or the other to indicate whether the x-ray had actually been taken.

A I am surprised that there is no record of the image anywhere. In fact, there are no x-rays available for any of her orthopaedic episodes as far as I am aware. They are unretrievable.

Q One point then is the retrievability. No doubt that is something that counsel on both sides have explored already. The other is the note that we have ourselves is the nursing note. Would you expect there to be a reference to, "Patient sent off for x-ray"?

A Yes. I would expect it to be in the nursing record, "Patient went for x-ray today at X, Y, Z. Returned at A, B, C."

Q Where there is no such indication, are you able to make any inference?

A My inference is that the x-ray was not taken.

THE CHAIRMAN: Thank you. That is all from me. Now we are at the point where I have to ask the barristers whether they have any questions arising out of the questions that were asked by members of the Panel. I am going to turn first to Code A

Code A: I do not, thank you.

THE CHAIRMAN: Code A?

Code A: No, thank you.

THE CHAIRMAN: So I am pleased to be able to tell you that does complete your testimony. We are most grateful to you for coming to assist us today. It is only through the presence of witnesses such as yourself that this Panel is able to get a clearer picture of what happened often months, even years, in the past and for your assistance in that regard we are extremely grateful. You are now free to go.

(The witness withdrew)

Code A: The next witness is Code A please.

Code A, Affirmed
Examined by Code A

(Following introductions by the chairman)

Q I think it is Code A. Is that right?
A That is right.

Q Code A, so far as your involvement in the various inquiries into what happened at the Gosport War Memorial Hospital is concerned, I think you have made a number of statements – is that right? – the first starting in 2000 in relation to Code A and then you were making statements in 2004.
A That is right.

Q Then in 2006, you were interviewed by the police in July and August I think over a period in excess of 20 hours.
A That is right.

Q So you have said a great deal about the events particularly concerning three patients. I am going to ask you some questions about that period in your life. If you find it difficult to remember, please just say so and if you need to have reference to material, then we may well be able to assist you. You will be able to have the patient notes in front of you when you are referring to them. Can I ask you first about your own medical background, please? I think so far as your own qualification is concerned, you qualified in Glasgow in 1974.
A Yes, that is correct.

Q You became a member of the Royal College of Physicians in 1978, a Fellow at Glasgow in 1988 and a Fellow of the Royal College of Physicians in London in 1990.
A That is correct.

Q As far back as the late 1970s and early 1980s, I think you were then beginning to consider a career in geriatric medicine.
A That is correct.

Q You became a consultant in geriatric medicine at Southampton General Hospital in August 1982.
A That is correct.

Q Did you remain there until about March 1998?
A That is correct.

Q Then I think you took up a role in April 1998 as a consultant in geriatric medicine and also medical director of the East Hampshire Primary Care Trust.
A First of all, it was Portsmouth Healthcare Trust.

Q That was its former name, as it were.
A Yes.

Q Then it evolved into the East Hampshire Primary Care Trust.
A Yes. I had a similar role with Gosport Primary Care Trust.

Q I want to deal, please, with your occupation since April 1998 as a consultant at Portsmouth. Where were you based?
A When I first started, I was based at Queen Alexandra Hospital.

Q Is that in the Portsmouth area?
A Yes. That is in Portsmouth. At that time, there were two district general hospitals in Portsmouth: the Queen Alexandra and St Mary's, and we had beds in both hospitals.

Q I think in early 1999, you took on the responsibility of one of the consultants at the Gosport War Memorial hospital.
A That is correct.

Q How many other consultants were there who were looking after patients at that hospital?
A One: Code A That is inpatients I am talking about.

Q How did you take on that role? How did it evolve that that hospital required a consultant?
A There had always been, as I remember , one consultant who oversaw Daedalus Ward and one consultant who oversaw Dryad Ward and our responsibilities were rotated every now and again.

Q I think you remained in position from early 1999 to about March 2000.
A That is correct.

Q That was as consultant specifically for the inpatients on Dryad Ward.
A That is correct.

Q In that role, did you come across Code A
A Yes.

Q Had you had dealings with Code A prior to that?
A Not to the best of my recollection.

Q You were aware no doubt that she was a local general practitioner.
A Yes.

Q And she had taken on the job of clinical assistant at Gosport War Memorial Hospital.
A Yes.

Q Were you aware that prior to the move to the Gosport War Memorial Hospital, she had worked in the same position at the Redclyffe Annex?
A No, I was not aware of that.

Q Were you aware that prior to you arriving there, she had been in post for quite some time?
A Yes.

Q Did you understand the position to be that when Code A was not available, her work would be undertaken by locums, effectively partners at her practice?
A That was my understanding.

Q So there was an agreement of cover by the partners at her practice in relation to both Daedalus Ward and Dryad Ward.
A That is my understanding.

Q What role did you have in a supervisory context in relation to Code A?
A Well, as the consultant in charge of the ward, I am ultimately responsible for the medical practice within that ward. At that time, I conducted a weekly ward round. My colleague, Code A also conducted a weekly ward round. Both ward rounds I think were on Monday afternoons, which meant that – in an ideal world, one would wish the clinical assistant to accompany one on the ward round. To try and overcome that problem, Code A would attend my ward round on a fortnightly basis and on the alternate Monday would attend Code A ward round.

Q So you would be going along to Dryad Ward once a week.
A Yes.

Q That was Monday afternoons, was it not?
A Monday afternoons.

Q Code A would join you on your ward round once a fortnight?
A At best.

Q At best. Does that mean there were occasions when she was not able to make the ward round?
A That is correct.

Q How long would your ward round normally take and what would you do?
A It was about three hours long and I would, with the senior nurse on duty and Code A if she were there and with the senior registrar if one were attached to me at the time, take the notes trolley and do a ward round. In other words, look at every patient.

Q If there were patients causing Code A particular concern, would you discuss those with her, or would you expect those to be raised with you so that you could discuss those with her?

A A Code A, if she was there, would raise issues with me. If Code A were not there, then the nursing staff would point me in the direction of the patients who were causing concern.

Q Tell us something, please, about your understanding of Code A experience and seniority?
A She was a very experienced general practitioner who had been functioning in that role
B at the War Memorial Hospital for I think ten or 11 years before I arrived there.

Q Did you come across Code A when you were there?
A Yes, I did.

Q Would she on occasion accompany you on ward rounds?
A Yes.
C

Q Were there occasions when both Code A and Code A accompanied you, or would it be one or the other?
A There would always be a senior member of the nursing team there, and Code A if she was available.

Q In general terms how would you say that the ward was run?
D A Very well.

Q Your appraisal of Code A?
A I beg your pardon?

Q Your appraisal of Code A? What would you say about her?
A I thought she was a very kind, caring ward sister.
E

Q By the time you arrived in 1999, as you have already indicated, I think, both of those individuals would have been at that hospital for a fairly considerable period of time?
A Correct.

Q How easy did you find it coming into your post and having to take charge, as it were?
A Well, I do not recall encountering any sort of great difficulty. I felt that the nursing
F staff were very mature, sensible nursing staff, and I found in general it was a pleasure to work in that ward.

Q We have heard a certain amount about how full the ward was at various times.
A Yes, that is correct.

Q You were able to get through all of the patients in an afternoon, were you, or not?
G A Yes.

Q Did the occupancy of the beds vary from time to time?
A Not greatly. I would say most of the time the beds were one hundred per cent occupied.

Q In that respect, can you remember whether you had any conversations with Code A
H about how busy she was?

A I recollect having a conversation, I think it would be in early 2000, about the pressures of the job.

Q Can I ask you a little bit about the sort of patients that were occupying those beds on Dryad Ward? What sort of patients did you deal with?
A Well, largely they were continuing care patients, in other words patients who were going to be there for the rest of their lives. That was a little bit different from my previous post in Code A, where most of the type of patient who were in Dryad Ward at that time would actually have been in a nursing home. So that was slightly unusual. I said in statements that over the course of that year, I think that because of the move of patients who would formerly have been NHS long term continuing care patients out into nursing homes, we started to have beds become free on the ward, and at that time, even as there is now, there is always huge pressure at the front door of the hospital to move patients on who can be moved, and we were sort of put under pressure to take patients who might not be continuing care, in other words the sort of patient who I would describe as they have not made a full recovery from their illness, not quite clear in what direction this patient is going to go; are they going to get better or might they become a continuing care patient.

Q Does that indicate that those patients required more care?
A They could be more physically dependent. What they might also warrant though is occupational therapy and physiotherapy assessment, but it is also possible that they could have been less stable medically than patients who had been previously transferred over.

Q Now, some of those patients of all groups presumably at one stage or another might require analgesia.
A Yes.

Q I want to just examine with you for a moment what your understanding at the time was. Did you know of the principles of the analgesic ladder?
A I was aware of the principles but not the term.

Q Your understanding of the principles would be what?
A That one would generally make an assessment of a patient's pain, and broadly speaking there are three levels of analgesia: paracetamol; secondly, non-steroidal or mild opiates; and, thirdly, strong opiates.

Q The principle of the analgesic ladder would be what in dealing with a patient's pain?
A To ensure that the pain was appropriately managed with the correct level of analgesia.

Q We know also that a number of patients who were looked after on Dryad Ward eventually went on to a syringe driver.
A Yes.

Q Can I ask you, please, what your experience prior to starting this job at the Gosport War Memorial Hospital had been of syringe drivers?
A Very limited.

Q What does that mean?
A Well, where I had worked before we did not have continuing care patients, and we had a palliative care ward on site to which one could refer for advice or indeed transfer

A patients over, so we were not dealing with many patients who were at the end of their lives and needing palliation.

Q So previously if you found a patient did need palliation, then you would refer them over?
A Possibly. I mean, I might on occasion deal with it myself, and if I felt that I was managing the patient appropriately I would be content with that. If I felt that the patient's
B pain control was causing me problems, then I would refer on.

Q Okay. Prior to beginning your work at Dryad Ward, had you yourself prescribed syringe drivers to people, with opiates?
A I think yes, but I could not be absolutely sure.

Q Is that an indication that if you had done it was not a common thing for you?
C A It is not a common occurrence.

Q Dealing with opiates, the various styles of morphine that there are, what experience had you had prior to coming to this job at Dryad Ward prescribing morphine?
A Probably prescribing morphine on occasion, and on occasion diamorphine.

Q For what purposes?
D A Well, usually for pain control, but also for people who might be distressed in the terminal stages of an illness, where it was unclear whether the distress was mental distress or physical distress or a combination of both.

Q It may be obvious, but when you are talking about the terminal stage of an illness, these are patients who are very ill?
A Yes.
E

Q As you know, because you were asked about it by the police, because on some occasions at least you saw it, variable doses were prescribed by Code A
A Yes.

Q Those were variable doses of, among other drugs, diamorphine.
A Yes.
F

Q Had you, prior to coming to the Dryad Ward, come across variable doses of diamorphine?
A Possibly. I mean, it is so long ago and I did not see many patients in my previous career who required syringe drivers, I mean, possibly on one or two occasions, but I really could not say.

G Q Can you recall an occasion or occasions when you discussed variable doses with Code A ?
A Yes, I remember one occasion.

Q What did your discussion revolve around?
A It revolved around the sort of, if you like, principle of variable dose prescribing. I asked Code A why she was prescribing a variable dose and she indicated to me that that
H was because at times she herself was not immediately available, or her partners might not be

A immediately available, and particularly at a weekend when she or her partners might be engaged in visiting patients at home, so as to allow a patient's distress to be relievable quickly rather than to wait for a doctor to attend she prescribed it for that reason, and I accepted these reasons.

Q What sort of variable doses did you think you were discussing with her, or were you discussing with her?

B A Well, I do not have a clear recollection of actually discussing a dosage range, but my recollection was that it was in relation to a patient who had received 20-80mg.

Q You raised that with Code A ?
A Yes.

Q Did you ever have any discussion with her about ranges such as 20-200mg?

C A I do not recollect having such a discussion.

Q Had you come across that sort of range prior to Dryad Ward, first of all?
A No.

Q Have you ever come across it since?
A No.

D

Q At the time did you realise, and we will have to look at some prescription sheets in due course, that those sort of prescriptions were being written by Code A ?
A No. I was certainly aware of variable dose prescribing, but I cannot recollect seeing prescriptions for 20-200.

Q If you had seen such a variable dose, is that something you would have potentially

E raised, or not?
A I should have raised that with Code A

Q Now, we are also I think in due course going to hear something about anticipatory prescribing.
A Yes.

F Q Have you heard that expression before?
A Yes.

Q Is that something that you have come across elsewhere or only on Dryad Ward?
A I have come across it elsewhere, and in fact we practise anticipatory prescribing on our palliative care ward in Queen Alexandra Hospital today.

G Q Just give us examples, please, of the appropriate ways that anticipatory prescribing can be performed, in what circumstances.
A Well, as I say, it is on the palliative care ward and it is usually the type of patient who again has been very ill, it is not really clear which course their life is going to take, in other words are they going to recover from this illness or might they soon become terminally ill; in other words, the timescale I am thinking of is becoming unwell within the next few days.

H Q What sort of anticipatory prescribing would you then expect, or might you find?

A A In terms of, what, the range of drugs, or dosages, or---

Q First of all, drugs, and dosages.
A Well, I am not involved with the palliative care ward at the moment, but diamorphine is obviously one. I think midazolam and haloperidol, and there is a fourth, and I am not sure off the top of my head what the fourth drug is.

B Q The sort of dosages that you come across in appropriate patients would be what?
A I honestly cannot tell you---

Q You cannot assist.
A ---what the current practice is in the palliative care ward.

Q All right. What would you say about the concept of anticipatory prescribing of
C opiates for patients who were not then in pain?
A Well, I think in the circumstances I have just described, if somebody is very frail, been seriously ill, in whom one did not know which direction their course were to take, I think it is not unreasonable, in fact good practice, to think about anticipatory prescribing, because I think it is better that doctors who are experienced in doing that do it during nine to five, in other words the patient has been seen by someone who is practising every day in palliative care rather than leaving the prescribing to out-of-hours junior doctors who may
D know very little about informed palliative care prescribing.

Q If the doctor is going to write out an anticipatory prescription of that nature, what sort of instruction, if any, would it be necessary to go with that sort of prescription?
A I think on the prescription chart there is a sort of small square for indication for pain, for distress, usually an indication about how frequently the drug may be administered, and obviously the dose.

E Q That would be an instruction to whom?
A For the nursing staff.

Q In terms of the ability to increase a dose, and I am sticking to opiates for the moment, again what was your understanding of the incremental nature of the increase in doses of morphine?
F A Well, at that time, and I would have to confess it reflects my sort of inexperience of palliative care prescribing, but I would have thought that doubling the dose every day would have been appropriate, but I had very limited experience of palliative care prescribing. That would have been my understanding at the time.

Q You are referring to palliative care prescribing, palliative in those circumstances meaning in your mind---
G A Well, I think I am talking about any, sort of – where a patient is in significant pain and distress for whatever reason, they may be palliatively unwell or in pain or distress for some other reason.

Q If you had at that stage been required to prescribe opiates, would you yourself have wanted to check in the *BNF*, or not?
A Almost certainly.
H

Q Now, the *BNF* of course is a guide.
A Yes.

Q It is not a protocol. It does not require you to stick, as it were, to it, but to what extent would you have followed the guidance in the *BNF*?
A I think if it was any departure from normal, or if I encountered a patient on a preparation with which I was not familiar, then I would certainly look at the *British National Formulary*.

Q Did you also have an understanding of conversion rates from oral morphine to subcutaneous morphine?
A I think perhaps you mean subcutaneous diamorphine.

Q You are quite right, I do mean diamorphine. I am using morphine as the generic term.
A I mean, my understanding at that time was a conversion factor of 2 to 1, although that has since been amended to sort of 3 to 1, in other words you would half or third the dose of morphine to convert to diamorphine.

Q At the time in 99, when you were at Dryad Ward, your understanding would have been one half, would it?
A That is correct.

Q Does that reflect – and I do not mean this rudely – your training? Is that how you were trained or does that simply reflect inexperience?
A That was my understanding of what the conversion ratio was.

Q In terms of the prescribing and use of these sort of drugs, how would you compare your experience with that of Code A and Code A?
A They had much more experience of dealing with this than I had.

Q And did that reflect itself in your discussions and your relationship with them?
A I am sure it did.

Q In what way?
A I felt they had much more experience of using these drugs than I had and I was happy to rely on their advice.

Q I want to have it clear. There is one occasion that we are going to look at when you overruled something---?
A Yes.

Q --- that Code A had done, but other than on that occasion are you saying that you deferred to their opinion?
A I was aware that Code A and Code A had a lot of experience of managing palliative care more than I had, and I would just say, I was happy to rely on them.

Q You spoke about a conversation that you had had about a variable dose with Code A?
A Yes.

Q And you described her explanation for why it was necessary?
A Yes.

Q You may have said this already, but did you at that time accept the explanation that was given to you?
A Yes, I did.

Q In terms of the use of syringe drivers you told us already that your own experience was limited?
A Very limited.

Q Very limited. In terms of the use of syringe drivers at Dryad Ward the experience of Code A – would that have been greater than yours?
A Oh, yes.

Q And again in terms of the use of syringe drivers and whether it was appropriate to utilise them or not, is that something you would have deferred to their opinion or not?
A One generally looks to using a syringe driver when someone will not be able to take oral medication or it may be distressing for them to have repeated injections. That is the sort of situation in which one would be looking to employ a syringe driver.

Q I understand that. But if you felt that a syringe driver had been set up with a patient by a doctor as experienced, as you have told us, as Code A or potentially, I suppose, by Code A, is that something in normal circumstances that you would query or challenge?
A I would certainly ask why a syringe driver had been commenced.

Q Did you actually do that in this case? When you were on Dryad, did you ever ask about that, can you remember, or not?
A I am sure I would have done.

Q I want to move on, please, to some patients that you dealt with. You have explained, of course, that you did not start there until 1999. So far as we are concerned, the patients that I think you dealt with directly would be Code A?
A Yes, and there is also Code A

Q We are not dealing with Code A in this case. I think also you wrote a letter in relation to Code A. Do you recall that now or not?
A This was after assessing her in Haslar Hospital, was it?

Q Yes.
A Yes.

Q I think we shall start with her because I think your dealings with Code A were very limited.
A That is correct.

Q You will see on your left there are a number of bundles. Could you take up bundle E, please. Could you have a look at page 24, please. I think we have now added a second page

to this, 24 and 26. I am not going to ask you a great deal about this at all, but is this effectively your letter to Code A?
A Yes.

Q At the Royal Haslar. Why were you reviewing this patient?
A Because one of our roles as consultants in geriatric medicine was to review elderly patients on non-elderly medicine wards where it was felt that our involvement would be appropriate, either in terms of giving advice or taking over the patient's care.

Q If we go to the second page, I think you summarise, helpfully, your findings. You say:

> "When I saw Code A she was clearly confused and unable to give any coherent history. However she was pleasant and cooperative. She was able to move her left leg quite freely although not able to actively lift her extended right leg from the bed, she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport War Memorial Hospital. I understand that her daughters intend to give up the place in Glenheathers Nursing Home as they have been unhappy with the care but would be happy to arrange care in another nursing home."

When you talk there about giving her the opportunity to try to remobilise, first of all can you recall this patient now?
A Very vague recollection.

Q Is there any reading that we should do between the lines here when you use that expression? What are you saying about Code A?
A I think I felt her prospects for remobilising were not good.

Q Why is that?
A We know that patients who are confused and have dementia, it is often difficult for them to assimilate instructions, so often when they are seen by physiotherapists they are unable to remember what they have been instructed to do the day before. So it is quite difficult to make progress.

Q Nevertheless, you were arranging for the transfer of this patient to Gosport War Memorial Hospital?
A Yes.

Q For what purpose?
A Because I felt she should be given the opportunity to.

Q This patient, in fact, was admitted to Daedalus Ward on 11 August 1998. Was there any distinction between Dryad and Daedalus Ward in terms of rehabilitation?
A Yes.

Q Tell us about that, please.

A Daedalus Ward was a rehabilitation ward, and Dryad Ward had been designated as a continuing care ward. There was, as I recollect, no routine physiotherapy or occupational therapy available on Dryad Ward whereas there was on Daedalus Ward.

Q Did that change? Did you begin to get more rehabilitation patients on Dryad Ward as time went on?
A Certainly patients who were not clear continuing care patients.

Q And how did that change come about?
A It came about, I think, because of the move of what formerly have been NHS long-stay patients into private nursing homes, and so that created capacity within the continuing care ward. Because of pressures at the front door, one looked to see who would be the most suitable patients to transfer to Dryad Ward, in other words, ones who were not likely to need significant amounts of input from physiotherapy or occupational therapy.

Q I think that was your only dealing with this particular patient?
A Yes.

Q She was transferred to Daedalus Ward as we know and, of course, that was not your sphere at that hospital.
A Yes.

Q We can put that away. I want to turn, please, to your dealing with Code A, who is our Patient I. Could you take out Patient I's file, please. We are going to start just by reviewing her history, I hope, because I think you saw this patient first of all at the Haslar Hospital?
A Correct.

Q Could we start, please, at page 356. You will have to get used to this, but the page numbers to concentrate on are those with a little line either side. This is not your note, but I think it may just help you to bring the patient back to mind. We can see that she had had an accident. She had been pulled over by a dog, apparently, and landed on her right hip. It is described as a direct blow. She had a fractured right subtrochanteric fracture. Is that right?
A That is correct.

Q If you go to page 374 – in fact would you look at the page before that, 373. Your note appears on page 374, I think. Is that right?
A Yes.

Q Let us just look at the note before that. This is a note made, I think, after the lady had been operated upon. We can see that there is a note to Code A

> "Many thanks for reviewing this pleasant 92 year old lady who was admitted on the 18th March having sustained a sub-trochanteric fracture to the [right] femur ... She was previously well, with no significant past medical history, living alone and independently with no social service input. She was transfused with 3 units of blood, but otherwise made an unremarkable post-op recovery. She has proved quite difficult to get mobilised, and her post-op rehabilitation may prove somewhat difficult. Additionally the quality of her skin, especially her lower legs is poor and at great risk

of breaking down. Code A would appreciate your advice regarding her rehabilitation and consideration of a place at GWMH."

That is written by a house officer to Code A. Could we look at your note, please, of 23 March and could you just take us through that?
A You mean just read it?

Q Yes
A

"Thank you.

A delightful 92 year old lady, previous well, with sub-trochanteric fracture of the [right] femur. She is still in a lot of pain which is the main barrier to mobilisation at present – could her analgesia be reviewed?

I'd be happy to take her to GWMH provided you're satisfied that orthopaedically all is well with the [right] hip.

Please let me know."

And there is a telephone number.

Q I think at that time, and you can have a look at some drug charts from the Haslar if you wish, the patient was on paracetamol. The drug charts are at 328. Yes?
A Yes.

Q Together with that note that we just looked at, could we now go to page 301. This is a note from you, again to Code A, dated 26 March 1999. You referred to seeing her on ward E6 on 24 March. The last note we looked at was 23 March. Is it likely to reflect the same visit?
A Yes.

Q You say in the third paragraph down:

"When I saw her she was fully orientated and able to give a good account of herself. The main problem was the pain in her right hip and swelling of her right thigh. Even a limited range of passive movement of the right hip was still very painful. I was concerned about this and I would like to be reassured that all is well from an orthopaedic view point. If you are happy that all is well, I should be happy for [her] to be transferred to the War Memorial Hospital ...".

So the purpose of this, perhaps, is obvious. You wanted to make sure that she was all right for transfer?
A Yes.

Q The pain and the swelling in her right thigh would be an indication of what, if anything – or is that just post-operative?
A You may get some bleeding post-operatively and I would suspect that is the most likely reason at that time for her thigh to be swollen. Another possibility is she could have had a deep venous thrombosis, but I think if it was centred around ---

Q Could you say that again? A deep venous ---?
A A deep venous thrombosis. It would really depend on clinical examination at the time, but if it is centred around the wound then the most likely thing would be that it would be a wound haematoma bleeding into the wound.

Q I do not think that we have any response from Code A. This patient was transferred on the day that this letter was written on 26 March to Dryad Ward. If we go to page 23, is this a transfer note effectively?
A Yes.

Q Written by whom?
A It looks like the signature is – is it – Code A?

Q And it is addressed, "Dear Sister". Would that effectively be addressing it to Code A Code A?
A Yes.

Q We can see the note that is made. It describes what has happened to her.

"Post operatively, she is now mobile from bed to chair with two nurses and can walk short distances with a zimmer frame. She has no urinary catheter and although she is continent during the day she has been sometimes incontinent at night.

The skin on her lower legs is paper thin so she is not to TED stockings."

Those are those tight stockings to prevent a DVT. Is that right?
A Yes.

Q

"Her right lower leg is very swollen and has a small break on the posterior aspect. This has been steristripped. Her consultant recommends they be elevated.

She needs encouragement eating and drinking but can manage independently.

Drugs have not been included as her only medication is analgesia (paracetamol) PRN."

Does that reflect the position on her transfer?
A It certainly reflects what Code A.. Presumably it reflects what she observed.

Q Is this a patient who in your view was appropriately transferred to Dryad, or more appropriately would have been transferred to Daedalus Ward?
A I think if at the time there was no physiotherapy or occupational therapy available on Dryad Ward, it would have been more appropriate that she should be transferred to Daedalus Ward.

Q Can we go to page 27, please? Do you see a note there by Code A at the top?
A Yes.

Q We see on 26 March:

"Transfer to Dryad ward
Fracture of neck of femur
Previous medical history – nil of significance
Barthel"

But there is no Barthel score. Then:

"No weight bearing
Tissue paper skin
Not continent

Plan – sort out analgesia"

Can I just ask you to help us with this? That does not seem quite reflective of the note that has gone before by the previous assessor. Help us with this. If there is a difference between the state of the patient when they arrive on Dryad Ward and the state as it is described in the previous notes or in the transfer letter, what, if anything, would you expect to be done?
A A number of things could be done. One could contact – the nursing staff could contact the ward to speak to Code A. It would also be important to examine the patient and see if there is any obvious reason for the apparent change. Might I say something?

Q Yes.
A Code A note was really quite at variance with what I found two days before.

Q Just keeping a finger where you are, let us go back to the letter that you wrote at page 301. You say that she is fully orientated and able to give a good account of herself.
A Yes.

Q And:

"The main problem was the pain in her right hip and swelling of her right thigh. Even a limited range of passive movement … was still very painful."

Yes?
A Yes.

Q Does that indicate that she is not weight-bearing?
A I would be very surprised if this lady were able to weight bear without very significant help and support.

Q When you talk about somebody weight-bearing, does it mean walking on their own or walking with assistance?
A I would say standing in the first instance.

Q The purpose of this transfer, if it were possible, was to mobilise the patient.
A Yes.

Q Let us go back to page 27 and let us see what happened. First of all, the plan is described as "Sort out analgesia".
A Yes.

Q Help us. Would you expect to see any other sort of plan written out by the assessing doctor, or not?
A I think it is difficult, because one cannot remember the patient, but clearly if Code A has written "Nil of significance" in terms of past medical history, I said this lady was alert and orientated or words to that effect, so I think the most important thing would be reviewing her analgesia and then – after a hip operation, it is very common for people to be in pain and discomfort. The issue then is, one would expect that pain and discomfort, if all has gone well orthopaedically, to gradually lessen with time.

Q If it does not, what is that an indication of?
A There would appear to be a problem somewhere.

Q Would you expect that problem to be assessed?
A Yes.

Q And hopefully diagnosed?
A Yes.

Q And a plan written up to deal with it?
A Yes.

Q The next note is I think some 12 days later. Whose note is this?
A That is mine.

Q Could you read it through for us, please?
A Yes.

"Still in a lot of pain and very apprehensive.
MST [increased] to 20 mg bd yesterday
Try adding flupenthixol
For x-ray right hip as movement
still quite painful – also about
2" shortening of right leg."

Q Again, it may be obvious, but what does that indicate to you?
A There is clearly a continuing problem with the right hip.

Q What did you think the nature of that problem might be?
A There would be a number of possibilities. The hip could have been dislocated, there could be a deep-seated wound infection, a superficial wound infection. Given that this lady is 92 and she has had a fracture, it is likely that she has osteoporosis. I think she had a dynamic hip screw inserted and if the bone into which that insert is very soft, then the head of the femur can collapse and that can cause shortening of the leg. That was the purpose behind requesting an x-ray, to see if we could get to the bottom of what was going on.

Q If Code A had formed the same view when she reviewed this patient, would she have been able to ask for an x-ray? It does not take a consultant to ask for an x-ray, does it?
A No.

Q You also note that there is a two-inch shortening of the right leg.
A Yes.

Q How would you have ascertained that?
A From examination of the patient's leg.

Q Standing?
A Oh, no. It would be lying on a bed. I cannot say for sure, but almost certainly. We generally measure leg shortening with people lying in bed.

Q The last note was on 26 March and this note is now 7 April 1999.
A Yes.

Q Does that surprise you in any way, or not?
A If the patient had been in a lot of continuing pain, then I think it would have been appropriate that an assessment be made of the patient.

Q What we do know from the drug charts – and I am just going to use the chronology that we have for the moment – is that this patient had been administered 20 mg of MST since 31 March.
A Yes.

Q Prior to that in fact she had been prescribed and administered Oramorph.
A Which page is this?

Q If you go to page 178, do you see the prescription for MST, "Morphine MST", dated 31 March halfway down the page?
A Yes.

Q You have told us obviously that Code A had considerably more experience than you prescribing certainly diamorphine. What about opiates?
A Diamorphine is an opiate.

Q I am sorry. What about MST?
A Again, it is an opiate. It is morphine.

Q Who had the greater experience, would you say?
A Of prescribing MST?

Q Yes.
A Probably Code A. Probably.

Q Where a prescription like that is written, would you necessarily expect to see anything in the clinical notes?
A I think that in general terms when one is introducing opiates, there should be a note in the clinical record.

Q Why?
A Because opiates are controlled drugs and they are controlled for a reason.

Q Did you expect this patient to go off for x-ray?
A Yes.

Q Who, following your note on the 7th, would actually have had to arrange that?
A I am not clear whether – I might have written the x-ray card on the ward round or, if Code A was there, she might have written it. I could not say.

Q We have a nursing note at page 134. Do you see in the middle of that page:

"7.4.99 Seen by Code A For x-ray tomorrow at 100 hrs."

A Yes.

Q When you write a note like that in the clinical records, who would you expect to read it?
A The medical staff and possibly nursing staff too.

Q The medical staff in this case would be - ?
A Code A or if there was a senior registrar or one of Code A partners who were covering.

Q The next clinical note that we see is written by who?
A By me.

Q Does that surprise you in any way?
A One would have expected by that time that the x-ray had been undertaken and a note made of the result.

Q Let us have a look at what had happened on 12 April. Could you read through your note, please, first of all?
A Yes.

"Now very drowsy (since diamorphine infusion established)
reduced to 40mg for 24 hours
if pain recurs, increase to 60mg.

Able to move hip without pain
but patient not rousable."

Q Can we just deal with the necessity of making notes? You have made notes in relation to both of your assessments of this patient at this stage.
A Yes.

Q How important do you regard it to make a note?
A I regard it as very important.

A Q Again, I am sorry to ask such obvious questions, but why?
A So that there is a clear record available, both to me when I might see the patient next or to any other medical practitioner who is called or for the nursing staff.

Q Can we have a look, please, keeping a finger where you are, at page 174? Again, it is the drug chart. Do you see at the top there a prescription has been written out by Code A
A Yes.

B

Q For between 20 and 200 mg of diamorphine.
A Yes.

Q If we look below that, we can see a prescription for hyoscine.
A Yes.

C Q And if we look below that, a prescription for midazolam, between 20 and 80 mg.
A Yes.

Q The effects of midazolam are what?
A Sedative.

Q Does midazolam have an effect on either the heart rate or the respiration rate?
D A I am not a pharmacological expert, but I would imagine it would have an effect on your breathing, but not on heart rate.

Q The diamorphine has an effect on what?
A Breathing, consciousness.

Q There we have an example of what I asked you about as a generality before: a variable
E dose of between 20 and 200 mg.
A Yes.

Q You have told us I think that you had never seen that before.
A Well, I did not recollect that prescription.

Q Do you have any view about it?
F A I think, as I said before, the dosage range is very wide. When I talked before about variable dose prescribing, if I remember correctly, it was in the context of over a long weekend, where Code A or her partners might not be available and we can certainly see that over a course of a long weekend it might be necessary for someone's diamorphine to be increased from 20 to 80 mg, but I could not see that with 20 to 200 mg.

Q Do you think it is an acceptable prescription or not?
G A No, I do not.

Q The starting dose appears to be 80 mg.
A Yes.

Q You reduced it by I think half.
A Yes.

H

Q Tell us why you did that.
A Because I thought that was too large a step up in dosage.

Q What effect do you think it was having on the patient?
A Over-sedation of the patient.

Q If this patient had been up to this stage on MST – and MST, we know, I think is an oral dose.
A That is correct.

Q Is it a tablet?
A Yes.

Q We know I think from the drug chart that MST – I am going in fact from our chronology, but if we look at page 178, we can see that there is a dose of morphine MST at 10 mg.
A Yes.

Q Prescribed on 31 March. Then on 6 April, a new dose of 20 mg bd. Is that twice daily?
A Yes.

Q Those are regular prescriptions to be given at eight o'clock in the morning and eight o'clock at night.
A Yes.

Q We can see, if we go along the row, that those were indeed administered.
A Yes.

Q If you keep your finger at 178 but also go to 160, please, we can see, I think, that on the day before – you came along on the 12th – on 11 April the patient had been given, in addition to her MST, some Oramorph.
A Yes.

Q That would appear to have been, I think it is, 5mg.
A Yes.

Q Because it is two and a half millilitres and there is 10mg in 5ml.
A Yes.

Q So on the day before that syringe driver was started, the patient appears to have been on 45mg total of morphine, whether it is MST or Oramorph?
A Yes.

Q You told us earlier about your own understanding of the conversion rate, which I think has been reviewed since these events?
A Yes.

Q But at the time your understanding of the conversion rate would have been to halve it?
A Yes.

Q Which would mean a subcutaneous dose of between 20 and 25mg?
A Yes, but I think it is perhaps important to say that at this stage this lady's pain was still not controlled.

Q Now, is that an explanation for the 80mg dose, or is than an explanation for why you only reduced it to 40?
A It is an explanation of why this lady needed a higher dose of opiates than the 20-25 she suggested.

Q We have to add to that, I suppose, your understanding at the time that you could double up the dose---
A Yes.

Q ---as your incremental increase.
A Yes.

Q So first of all we start off with your understanding that you should halve from oral if going to subcutaneous---
A Yes.

Q ---but then your understanding that you should double up if an increase was required?
A At that time that was my understanding.

Q Is that how you got to 40?
A Yes.

Q Well, you tell us, how did you arrive at the figure of 40?
A I think that would be the way I would have done it.

Q Using your own figures would that have been a substantial increase, or as much of an increase as you would want to allow, or would you have gone higher than that?
A Than 40?

Q Yes.
A No. I think 40 was the right dose in these circumstances.

Q What was the danger, if any, for this patient of the dose that she was then on, of 80mg?
A Over-sedation and respiratory depression.

Q What is the danger of that?
A Well, if patients are sufficiently over-sedated, respiratory depression can result in death.

Q If we just follow this through, back to your clinical note, please, page 27, you have recorded:

"Now [very] drowsy (since diamorphine infusion established) – reduce to 40mg/24 hrs – if pain recurs" –

and then that is an arrow up, I think, to 60mg, is that right?
A Yes, that is right.

Q What is the note below: "Able to move hips"?
A "without pain but [patient] not rousable".

Q "patient not rousable" perhaps we all understand. What efforts would you make to rouse the patient?
A Well, first of all speak to the patient. If they do not respond to speech, then touch them, perhaps shake an arm. In extreme circumstances what one can do is give the patient a painful stimulus, for example squeezing a toe, squeezing a finger, earlobe, or, in someone who has been in pain from the hip, then moving the hip would be---

Q You were unable to get any response from the patient?
A Yes.

Q What was your understanding of how long it would take for your reduction to have effect?
A I would have thought that would have been having an effect within an hour of reducing it, but I am not an expert in pharmacology.

Q We can see from the clinical record that on 13 April at 1.15 in the morning the patient was confirmed to have died.
A Yes.

Q Now, I just want to look at timing, please, so I am going to ask you to be given the original – we have now created a file with all of the originals that we have got in it, and I am going to ask for the original prescription sheets for Patient I to be handed to you. (Same handed) It is difficult for us to read, on page 174, but can you just help us with the timing: I think the original 80mg was started at eight o'clock in the morning, is that right? Sorry, you will have to find the right page first.
A Yes. Well, it looks like eight o'clock or nine o'clock in the morning; I think probably eight o'clock.

Q I see what you mean, yes. The midazolam, I think perhaps that is a bit easier to read.
A Well, that looks like nine o'clock.

Q So that appears to be when the syringe driver was initiated.
A Yes.

Q What have you written underneath?
A I beg your pardon?

Q Have you written anything underneath when you have reduced the dose?
A On the drug chart you mean?

Q Yes, on the drug chart, which I thought you were looking at.
A I do not think I have written anything on the drug chart.

Q Can you tell us, please, at 16.40 what happens?
A Oh, "Dose discarded 40mg 16.40".

Q Would that be as a result of your intervention?
A I presume so.

Q So at 16.40 effectively a new syringe driver is started?
A Yes.

Q With your reduced dose. Did you give any consideration to the midazolam?
A I do not recollect doing so.

Q You do not recollect it?
A No.

Q Just looking at that sheet in front of you, Code A had prescribed, concentrating on midazolam, 20-80mg, and when the syringe driver was restarted it looks from our copy as if the midazolam was increased to 40 from 20.
A It does.

Q Can you help us as to how that happened?
A I have no idea.

Q Would you have directed the increase?
A I would find that astonishing if I directed that increase.

Q Why do you find it astonishing?
A Because when I saw the patient I thought the patient was over-sedated, and it would seem totally counter-intuitive to increase the dose of midazolam.

Q You have directly brought about the reduction in diamorphine?
A Yes.

Q Now, just stepping back from the drugs, and then we will take a break, this patient had continuing pain from her hip.
A Yes.

Q You had directed that an X-ray take place in your clinical note of 7 April.
A Yes.

Q What did you want to happen with this patient?
A At what stage are you talking about?

Q On 7 April when you intervened.
A Well, to have an X-ray to find if we could get to the bottom of why this lady was having so much pain.

Q An explanation of the two inch shortening of the leg?
A Yes.

Q That does not appear to have happened.
A No.

Q By 12 April, when you come across this patient, you have found an unrousable patient.
A Yes.

Q Can you recall if you made any enquiries about what had happened about your note?
A I cannot recall.

Code A Sir, I think that is all that I need to ask about this patient, but I will review my notes, if I may, over the short adjournment.

THE CHAIRMAN: We are going to break now for lunch. We will return at 5 minutes past 2. In the interim period, please remember that you remain on oath in the middle of your testimony and you should not discuss the case with any person nor allow any person to talk to you about the case. Thank you very much. 5 past 2, ladies and gentlemen.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Yes, Code A

Code A There was just one more question I wanted to ask you about the previous patient. Do you still have the bundle in front of you, bundle I? We have seen what happened with this patient: the problems with the hip; the diamorphine that was prescribed, and then your reduction, yes?
A Yes.

Q We know the patient died the following day.
A Yes.

Q If we go right to the back, please, to the death certificate, and you will find a little tab, and if you just turn over the final interlever, the cause of death is given as?
A Cerebrovascular accident.

Q Where does that come from, as it were? What is that based upon, do you know?
A No.

Q Is there any indication of that that you have seen in this patient's terminal stage?
A No.

Q Let us move on to the next patient. If you can put that file away, please. I want to ask you about Code A If you could take up file J. This gentleman we know, just to remind everybody, if we go back to 6 August, this is prior to you having any dealings with him, I think, the first note we have got for this gentleman, the easiest place to find it is page 47, we know that this gentleman was admitted to accident and emergency at Queen Alexandra Hospital on this date, 6 August.
A Yes.

Q We can see that the problems are set out, and he has got cellulitis. Is that actually an infection?
A Yes, it is an infection of the skin and subcutaneous tissues.

Q Cellulitis in the left leg. He has got chronic leg oedema, poor mobility, morbid obesity, TBP?
A No, I think it is increased BP, which is increased blood pressure.

Q Oh, sorry, arrow up?
A I think so.

Q Then "AF", is that atrial fibrillation?
A That is correct.

Q Then if we go on to page 49, are either of those notes made by you?
A Yes, the first one.

Q The top one, 9 August.
A That is correct.

Q Can you just take us through that, please?
A Yes. "Cellulitis of [left] leg settling – switch to oral fluclox" – that is flucloxacillin.

Q Which is what?
A It is an antibiotic. "Oedema [left greater than right] foot – continue frusemide", which is a water tablet. "Arthritis of knees [left greater than right] +++ Arthritis of hips – mild [left greater than right] CNS intact Apyrexial BP [satisfactory] – continue felodipine but [reduce] to 2.5mg ([because of] oedema)".

Q I am sorry, what is that last entry all about?
A Felodipine is an agent which is used to control blood pressure, but one of its side effects is it causes swelling of the legs, and I have recorded in the third line of my note that Code A had oedema with both feet, more so on the left side, so it was trying to get rid of that, because you are more at risk of having cellulitis if you have got edematous, swollen legs.

Q Below that we can see an entry which, I think, is not yours but we can see that the patient is described as being well.

"Cellulitis improving on antibiotics"

He is awaiting physiotherapy?
A Yes.

Q Over the page, page 50:

"Patient well.
Cellulitis improved on [antibiotics]
Continue physio
Apyrexial"

Apyrexial?
A Yes.

Q Meaning no temperature?
A No temperature.

Q Then again, just glancing through this quickly, the next entry is the same day:

"Clinically brighter.
Leg looking better marginally
Pressure sores being dressed

...

Continue nursing care as now and try to mobilise."

A Yes.

Q Over to 13 August, please. I do not think this is your note, is it?
A No. It is Code A

Q I do not think we need to go through this in any detail. We can see much better than on admission; carry on with antibiotics, take them 10 days. That is on the middle of the page. Then, right at the bottom, do we see:

"Transfer to Dryad Ward on 16/8/99"

A Yes.

Q Page 52, the following page. I do not think he did get transferred on the 16th?
A No, I do not think he did.

Q I do not think your notes appear. Would you just look through the next couple of pages. I think it is most Code A ?
A Yes.

Q Is that right?
A Yes, and my colleague, Code A

Q Can we then go, please, to page 55. This is 23 August. This is a note which we think is made by Code A ?
A That is correct.

Q Code A worked where?
A He was a senior or specialist registrar who would be based at Queen Alexandra Hospital but at that time he was working with me and he would on occasion come out to Gosport with me.

Q Are you able to help us. This is a note by him. Do you know where this assessment took place?
A I think it was at Gosport.

Q I think that accords with Code A statement as well. It is just that the letter-headed paper, I do not think we have seen as coming from GWMH before.
A Sorry?

Q This is page 55.
A Yes.

Q Do you --- Sorry, go on.
A I was just going to say on the previous page it says "for Gosport" on the 23/08.

Q That would seem to indicate that although Code A was working at the QAH, this was an assessment which actually took place on the ward. That is Dryad?
A Yes.

Q Just looking through this, what is happening here? What is Code A doing?
A He has outlined the patient's problems and conducted an examination. Then he has written a plan at the bottom: repeat haemoglobin; I think it is urea and electrolytes, and liver function tests on Friday.

Q In terms of a note, just by way of example, you presumably have made many such notes in your time?
A Yes.

Q Is this an acceptable note of an assessment and examination?
A Yes.

Q And is that the sort of note that you have seen many times before?
A Yes.

Q And it describes what the patient's problems are. It describes what his present position is, and we see in the middle of the page is it "MTS"?
A "MTS = very good", I think it is. "No pain." I cannot read what ---

Q I think it is "Better in himself"?
A "Better in himself". I think the next bit is "0 JVP", which is jugular venous pulse, which is a clinical sign that we look at to tell whether someone might have heart failure.

Q And that would indicate that he is or is not in heart failure?
A Not in heart failure. Then the next line, I think, is "CDs [tick]", which means he thinks the cardio vascular system is unremarkable on examination. The next thing is "Rs", which is ticked.

Q "Rs"?
A Respiratory system.

Q So he is checking all the functions?

A A Yes.

Q Vital functions.
A Then I think "PA" is the next thing.

Q Then we see "Obese"?
A It says "obese", and then, "Legs slightly..."

B

Q Oedematous?
A Oedematous, yes. "Chronic skin change. Ulcers dressed yesterday."

Q Do you have a recollection now of this patient?
A No.

C Q No.
A Not really.

Q We have heard that he was a very large gentleman?
A Yes.

Q With very bad ulcers, but that does not ring any bells with you?
D A I have a vague recollection of a patient who when he was admitted to Ann Ward at Queen Alexandra Hospital, who was extremely obese and, if I remember correctly, and if it is Code A, the nursing staff had to put two beds together to accommodate. That is the only real memory I have – if my memory serves me correctly.

Q I think we go to some drug charts towards the back. Start at page 179, and then go backwards, as it were. We can see that the patient had been on paracetamol, which he
E declined at the Queen Alexandra Hospital on a number of occasions?
A Yes.

Q Then could you go to 173. There is an entry in the middle for something called Clexane?
A That is correct.

F Q We can see, I think, that all of these drugs were prescribed on 23 August?
A Yes.

Q Do you see?
A Yes.

Q It seems to be that these were prescriptions by Code A?
G A Yes.

Q Do not say "yes" if you are not sure about it. Do you recognise this signature or not?
A The first three certainly look like Code A signature. I am not sure about the fourth.

Q In the middle of that page, we can see that a drug called Clexane was prescribed?
H A Yes.

Q Do you know what Clexane is for?
A Yes. It is what is called an anti-coagulant. It is used to prevent and treat deep venous thrombosis and pulmonary embolism.

Q That seems to have been prescribed for this patient and at some stage certainly administered?
A Yes.

Q The other drugs that we can see are doxazosin?
A Doxazosin, which is for high blood pressure.

Q Frusemide?
A Which is a diuretic, or water tablet.

Q And paracetamol?
A Pain killer.

Q And then, is that a cream?
A I think it is 50-50 cream. I am not sure what that is.

Q And the very last entry there?
A Is magnesium hydroxide, which is a laxative.

Q Again, I am afraid we are going to have to do this thing of keeping a finger where you are from the prescription charts and then going back to the clinical notes. Could you go back to page 56?
A Yes.

Q There is an entry right at the top there which I think is Code A Is that right?
A Yes.

Q

"Called to see"

is it –

"pale, clammy, unwell.
Suggest ? MI..."

Can you read the next words?
A Yes. It is –

"Treat stat diamorph and Oramorph overnight.
Alternative possibility GI bleed but not haematemosis
Not well enough to transfer to acute unit
Keep comfortable
I am happy for nursing staff to confirm death."

Q In what circumstances would you expect those words to be used, the last sentence: "I am happy for nursing staff to confirm that"?
A I think if you felt that someone was terminally ill.

Q The suggestion of "MI" – myocardial infarction. What is a myocardial infarction?
A It is a heart attack.

Q Are there circumstances where diamorphine can be an appropriate drug?
A Oh yes, indeed.

Q The reference to a GI bleed?
A Yes.

Q Is that what you would call a differential diagnosis?
A Yes.

Q If this patient were having a GI bleed, as we may see in due course that is possible or even likely, is that a treatable event?
A Potentially.

Q Potentially how? What would you do?
A By transfusion, and then investigation of the cause which would usually be by what is called endoscopy. At endoscopy it is possible to carry out specialised treatments to try and stop bleeding, if that is felt to be the appropriate thing to do.

Q Try and find out the cause of the bleed, presumably?
A Yes.

Q And if you could treat it?
A Yes.

Q Of itself, is it inevitably a terminal event?
A Not of itself.

Q Underneath this entry we have another entry, I think, from Code A

"Remains poorly but comfortable. Please continue opiates over week-end."

A Yes.

Q That entry on 26 August – can you keep a finger there, please, and then go to the drug charts at 174. Do we see that on 26 August Oramorph was prescribed?
A Yes.

Q I am going to ask for you to be given the original prescription sheet for this please, because I hope you will find the writing a bit easier to read. (Document handed to the witness) Do you see against the entry for diamorphine "40-200 mg"? There is an entry to when it was first administered?
A First administered on the 26th.

Q Do you see just above the word "Dose"?
A Yes, 30?

Q It says "30"?
A Yes, yes. And then 31st, the following one, so I presume that refers to the day it was --

Q Actually administered?
A Yes.

Q The date above that appears to be the 26th?
A The date of ---

Q The date above that?
A Yes. A lot of prescriptions.

Q And you would take that to be the date of prescription?
A Yes.

Q And the prescription there was for diamorphine between 40 and 200 mg?
A Yes.

Q And that is the sort of wide range – I will not ask you again – that you spoke about earlier?
A Yes.

Q You said you had not seen before?
A Yes.

Q Or here, or since?
A Yes.

Q That starting dose of 40 mg, do you have any comment to make about that? Did you see that at the time or not?
A I think... I am sorry. The Oramorph starting dose – I beg your pardon. That is the prescription above – the Oramorph.

Q No. The Oramorph had already started, I think.
A But it had never been given.

Q I think you are right. I think it had been prescribed on 26 August. Just give me a moment.
A I think it is over the page.

THE CHAIRMAN: It is page 175, Code A

Code A I think the Oramorph had first been given, in fact, on the 27th, and it was ---

THE CHAIRMAN: Code A if you look on page 175, below the first row, there is a second Oramorph which in time is the first.

A

Code A You are quite right. I am grateful. So there are two entries for Oramorph on page 175 and we can see that there is an initial, I think, under the 26th at 22.00 hours?
A Yes, yes.

Q Can you help us with the dosage that was actually given?
A It looks like 20 mg.

B

Q Thank you. In the clinical notes that we have been looking at, back at page 55, there is reference to the possibility of an MI - yes?
A Yes.

Q There is no reference to pain?
A No.

C

Q This patient, we know, was put onto a syringe driver?
A On the ---

Q It was ---
A On the 30th.

D

Q Actually administered, it was prescribed, as we have seen previously, but he was put onto it on the 30th at a rate of 40 mg?
A Yes.

Q Can you just help us with this. Treating a myocardial infarction, if that is what was being done, is there a dose, a normal dose, that one would give for myocardial infarction, as opposed to for pain?

E

A Depending on the size of the patient – 2.5 to 5 mg. But this was a very large gentleman.

Q Yes. So do you use what?
A It might have been up to 10 mg, an initial dose of diamorphine.

F

Q To treat a myocardial infarction, if that is what the concern was, would you have used 40 mg?
A Usually with myocardial infarction you would give a single dose.

Q Not a syringe driver?
A Not a syringe driver straight off.

G

Q Staying on page 56, underneath the entry that we have been looking at do we see an entry for 1 September?
A Yes.

Q Whose note is that?
A It is mine.

H

Q Could you help us with it, please?
A

"Rather drowsy, but comfortable.
Passing melaena stools
[Abdomen] huge, but quite soft.

Pressures sores over buttock and across the posterior aspect of both thighs

Remains confused
For T.L.C. – stop frusemide and doxazosin
Wife aware of poor prognosis."

Q Can you help us, please, why you formed the view at that stage that you apparently did that this patient was effectively for palliative care?
A He was a very large man who had become immobile prior to admission. I think the final precipitant probably of his loss of mobility was his left leg cellulitis, but it was clear that this man had been struggling to remain mobile without any intercurrent illness prior to his admission to hospital. I have recorded in my earlier note that he had arthritis +++ of his knees, he had grade 4 pressure sores. My view is that this man was extremely unlikely ever to leave hospital and, probably worse than that, that this man's life expectancy was likely to be extremely limited. When I saw him, he was obviously having a very significant gastrointestinal bleed – that is the reference to passing melaena stools – and I felt that he was terminally ill.

Q Had this problem been recognised earlier, could something have been done for him?
A Possibly, but I think it would be important to state that his pre-existing problems would remain. In other words, his arthritis, his grade 4 pressure sores and I think there was something else which I cannot bring it to mind.

Q On 26 August, when she first made a note about seeing this patient, Code A made her notes at the top of page 56 and appears to have prescribed on the same day Oramorph, diamorphine with a variable range and midazolam.
A Yes.

Q What do you say about that sort of prescription?
A I think without having seen the patient, it is difficult. If one is considering – this man was clearly unwell on 26 August, very unwell, and I think to give diamorphine was an appropriate measure. Given his multiple problems, I would have felt that this man's prognosis for life was extremely poor and I feel at that stage that he might well have needed regular Oramorph and diamorphine in the next few days.

Q Is that the sort of prescription you are saying you would have written?
A No, no. I am talking about diamorphine.

Q What I am asking you about this prescription, this range of prescriptions on 26 August: midazolam, Oramorph, diamorphine with a range of 40 to 200. Is that a prescription you would have written?
A I would not have written a prescription for diamorphine 40 to 200 or midazolam 20 to 80.

Q You would not?
A No.

Q Why not?
A Because I think the range is too great.

Q When you saw the patient on 1 September, you described him as drowsy.
A Yes.

Q Does that indicate to you the appropriateness or otherwise of the degree of sedation?
A It may be entirely appropriate, because it is sometimes not possible to relieve a patient's distress without them becoming drowsy.

Q That depends I suppose on the degree of pain.
A Or distress.

Q Is there any reference to distress or pain?
A In Code A first note, she refers to him being "pale, clammy and unwell." Often when people are clammy, they can feel pretty unwell and distressed. Often if people are unwell, they become clammy and be feeling distressed.

Q They may be distressed presumably or they may not be distressed. Do you see any note of pain or distress?
A No, I do not see any note of pain or distress.

Q Can we move on, please, to the next patient, Patient K, Code A and could you take up file K? First of all, can you help the Panel by telling us whether you have any independent recollection of this patient?
A Not really. I remember meeting her daughter, but I do not have a very clear recollection of Code A

Q Could you go to page 155, please? This patient, as we see at the top of the page, had been transferred to Dryad Ward for continuing care.
A Yes.

Q She had been through Mulberry Ward, as we can see at the top, then went to the Queen Alexandra and then to Dryad.
A Yes.

Q Then there is a record by Code A Did you see the patient on 25 October?
A Yes.

Q Can you help us, please, with what you found?
A Yes.

"Mobile unaided
Washes with supervision
Dresses self
Continent
Mildly confused
Blood pressure 110/70

A Normochromic anaemia – chronic renal failure.

Was living with daughter and son-in-law
Sensitive Personnal Data
Sensitive Personnal Data

B Q We have heard quite a bit about this patient, but "mobile unaided" and "dresses self" seem to be an indication that certainly physically she was fairly comfortable.
A At that time, yes.

Q I just want you to help us, please, with the drugs that this lady was being administered. Could you go to the prescription charts, starting at page 279C? We can see I think that the patient was on thyroxine, which is obviously to treat hyperthyroidism.
C A Yes.

Q Frusemide.
A Yes.

Q For what?
A It is usually used for cardiac failure and sometimes used for ankle swelling.
D

Q And amiloride, is it?
A Yes. That is used for cardiac failure too.

Q Trimethoprim, is it?
A Trimethoprim is an antibiotic.

E Q Underneath that, although that is rather later, we can see fentanyl.
A That is right.

Q I think also in fact that at this time there was also a prescription for Oramorph. If we go to page 279B, do we see that on 21 October there was a prescription for Oramorph?
A Yes.

F Q Can we go back to the clinical notes? Your note was made on 25 October. The next note in the clinical notes is what?
A I think it is 1 November, which is my note.

Q That appears to be the next note sequentially.
A Yes.

G Q Can you read it through for us, please?
A Yes.

"Physically independent but
needs supervision with washing and dressing
help with bathing
Continent
H Quite confused and disorientated

A

Eg, undressing during the day.
Is unlikely to get much social
support at home.
Therefore try home visit to
see if functions better in own home."

Q There is no note between 25 October and 1 November. If the patient's condition had
B not changed, would you necessarily expect there to be any note?
A No.

Q Again, going back to the drug charts, please, a drug called chlorpromazine was issued.
If we go to page 279B, we can see right at the top chlorpromazine was given.
A Yes.

C Q Can you tell us, please, what chlorpromazine was used for?
A It is a tranquilliser.

Q That sort of dosage of chlorpromazine of 50 mg?
A A substantial dose.

Q If we go to 15 November, back to the clinical notes at page 156, we can see that
D apparently there had been something of a change in the patient's condition.
A Yes.

Q This is not your note, I do not think.
A It is.

Q I am sorry. Before we go through the note, where are you getting this information
E from?
A From the nursing staff or Code A, if she was present on the ward round.

Q So this is not obviously based on what you have seen of her?
A No.

Q Can you just take us through your note, please?
F A Yes.

"Very aggressive at times
Very restless – has needed thioridazine"

Which is another sedative drug, tranquilliser rather.

G "On treatment for [urinary tract infection] – MSU sent"

That is a mid-stream specimen of urine because of blood and protein in the urine.

"[On examination] Pulse – 100/regular
Temperature 36.4
[Jugular venous pressure not elevated]
H HJR ..."

This is hepato jugular reflux. It is a test of whether someone might be in heart failure. It was negative.

"Oedema +++ to thighs
[heart sounds] – nil added"

Meaning the patient had normal sounds –

"Chest clear
Bowels regular – PR"

That means "per rectum"; a rectal examination had been done on 13 November 1999.

" ... empty
but good bowel actions since."

Then in brackets an asterisk with "MSU – no growth". What that probably reflects is that a member of the nursing staff had gone off and found the result of the specimen of urine and it said there was no growth.

"Asked Code A to see."

Code A is a consultant in old age psychiatry.

Q The fact that this lady appears to have a UTI or consideration for a UTI, is that something that would normally be noted in these clinical notes, or not? It has been noted by you obviously.
A Yes, ideally, but urinary tract infections are quite common and it certainly often would be my experience in the past that people have not recorded things like a urinary tract infection in the notes because it is thought to be relatively minor, but it should be in ideal circumstances.

Q If we look at the note underneath yours, is that a sort of referral?
A Yes.

Q It is a referral written in the clinical notes.
A Yes.

Q That is to Code A who I think is the doctor that you have just been referring to.
A Yes.

Q That says:

"Thank you so much for seeing Code A I gather she is well known to you."

Can you read it any better than we can?
A I think it is:

A "Her confusional state has increased in the last few days to the point where we are using thioridazine."

Q That is the sedative that you have referred to, is it?
A Yes.

Q Then there is a reference to her renal function.
B A Yes.

"Her renal function is deteriorating. Her MSU showed no growth. Can you help? Many thanks."

Q The patient I think in fact continues on thioridazine. It is administered, according to the drug charts – and I will lead you on this, if I may – on 17 November in the afternoon.
C A Yes.

Q Then if we go to the top of page 157, can I ask you this? We have seen your two notes on the 1st and the 15th. If a patient deteriorated, first of all, would you be available to be spoken to by Code A if she required any assistance?
A Yes. I might not be immediately available, but I should be available.

D Q Was that your role?
A To be available, yes.

Q And to give advice if it was needed.
A If Code A felt she wanted advice, yes.

Q Then at the top of page 157, we can see:
E

"Elderly Mental Health

Thank you. This lady has deteriorated and has become more restless and aggressive again. She is refusing medication. She does not seem to be depressed and her physical condition is stable."

F Yes?
A Yes, I think that is what it says.

Q Then I think it is:

"I will arrange for her to go on the waiting list for Mulberry Ward."

G Mulberry Ward we have heard quite a bit about. It was the elderly psychiatric ward.
A Yes.

Q The next note is made by Code A You at the time did not have any dealings at this period of time.
A No further contact after that last note.

H

Q I just want to ask you one matter about this. If we look at the next note made by Code A on 19 November:

"Marked deterioration overnight
Confused, aggressive. Creatinine 360
Fentanyl patch commenced yesterday
Today further deterioration in general condition."

In what circumstances to your knowledge is a fentanyl patch be appropriately used?
A For a patient who is in pain and/or distress.

Q Pain or distress.
A Yes. I think its licence indication is for pain, but, like diamorphine and opiates, they are often used where it is unclear as to whether the patient's distress is physical or mental or a combination of both.

Q Where a doctor has taken the decision to place a patient on opiates - and fentanyl is an opiate, is it not?
A Yes.

Q Is that something that you would or would not expect a note to be made in a clinical record, the reasoning behind it?
A Yes, I would expect a note to be made of the reason for it being started.

Q We can see that the note on 19 November finishes – I think it is "Please make comfortable. Am happy for nursing staff to confirm death".
A Code A has written "Confused and aggressive", which is clearly someone who is distressed.

Q If we go to page 281 – have you got the original prescription sheet still? Have you got it?
A I am not sure.

Q If you pass the file to us we can find it for you and hand it back. (Same handed) (After a pause) You are going to have the file handed back to you. (Same handed) If you would like to take the prescription sheet out. I just want to concentrate on the drugs that were prescribed and administered on 19 November. Now, I am afraid I cannot tell you where it will be on the original, but you will find at the very bottom of one of the pages, I think, an entry for fentanyl.
A Yes.

Q We have that on our 279c. We have already looked at 279b, which is 19 November, chlorpromazine.
A Yes.

Q Then we can look, our page 281, at diamorphine 40mg and midazolam 40mg.
A Yes. Midazolam 20-80mg.

Q Yes, but actually it was 40, was it not?
A Started on 40.

Q Started on 40. So on 19 November, it appears, in the morning at least, that this patient had in her system fentanyl, chlorpromazine, midazolam, diamorphine. Is that the sort of prescribing that you would ever have written out?
A I think I would have been more cautious in my use of diamorphine and midazolam.

Q More cautious?
A Yes.

Q How much more cautious?
A Well, I am not an expert in opiate prescribing and fentanyl in particular, and what I would have wanted to do is make reference to the *British National Formulary* to see---

Q I was just going to ask you that: you have said on a number of occasions that you are not an expert in prescribing, opiate prescribing particularly.
A Yes.

Q Would you have had reference to the *BNF*?
A Would I?

Q Yes. Would you have followed the guidance?
A Yes.

Q Do you say you did not see these prescriptions? Sorry, you are shaking your head.
A Sorry. No, I did not see them.

Q If you just give me a moment, please. (After a pause) You told us about your view so far as the clinical notes are concerned of recording the use of fentanyl. What do you say about the necessity or otherwise of recording the prescription and the use of the other opiate drugs?
A I think the change should have been recorded.

Q Can I finally just ask you this: you have got the original prescription sheets in front of you.
A Yes.

Q Can you just take one up, and it may be if you use this as an example. Throughout these prescription sheets in relation to the patients that we have been dealing with on Dryad Ward, the three patients that you have been talking about, Code A has prescribed a wide variable dose, yes?
A Yes.

Q Can you explain why you did not see those?
A I mean, I must have seen them, but I do not recollect seeing them.

Q If you saw them, why did you not take action about them?
A Well, I should have done.

Code A: I see. Would you wait there, please.

THE CHAIRMAN: I think we have reached the point where we should give the doctor a break. He has had an hour of examination in-chief. So we are going to break now. You will be taken somewhere where you can get some refreshment, and we will return, please, at quarter-past three, everybody. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Code A

Cross-examined by Code A

Q Code A obviously I am asking you questions on behalf of Code A you will appreciate that.
A Yes.

Q I have quite a number of matters to ask you about. What I will try to do is to ask you about general matters first of all, to seek your assistance about various points, touching upon points you may have already mentioned yourself, but I am inviting you to flesh them out and so on, and then towards the end of my cross-examination I will turn to the individual patients you have been asked about. It may be that at times we will come back to a particular topic, but I will try and keep it in that sort of order. First of all, this: you have described in your own statement, and I quoting your words, that you thought Code A was a good doctor.
A Yes.

Q I would like you to flesh that out a little bit more. Why do you say that?
A Well, I felt that she was assiduous in attention to her duties when working at War Memorial Hospital. I obviously was only there for one afternoon per week, and, in situations like that, one often relies on the nursing staff for feedback about how a doctor is performing, and the nursing staff were, I would say, fulsome in their praise for the support that Code A offered them. I never ever heard it suggested that Code A had not attended or been unhelpful in giving advice. She was a great source of support to the nursing staff, and I felt the patients were being well looked after.

Q So I think it follows, from what you have been asked and the remark you made, that you were not somebody who had concerns about the standard of nursing care, and you were not somebody who had concerns about the standard of medical care?
A That is correct.

Q Did you also, so far as you could get the picture, whether from others or your own observations, form any conclusion about Code A attention to the needs of relatives?
A I mean, I think that is difficult to answer, because I was, as I say, there once a week, but certainly what I am aware of is that Code A did come in in her own time to speak to relatives.

Q I think at one point in the voluminous records we have of things that have said, either by way of interview with the police or your evidence at the inquest, that the impression you got was that she did a lot of counselling and advising of relatives.
A I certainly know she would see relatives at the request of the nursing staff.

Q Did she on any occasion seek your advice about things?

A A I would say on three or four occasions during the year perhaps Code A sought my advice.

Q You have indicated to the Panel that Code A was more experienced than you were in certain areas, is that right?
A Yes.

B Q It nonetheless remains the case, does it not, that she was, as it were, responsible to you?
A Indeed.

Q You were the person whom she was entitled to expect would correct her if she was doing something wrong.
A Yes.

C

Q She was entitled to expect that you would advise her and guide her if you felt that she needed advice and guidance.
A Yes.

Q In general approaches to care and a whole range of other matters.
A Yes.

D

Q I think also it follows from what you have already told us that if you thought something was wrong about her practice, or something which ought to be corrected or amended, you would say so?
A Yes.

Q It was not as if you hesitated to exercise your proper supervisory duties?
E A No.

Q Obviously there were a number of pressures on Code A
A Yes.

Q She was working as a clinical assistant to deal with the needs of a number of patients in two wards, Daedalus and Dryad.
F A Yes.

Q Obviously her duties with regard to, whenever she could, seeing relatives, another aspect.
A Yes.

Q Somebody who had far from unlimited time in order to carry out those duties.
G A Indeed.

Q It is not her fault; that was the fault of the way the thing was set up.
A Yes.

Q It is not obviously your fault, but would it be right to think of both of you, different roles, because no doubt you were under pressure as well, and I will come to that in a moment,
H

A both of you endeavouring to perform your respective roles as best you could in the circumstances you found yourselves?
A Yes.

Q The Panel have already heard about the comparatively limited amount of time that she had in order to perform her functions - I do not think there is any dispute about it, so I need not trouble you with that – but you knew that she came in and did a morning round, or check,
B every morning Monday to Friday?
A Yes.

Q You knew that also she would come back, usually in the middle of the day, and hopefully also be available for you when you did your ward rounds?
A Yes.

C Q Also, that she was somebody who would attend on occasion, not necessarily every day but on occasion, later on in the day perhaps to see relatives, or whatever it might be?
A Yes.

Q A significant number of patients to attend to on the two wards.
A Yes.

D Q Patients in general terms who presented with a number of different problems.
A Yes.

Q May I just ask you, while we are dealing with that, about the state on the wards? I appreciate you can assist us with Dryad, a well run ward and all the rest of it, there is no dispute about that, but just the general nature of the patients? Do we have a picture of everybody just sort of sitting around, or lying in their beds peacefully and not doing
E anything? What is the general picture in terms of patients with dementia and so on?
A Well, it would be a very sort of mixed picture. There would clearly be some patients who would be extremely dependent and probably presented a heavy nursing burden, but in terms of medical attention did not require very much, and that was the predominate population, as I understand it, when the ward was established, but that gradually changed so that, as I have said before, patients of increasing dependency, and by that I mean in terms of
F getting someone out of bed involves more effort than nursing someone who is usually confined to bed. Also, because the patients were probably being transferred at an earlier stage than had been previously done, they would have been more likely to be medically unstable than they had been in the past, or develop medical problems while they were there. So in that sense I think the workload medically certainly increased, and I would suspect that the nursing workload did too, because what we tried to do when we were presented with patients who we felt did need some physiotherapy and occupational therapy we managed to
G negotiate they would at least be assessed by a physiotherapist or occupational therapist, but the nursing staff would have to try and carry out what the physios had recommended.

Q You have already spoken about the problems that might exist with patients who just were not able to cope with that, for example patients suffering from dementia and so on, but there really were not any facilities for physiotherapy on Dryad?
A No.

H

Q I also want to ask you about the difficulties that might arise with regard to nursing with patients suffering from dementia and so on. Might they present problems in terms of---
A Well, indeed; restlessness, confusion, et cetera.

Q Different people seem to use different expressions but I think you probably covered the spectrum in a very general sense. Can I just ask you about the pressures on you yourself?
A Yes.

Q You were under quite a lot of pressure?
A Yes.

Q You had not only your role as a consultant, which you described, but you were also, I think you told us, the medical director of the Plymouth Healthcare Trust?
A Portsmouth Healthcare Trust.

Q I am sorry – not Plymouth. Portsmouth. That no doubt took up a certain amount of your time?
A A very substantial proportion.

Q And there was a further pressure, again which you said something about but I would like you to expand on this a little, in terms of the desire of the two main hospitals we are concerned with, obviously – Queen Alexandra and the Haslar – the desire to move, and I do not mean in some frightful, inhumane sense, but the desire to move on patients as quickly as possible to free up beds on acute wards?
A That is correct.

Q No doubt a pressure felt in many other places in the country, but what is the effect of that in terms of the impact on Dryad?
A I think that it meant that patients who were not wholly suitable for transfer to Dryad Ward were transferred.

Q Can I ask you about that by way of enlargement on what you have told us. Did you find in your experience that the hospital sending the patient on to Dryad, seeking and obtaining the transfer to Dryad, was sometimes presenting a slightly rosier picture of the patient's general medical stability?
A Yes.

Q And how would that manifest itself. We have come across one example already, I think, in what you said, but in general terms how did that show itself?
A Because of the interest in moving patients on from specialty wards they would make light of, perhaps, new medical problems that had developed. So, for example, if someone was being transferred from a cardiology ward who had had a stroke, they did not necessarily say, "This patient has had a stroke." What often happened was there was a considerable delay between my colleagues and I assessing a patient on an acute ward and them being transferred – up to three weeks.

Q I am sorry. So first of all the gap between your assessment and the actual transfer - yes?
A Yes. And as a result the patient's condition had often changed in that time, but because we had accepted the patient and they are on the waiting list, the wards were only too

happy to let the patient come and perhaps not be as forthcoming as they perhaps ought to have been about the problems the patient had, at the time of transfer.

Q It would not necessarily be a surprise – I appreciate it depends individual patient to individual patient – if the assessment and view of a patient arriving on Dryad would be different from the transfer letter assessment?
A Oh, quite different on occasion.

Q I am leaving aside the question that in some patients, as we have already heard, there might in fact be a deterioration as a result of the very transfer itself?
A Yes.

Q Which is something, again, you would be familiar with?
A Yes.

Q As a possibility. I think it follows from what you have said already, that would have a knock-on effect with regard, for example, to the prospects of mobilising a patient for rehabilitation generally?
A If patients had had an intercurrent illness develop in the interim, then that could clearly prejudice any chances of rehabilitation. Also, there was a tendency for staff on other wards to say things to relatives like, "We'll transfer to the War Memorial and they will soon have her walking in no time", in the interests of encouraging the transfer and persuading the relatives to accept the transfer.

Q So an effect, is on the expectation, as it were ---
A Absolutely.

Q --- of the relatives. Are we talking about a minor problem or a real problem, or what?
A Sometimes a very significant problem.

Q How would those manifest themselves?
A Patients or relatives being told that they were coming to the War Memorial Hospital for rehabilitation when the reality would be that on assessment the chances of rehabilitation were remote.

Q How might that manifest itself in terms of the relatives feeling towards the staff?
A Dissatisfaction, concern and, not unnaturally, relatives want to listen to the more optimistic prognosis.

Q I think around 1999, and that is really the period we are concentrating on so far as you are concerned ---
A Yes.

Q Around 1999. It was not the practice to have any staff reviews or regular supervision?
A No.

Q Again, lack of resources. Is that what we put that down to?
A No. Appraisal was not compulsory at that time – the sort of appraisal I am talking about, medical staff appraisal.

Q But in terms of supervision by consultants, were there constraints upon that or not?
A In terms of time, yes.

Q May I just ask you this in a general sense, about what you would expect as a consultant with regard to a decision made by the clinical assistant, in this case Code A obviously the only real person at the time we are concerned about. Would you expect or would you not expect to be informed by the clinical assistant if the position had changed with regard to a patient?
A No. I would only expect her to contact me if she had significant concerns about that change.

Q Would you expect or not expect contact with you if Code A decided the time had come for a patient to receive analgesia subcutaneously, in other words via a syringe driver?
A No, I would not have expected that.

Q Or, as another illustration, Code A deciding that it was appropriate for to record the fact that she was happy for nursing staff to verify or confirm death?
A Sorry. Could you just repeat that.

Q Would it be something you would expect or not expect, for Code A to contact you about in terms of her concluding that she wanted to record the fact that she was happy for nursing staff to verify or confirm – whichever word was used – death?
A No. I would not have expected her to do that.

Q I want to ask you more than one thing about prescribing practice by Code A but I am going to try and deal with it in sections. I appreciate they may slightly blur, the one into the other. What has been described as anticipatory prescribing?
A Yes.

Q What do you understand by that expression?
A It is prescribing of a medication and for someone who does not require the medication at that particular moment, but in whom one might reasonably anticipate they would need in a shortish timeframe.

Q That is something that you knew Code A did?
A Yes.

Q And I may have misunderstood you. Were you also saying that Queen Alexandra, for example, anticipatory prescribing takes place?
A It does at Queen Alexandra Hospital but just, perhaps, in relation to the last question, I cannot remember a specific incident of Code A engaging in participatory prescribing, but I think there are occasions when it is appropriate.

Q Was there any occasion when you spoke to Code A – again, I want to make sure we are talking about the same thing – was there any occasion when you spoke to Code A about anticipatory prescribing?
A I do not recollect ever doing that.

Q Because you have told us that you did have a conversation with her about the principle, I think, of variable doses?

A A That is correct.

Q So we are talking about something different when we are talking about anticipatory prescribing?
A Indeed.

Q But had you been aware of Code A prescribing in anticipation ---?
B A Yes.

Q Assuming it is not absolutely barmy, but reasonable anticipation, as it were, you would have been perfectly happy with that practice?
A Yes.

Q Then can I turn to variable doses, as to what we are talking about, because you
C indicated that before you came on to Dryad, in the sense of becoming the consultant and therefore taking on Dryad, you had possibly had experience of variable doses of diamorphine, maybe on one or two occasions, but you had a discussion with Code A about this topic. What was it you were raising with her?
A It was why she was engaged in variable dose prescribing – larger range variable dose prescribing.

D Q What do we mean by "larger range variable dose prescribing"?
A The recollection I have was this was in the context of a patient who had been prescribed 20 to 80 mg of diamorphine.

Q So are we talking about two different things, or the same thing? I just want to make sure. Variable dose, in the sense that there is a range, or are we talking about variable doses also meaning a range which is quite wide?
E A Sorry. Could you repeat that?

Q If there is a range of a dose ---
A Yes?

Q --- whether it is 10 to 20, or 20 to 200, is that what we are talking about in terms of a variable dose?
F A Yes.

Q Right. The fact that there is not a set amount to be administered to the patient?
A Yes.

Q But there is a range?
A Yes.
G

Q All right? So by variable prescription we are talking about something where the doctor has prescribed a range for a particular drug to be administered?
A Yes.

Q And the example you had had in mind, or your recollection is ---
A My recollection.
H

Q When you spoke to Code A – I appreciate all the difficulties remembering exactly – was that it involved a variable dose prescription?
A Yes.

Q The diamorphine?
A Yes.

Q With a range ---?
A Yes.

Q --- which you recall as being, I think you said ---
A 20 to 80.

Q 20 to 80?
A That is my recollection.

Q And she gave you an explanation?
A Yes.

Q And it was an explanation which satisfied you?
A Yes.

Q Again, in general terms – I am not expecting you to remember every word she used, and I doubt very much if she could ever remember, but what in general was her explanation which she gave you?
A As I recall, she stated that at times it was difficult for her, or her partners, to be in immediate attendance and particularly so at a week-end when she or her partners could be visiting patients as part of the on-call GP arrangements. And she had done this so that patients would not have to wait and suffer as a result of nursing staff being unable to contact her or her partners.

Q Would you help, please, with the importance of that fact – the desire to prevent patients unnecessarily suffering?
A Indeed.

Q Where does that rate in importance in the scale of things?
A It is the overriding priority.

Q Because we are dealing with patients who were not patients on an acute ward recovering immediately from an operation, we are dealing with a different class of patient?
A Yes.

Q For continuing care patients, palliative care patients, would it be right to say that the relief of pain and suffering has a particular importance?
A Yes.

Q Would it be right to say in general terms that the level of pain tolerated on an acute ward would be rather higher than the level of pain tolerated on a continuing care ward?
A Sorry. I do not follow.

Q We have seen cases, for example, if we take the example of one particular patient, the lady with the hip.
A Yes.

Q On paracetamol, I think it was?
A Yes.

Q After her operation?
A Yes.

Q Although obviously still in pain?
A Yes.

Q Is concern about controlling the level of pain rather less on an acute ward than it is in terms of continuing care?
A I am not sure....

Q You do not see any difference or you do?
A I am not sure that I see any difference.

THE CHAIRMAN: Code A, I am sorry to interrupt at this point, but I need to say something that perhaps I should have said at an earlier stage. It is this. We, as a Panel, are acutely aware of the stresses and strains that come with the giving of evidence. We understand how very rapidly a witness can feel exhausted. It is very important that we receive evidence from you at a time when you are feeling fit and fresh enough to apply your mind fully. If at any time you feel that it is getting a bit much, and you need to take a break, or even that you have had enough for the day, you only have to indicate, and you will not be required to go on answering questions.

THE WITNESS: Thank you very much, but I feel fine.

THE CHAIRMAN: Good. Okay – thank you.

Code A You can feel fortunate, Code A, that counsel are not allowed the same latitude, whatever they feel about the amount of questions they have to ask.

Just on that topic, I was putting that general proposition to you that in general on an acute ward, somebody recovering from an operation, there may be less attention to the problem of controlling pain – I do not mean in the sense of ignoring it – than there would be in terms of patients on continuing care ward?
A I think if you mean because in an acute ward there are some junior medical staff 24 hours a day, absolutely, whereas in a ward like dry ward, we are dependent on GPs out of hours cover. It is a different situation.

Q That again brings me on to something I wanted to explore with you as well – that different situation, and the realities of endeavouring to care for patients on a continuing care ward like Dryad – patients coming in, maybe, for continuing care; coming in, in effect, for palliative care almost from the start and that sort of category of patient. Would it be right to consider that there is a balancing exercise that has to be carried out by ---?
A Absolutely.

Q We will start off with one obvious balancing exercise, and that is the question of note-taking?
A Yes.

Q You should know that there is no dispute on behalf of Code A that her note-taking was not adequate; it was not as good as it should have been.
A Yes.

Q It may be that in the 1990s the standard of note-taking by GPs, by other doctors, was rather lower than it is now in general terms?
A Yes. Before I came to Portsmouth, I worked in Southampton, where we had a four-ward continuing care type rehabilitation hospital, for which we had a GP in a similar role as Code A. His notes were equally brief. I know from colleagues who worked in other community hospitals in Portsmouth – I am talking in general terms – note-keeping was much briefer than it is now.

Q In any event, you would be aware of the brevity of her note-taking, but there was no occasion on which you thought it necessary to speak to her about it by way of pulling her up about it?
A No.

Q May I just ask you this as well. Was there ever any occasion when you had any difficulty understanding what the position was with regard to a patient as a result of the brevity of Code A notes?
A Never, I would see part of my role in the ward round as not just talking to medical staff that were present, but asking the nursing staff about what was happening, because medical staff cannot be there all the time. One is heavily reliant on nursing staff for information.

Q Again, give us an idea of how important that was to you, reliance on the information from the nursing staff?
A Critical. Critically important.

Q May I ask you this in general terms, about the nursing staff on Dryad. You told us about the standard of care, and I am not going into that again, but in terms of whether you felt you could trust the nursing staff to perform their duties properly?
A Without question. I said earlier that I was very impressed by the quality of the nursing staff we had on Dryad Ward.

Q When you asked Code A about the rationale or the reason for the variable dose, and she explained to you what the reason was, as I understand it, you yourself did not have any concerns that there was any real risk that a member of the nursing staff would suddenly do something absurd, and just up the dose by some ridiculous extent?
A Yes, I trusted the nursing staff.

Q Again, dealing with the problems that existed by virtue of the set-up – not Code A fault and not your fault – and the balance that had to be carried out, the balance between, "Do I spend time taking fuller notes or do I spend time attending to patients?" that is the choice, because that is really what it comes down to, is it not?

A A At times the pressure can be very difficult.

Q Where do you think the balance lay between spending time writing up more ample notes or time spent looking after patients?
A Oh, it has clearly to be with seeing patients.

Q Because of that problem, with Code A not being there save for the limited periods of time we have already discussed, there is a problem with what one does about making a decision as to what should be the starting dose for a particular drug. We are focusing on opiates here obviously. Would you agree?
A You have to make a judgment. There are guidelines about what the starting dose should be, but you have to make a judgment about the patient in front of you.

Q If you have a fully medically staffed ward, in the sense of somebody being available, as it were, all day, medical staff available all day, it is much easier to take an approach with regard to the administration of opiates which is bit by bit, a gradualist approach.
A Yes.

Q That luxury is not afforded if the doctor cannot be there save for limited periods of time in the day.
A That is correct.

Q So it would not be a surprise to find a doctor in those circumstances prescribing higher than might otherwise be the case if the doctor was there all day.
A Or certainly prescribing a wider range.

Q Or a wider range. But there is a difficulty, if the starting dose is too low, that the patient, when the time comes to start on the opiate, will have suffered unnecessary pain.
A Yes.

Q How would you assess the importance or the significance of the doctor's own judgment about this, the doctor who has seen the patient and knows what the situation is?
A It is critical.

Q Was Code A somebody in your experience of her who made medical judgments with little or no reason behind them?
A I would have said not.

Q There therefore has to be a balance struck, perhaps with the patient in the middle, but a balance struck between nursing and medical care dealing with the problem with the patient in terms of pain control and the pharmacological approach.
A Indeed.

Q Requiring judgment. Yes?
A Yes.

Q How would you weigh the significance of experience in this field? Is that something which counts for much or little or how do you see it?
A Considerable.

Q In your experience, would it not be surprising to find two doctors, perfectly genuinely, perfectly sensibly, coming to a different conclusion as to what the appropriate dose was with regard to the administration of opiates?
A Yes, it could happen.

Q One doctor might say, "I think in the circumstances 20 is about the right starting point." Another might say 10.
A Yes.

Q Another might say 40.
A Yes.

Q As long as there is a sensible reason for prescribing a particular drug at a particular dose range or limit, then that course is justified.
A Yes.

Q Still on the same topic of pressures that people were under, you have told the Panel about the change with regard to patients, the type of patient and so on, and the increasing pressures both on medical staff and nursing staff. I think there came a time in the early part of 2000 when you had a conversation with Code A about the pressures.
A Yes.

Q We know that there came a time when Code A handed in her resignation.
A Yes.

Q Without going into unnecessary detail, that was because of the pressures which had been put upon her in terms of demands on her time and the expectations and the reality of the situation she faced.
A Yes.

Q Indeed – and again it was probably not your decision, although you may have been involved in discussions about it – a decision was taken by the management side that what was needed was a full-time doctor.
A Yes.

Q Again, I am not worried about all the details, but would you assist the Panel with what came into place after Code A had resigned and left because of the pressures she was under?
A Yes. They appointed a full-time clinical assistant who was working 9 to 5 and Code A role then was covering 44 beds. Today it is actually 30 beds. It is covered by two junior doctors, plus half an associate specialist's time. So we have two and a half doctors looking after fewer beds.

Q Immediately after she left, there was one full-time doctor.
A That is correct.

Q It may be stretching your recollection too far, I do not know, but what was done in terms of night-time and weekends, when that doctor would not actually have been there? Was there some kind of on-call arrangement?
A Yes. There was an arrangement made I think with one of the local practices to cover all of – I cannot recall.

Q But we can think in terms of there being some sort of cover at the times when, am going to call it the 9 to 5 doctor, although that may be unfair, was not available.
A Yes. Perhaps if I might illustrate that. If I remember correctly, while Code A was in post, there would be approximately about 40 out of hours calls per month to Code A and her partners. After we appointed a full-time clinical assistant, I think it dropped to four.

Q Still on the same topic, with regard to the provision of services by consultants when Code A resigned, did that remain the same or did that change?
A I think that remained the same.

Q While we are on the question of consultants, Code A was not in post when you started on Dryad. Is that right?
A She was in post before. I took over from Code A

Q You were not there at the same time.
A No.

Q Code A was of course a consultant.
A Yes.

Q How did you find Code A in terms of her ability and experience?
A Extremely capable and likeable and just a lovely person.

Q I think it is right that you – obviously not only you yourself, but also Code A – were very grateful to Code A for the services and work that she had provided?
A Absolutely.

Q Was there an occasion, even if you cannot remember the exact details, when a complaint was made? I make the point now, it was nothing to do any of the 12 patients that the Panel are considering, but a complaint was made about a patient who had been on morphine tablets and those morphine tablets or the administration of them was discontinued by Code A
A That is correct.

Q And the patient was put on less strong medication.
A Yes.

Q What did that produce in terms of the family or the relatives' position?
A It produced a complaint.

Q Because?
A Because they felt the patient's pain was not being adequately controlled.

Q I am not going to go into any more detail of that. Do remember when about that was? Was that 1999?
A I would think it was in 1999.

Q There was another complaint relating to a patient – again, not one of our 12 – who had developed heart failure on a Friday – this is again from information which you have disclosed

– when Code A had prescribed morphine. That was quite appropriate in your opinion in that case.
A Indeed. It was someone who was in acute heart failure.

Q But you saw the patient yourself the following Monday and you took a decision to do what?
A To stop it, because the patient was better.

Q A further point in relation to transfers which I did not ask you about at the time we were talking about transfers. Would you assist with the question of notes being available with patients? We have seen examples of transfer letters and so on and you have told the Panel about how they might not present a very realistic picture. Not in every case, but they might not. In terms of the patients' notes, what did you find on transfer was a common occurrence?
A Missing notes, incomplete notes, no x-rays was a recurring feature of transfer.

Q I want to ask you about particular opiates. We have been talking about them in general terms, but I want to ask you about particular ones in certain circumstances. First of all, Oramorph. Was Oramorph a convenient and sensible opiate to provide, assuming of course the circumstances justified it, or was it something which caused problems?
A It would be I think most people's first choice of strong opiate.

Q In terms of opiates which we have heard mention of in terms of patients in this case, opiates such as co-codamol and co-dydramol, sometimes the choice between those two might result in the choice being Oramorph. Are there preferences for administering Oramorph compared to ---
A Co-dydramol and co-codamol are weaker opiates and I think one would look to prescribing them before prescribing Oramorph normally.

Q As you have already indicated to us, there may be circumstances where that is not appropriate.
A Exactly.

Q Oramorph again has the advantage of being flexible and of inducing a sense of euphoria to a certain extent.
A It can do.

Q It is helpful in general terms in cases involving heart failure.
A Yes.

Q Anxiety and distress.
A It is difficult at times, as I have said before, to determine whether someone's distress is physical or mental or a combination of both.

Q Then diamorphine. We need not trouble about the circumstances which justify that, because you have already given your evidence about it, but in terms of diamorphine being administered subcutaneously by means of a syringe driver, am I right in thinking that there was never any occasion in relation to any patients treated by Code A where you felt the use of and the commencement of a syringe driver was inappropriate?
A I never, ever felt that.

Q Can we take it that if you had felt that, you would not have hesitated to say so?
A That is correct.

Q Did you also find yourself in terms of dealing with relatives and the pressures of time so far as you were concerned that sometimes it was a struggle for you to find the time to speak to relatives when the need arose?
A It could be difficult at times. I do recollect coming down in the evenings to speak to relatives and coming I think on one or two occasions at a weekend when I was not on call.

Q In terms of matters which might arise in terms of dealing with relatives, you have already indicated to us the problems that might arise if expectations had been raised too high, for whatever reason, but I think also it was your experience – I do not think it is something that is in dispute – that in fact the decline of patients on a continuing care ward might occur quite suddenly into what really was a terminal phase.
A Oh, yes. A patient can gradually decline or they can suddenly decline.

Q No doubt if the decline was sudden, it would be something that would be, normally speaking, particularly shocking for relatives.
A Yes.

Q I think it is right – again this is taken from something you have said yourself either in interview or at the inquest; I think in interview – you yourself in 1999 were not aware of any guidelines or protocols for the use of opiates and sedatives.
A That is right.

Q You have already told us that you were not aware of the analgesic ladder, although you would know what that would mean.
A Yes.

Q It does not mean to say your approach was not in general that, and you were not aware of the Wessex protocol.
A No.

Q I think also you have indicated in the past that it was not unusual that there were no policies in place at Dryad with regard to the prescribing of strong opiate analgesic.
A At that time I do not remember them being in place anywhere, and that applied to Southampton too, from where I had just come.

Q Yes. Well, that flows on to the next thing I was going to ask you by way of clarification, which I think you have covered; there were not any at Queen Alexandra, for example, at that time. May I come, please, to the question of the range of dose. I appreciate the difficulties of trying to remember detail back to 1999, but it may be that you have actually clarified this in the last thing you said in answer to Code A but I am putting to you that you were aware in 1999 of Code A prescribing diamorphine in the range 20-200.
A No, I did not say that. I said I was aware of it being prescribed 20-80mg.

Q Yes. Well, that is why I want to clarify this. I may have misunderstood you, but at the very end of the questions you were dealing with I thought you said, when you were asked

about prescriptions in the range of 20-200, "I must have seen them and I should have done something about it".
A Indeed, I did say that.

Q So I just want to get it straight. You did see at the time prescriptions for diamorphine in the range of 20-200 or you did not?
A I do not recollect seeing them. That is what I said. I did not recollect seeing these two prescriptions.

Q Because I have to put to you, Code A that you would have seen them on a number of occasions, and that you did not at any time query it with Code A That is what I am putting to you.
A I did not query it with Code A I think I would have seen both of these prescriptions once. I did see them once.

Q I appreciate you did not have dealings with all the twelve patients we are dealing with in this hearing, but you did have dealings with a number of them, and I think with the exception of one of them they all had prescriptions which had a range of 20-200.
A That is correct.

Q So are you saying, "I might well have seen them at the time. I just do not remember it", or, "I categorically would not have seen them", or what?
A Well, certainly the one we have not discussed, which was for 20-200 as an as required prescription, where it was written on the prescription sheet I would not normally have looked. The patient was not on a syringe driver at that time, and, while I accept that it is my responsibility to have looked, I would not have done that in practice.

Q I think we had better, in fairness to you apart from anything else, just take an example of one of these drug charts, or prescription sheets, and just see what the position is. Might I have that? (To the Panel) There is a file containing a number of these and I may need to show the witness some. (Handed to the witness) I think, because some of them are now in pieces, they are not all folded together, if I could have the file for a moment I will show one example to you so we can establish what the picture would normally be. (Same handed) So the particular one I am asking the witness to look at, and I have not been through the entire file but I think it is one that is still intact, relates to Code A, Patient F. (To the witness) This is not a patient you dealt with. If I can just hold it up so that we can all see, this is the normal way in which these documents would be available to you when you did your ward round.
A Yes.

Q The first sheet has a prescription sheet, safety of the patient and all that, at the front. The inside sheet has various matters relating to the patient and so on, and has a column on the left "As required prescription".
A Yes.

Q On the inside of the first sheet.

THE CHAIRMAN: Sorry, Code A, may we at some point pass one of those around so that the Panel can be familiar with the layout?

Code A: What I am going to suggest is if I take the witness through it so he confirms this is what they normally look like, and then I can have that handed to the Panel and they can see. (To the witness) The second page, if you are reading it through in that way, having opened up the back fold, shows regular prescription drugs.
A Yes.

Q In this particular case none of them opiates. There is then a further sheet that covers the same thing, in this case blank.
A Yes.

Q In this particular case, and it would normally be folded like *this*, back page in, cover sheet---
A No.

Q Can we go on to that in a moment. If we just deal with the content of the sheet, the last sheet, if we open it all up, has "Daily review prescriptions", regular prescription details set out on the final page of this particular case, and in this particular case on that back sheet there is diamorphine 20-200, hyoscine 200-800, I think it is, midazolam 20-80.
A Yes.

Q All by Code A with the times and dates and so on. Before we hand this to the Panel so they can see it, you were going to make a point, and you shook your head when I was showing the thing folded up. Explain.
A The drug chart was kept inside a blue plastic folder which opened out in three parts like *that*.

Q So can I just pause. It would be sitting in the folder like *this*, would it?
A No.

Q All right. How would it be in the folder normally?
A The three parts of the blue plastic folder contained a piece of clear cellophane at the top and bottom, and the whole drug chart is slipped inside that.

Q If I can interrupt you, do you mean it was sitting inside the folder like *this*?
A When you opened up the blue plastic folder, that is---

Q That is what you would see? You would see the three inside pages. Carry on.
A So unless a patient were on a syringe driver or a variable dose prescription I would not have lifted the prescription sheet out of the blue folder to see what was on the reverse.

Q How would you know there was nothing there, because it is a regular prescription on the rear sheet? It is not saying anything – it says "Daily review prescriptions"---
A On the particular patient we are talking about, she did not receive the prescription which Code A had written up.

Q Yes. Again, not your fault, I am trying to take it bit by bit. So you are saying, and I will come back to that, I am just pointing out the last sheet, the one which you would have to turn over and look at---
A Yes.

Q It talks about daily review prescriptions.
A Yes.

Q What is the significance of that heading "Daily review prescriptions"?
A I think what it was designed with in mind was for using possibly with syringe drivers, with drugs like warfarin.

Q Yes.
A So in other words where you might think of changing the dose on a daily basis.

Q I am going to pause there, and then the Panel can see it for themselves and I will ask you some more about what you were going to say. (Handed to the Panel)

THE CHAIRMAN: Code A, while the Panel are looking at the document, if I have understood the evidence correctly, this blue folder in effect blocks out entirely a view of what is in effect the back of the form when it is opened out, so that the only thing that would be visible when it is in the blue folder would be those three inside pages, as it were.

Code A: I am going to ask the witness about that in a moment, because he was about to say something and I cut him off, and I want to make that quite clear when we take on board the shape of the thing. A lot of the others, the pages have come apart and they are separate. (After a pause) (Handed to the witness) Code A, you heard the Chairman's last point?
A Yes.

Q And I was going to ask you: we picture it unfolded?
A Yes.

Q In this, we will call it, the blue cover?
A Yes.

Q Supposing you wanted to look at what was written on the back sheet. What would you do when it is sitting in the blue cover?
A I would have to take it out of the blue cover.

Q So the back of the blue cover is not transparent, so you cannot see what is on the back of the sheet?
A No.

Q If, however, the prescription for diamorphine – and I am focusing on that for obvious reasons – was written on one of the inside pages. I am holding up an example which you will look at later on dealing with the case of Code A, our patient I?
A Yes.

Q I think Code A asked you about this. We shall come on to the photocopies in due course. You would see the range?
A Yes.

Q And there is a range plainly, in her case – diamorphine 20-200?
A Yes.

Q You could not have missed that, could you?
A I could not have done, but I do not recollect seeing it.

Q Really we have to conclude you must have seen it. We should conclude, should we not, that you did not take it up with Code A, although you had seen it?
A I have already acknowledged that I have no recollection of it. It is my responsibility to see that, to review prescription charts and where there was an entry like that to have taken it up with Code A

Q Because it would be a considerable concern for you as the consultant to check what the patient is on?
A Yes.

Q And to see what the prescribing history was?
A Yes.

Q In regard particularly to opiates of this kind?
A Indeed.

Q It obviously would have a significant effect upon your judgment and analysis of the situation?
A Yes.

Q We may have to come back to that just to illustrate the point with regard to the patients you yourself saw, but I am going to leave that for the moment, thank you. Perhaps you could fold that up, and then somebody can put that back in the proper little plastic folder for Code A (So done) Thank you very much. I want to ask you, please, and it is still in the same context ---

THE CHAIRMAN: Code A, I am sorry. The witness has been on the stand now for more than an hour, and I am getting indications from the Panel that they, at least, would appreciate a short break.

Code A Sir, of course.

THE CHAIRMAN: If that is a convenient moment, as you are about to move on – if there is ever a convenient moment.

Code A Of course. Just for the Panel's benefit, I am going to ask him about a couple of documents – they are not enormously long – but touching upon the same topic really, the same issue, and unless there are any other general questions I need to ask, I will be turning to the individual patients, which I will not be able to do within five or ten minutes. Those are going to take a bit of time. I imagine, depending on how long the Panel propose to sit this afternoon, that probably my questions may well run into tomorrow. I just say that to give you an indication.

THE CHAIRMAN: We normally sit until five o'clock as a general deadline. If we take a break now, then we are going to come back in in fifteen minutes or so and have not a great

deal more time. It therefore may be, if everybody is happy, we continue with the questions on this section now and then, tomorrow morning, resume and deal with the patients.

Code A: If that is convenient to the Panel, it may certainly be convenient to me and it may be convenient for the witness. I do not know.

THE CHAIRMAN: Would that ---

THE WITNESS: Yes, that is fine.

THE CHAIRMAN: Good, thank you. Panel? (The Chairman conferred with the Panel) Yes, very well. That is what we will do, Code A

Code A: Thank you very much. (To the witness) Code A, some further documents – not a great number of them. I would like you to look, please, at this one. First of all, I will get the witness to identify it before the Panel have it. This is a document which, as you will see in a moment – I will make sure you have a copy – is a letter from Code A Code A a lady whose name will be familiar to you, in October 1999 and it is headed "Learning Points from the Code A complaint". I am not asking you to read every word of it at the moment, but perhaps you would like to look at the last line but one where you see a Christian name. I would just like you to consider whether that would be referring, apparently, to you?

A I suspect it was.

Q It looks like it, but I think we have to confirm that with you.

THE CHAIRMAN: Code A do you wish us to receive this as an exhibit?

Code A: I think I have gone as far as I need to. It is October 1999, when you are still engaged, obviously, in the Dryad Ward. Does this ring any bells with you?

A I had not seen it until perhaps a couple of months ago.

Q At the time do you remember seeing it? I am going to ask for the Panel to have it, and then I can ask the questions if I need to about it.

THE CHAIRMAN: We will receive it as exhibit D4, please, ladies and gentlemen.

Code A: I am sorry to interrupt, but before this is handed out, I am a little troubled by this. The witness said he has never seen it, and he was not aware of it.

THE WITNESS: I saw it two months ago, just before the inquest.

Code A: He might have seen it two months ago, but how is that going to assist the Panel in relation to his state of mind at the time of these events, which is what he is being asked about. There may be a way of introducing this legitimately by calling evidence about it, but I do not quite understand how this witness can help you about his state of mind at the relevant events by looking at the document which he has not seen till two months ago.

Code A: Sir, the writer of this letter will be called in due course. I think I must put it to the witness to see what he has to say about it. Apparently it refers to him even if he has

not necessarily seen the letter itself, except shortly before the inquest. I am entitled to ask him about it. It is the only way the Panel are going to make sense of the questions.

THE CHAIRMAN: Code A if the letter is coming in advance of the witness ---

Code A I absolutely accept that. If the writer is being called, then I certainly accept it can be put in.

THE CHAIRMAN: Thank you very much.

Code A I understand the nature of my friend's objection if we were not going to call the writer of the letter.

THE CHAIRMAN: Thank you for clarifying that. As I indicated, we will now receive that in evidence and marked it exhibit D4, please. (Document marked and circulated)

Code A Do you still have a copy in front of your?

A I have it here.

Q We appreciate, without my reading through every word of the letter, that it is not to you.

A Yes.

Q Top right-hand corner: it is to somebody called Code A ?

A Who was the Chief Executive.

Q The Chief Executive of the then Portsmouth Healthcare Trust?

A Portsmouth Healthcare Trust.

Q And is he still the Chief Executive of whatever the new ---

A No.

Q He is not. But he was then? All right. And Code A was a manager at the Trust, I think?

A Yes, she is a manager in Gosport War Memorial Hospital.

Q Dated 27 October 1999, top right. "Learning Points from the Code A Complaint". She is thanking Code A for his memo and a copy of Code A letter. The first section is "Microfilming" and I am not going to trouble you with that. The next, 2b), is "Nursing Care Plans":

> "This has been picked up as part of the Clinical Governance Action Plan..."

And 3d) "Good Practice in writing up medication." That is the bit I want to focus on with you if I may.

> "It is an agreed protocol that Code A, Clinical Assessment, writes up diamorphine for a syringe driver with doses ranging between 20 and 200 mgs a day. The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not

written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient.

Code A may wish to raise this at the Medicine and Prescribing Committee.

I hope this cover all the points

Code A ?'

I think it may follow from what you have said, you never actually saw this letter at the time?
A I have never seen the letter.

Q Except for it was drawn to your attention before the inquest?
A Yes.

Q But the suggestion that you, Code A, may wish to raise this at the Medicine and Prescribe Committee. What happened there?
A I have no recollection of this now. I am not aware of any protocol which existed which allowed Code A to write up diamorphine for a syringe driver with doses ranging between 20 and 200 mg a day. I am not aware of any such protocol.

Q This is something you did not know anything about at the time? Yes?
A Correct.

Q Nobody had said to you, "This apparently is a protocol and you may wish to raise it." Nobody asked you to do that?
A Not to the best of my recollection.

Q In the ordinary course of events, would Code A, having received a message like this or a letter like this from Code A would you have expected him to pass it on to you or raise it with you?
A I would have expected him to.

Q All right, but you have no recollection ---
A Absolutely not .

Q Indeed, you are saying, "So far as I am concerned, that did not happen"?
A As far as I am concerned there was not an existing agreed protocol .

Q That I fully understand. I just want to make absolutely clear, in fairness to you, are you saying Code A never mentioned to you anything about ---
A I have no recollection of this at all.

Q All right. That is as far as I can take it with you. Do you want to add something - sorry?
A No.

Q Then there is another document which I would like you to look at, which is headed "Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion".

Take a look at it, see if it rings a bell and then I will see if you can assist us with that. (Same handed) Code A looking at that, does it ring any bells with you?
A Yes.

Q Down in the bottom left, it looks as though it is a document emanating from you.
A Yes, I was the author.

Q In that case, I think the Panel can have the document.

THE CHAIRMAN: Code A, are you content for us to receive it?

Code A: I have just been given it. At this stage I have no objection to it going in, on the basis that it is a document about which the witness can give evidence. Can I ask if this is being produced by a witness in due course, somebody who is going to speak about it?

Code A: This witness is going to speak about it, because it is his document.

Code A: I am sorry. I did not hear the witness say that.

THE WITNESS: Yes, I am the author of this document.

Code A: I beg your pardon. I did not hear. I accept that entirely.

Code A: Then perhaps it can be handed to the Panel. (Same handed to the Panel)

THE CHAIRMAN: We will mark it D5, Code A.

Code A: If you just take a moment to look through it, Code A, it may be you are familiar with it. (Pause for reading) Code A, I need to take you through most of this quite rapidly, I hope, and the Panel will be able to follow it as we go through it. Looking in the bottom left-hand corner, it is your reference, as it were, and it looks like the date is 3 December 1999.
A That is correct.

Q Would you just help us, please? How did this come about? Was this something you were asked to do or is it something you produced yourself by way of a protocol?
A I think where this originated from was the Code A complaint, where we had had an independent consultant come in to review that complaint. As part of reviewing that complaint, she wrote to the chief executive, expressing concern about the range of diamorphine that had been administered or had been prescribed for a particular patient. It was as a result of that – I think principally that – that I felt we needed to have clear policies and procedures in place for the prescribing of diamorphine.

Q Thank you very much. That gives us the context. May I make it clear, the Code A the witness is referring to is not the Code A we are concerned with as Patient H? Can we just look at what it says:

"INTRODUCTION

In community hospitals, particularly at weekends and bank holidays, medical cover is provided on an emergency call out basis.

This can lead to a situation whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met. To overcome this and also to give guidance to nurses who may be unsure as to who much analgesia (diamorphine) to administer within a variable dose prescription.

So we can see what you are talking about. Then:

"DOSAGE

Guidance from the palliative care services indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day i.e. up to 2 x 'Xmg' should be given."

You have dealt with that already.

"PAIN CONTROL CHART

It is suggested that a pain control chart (see appendix) should be completed on a four hourly basis for all patients receiving a diamorphine infusion.

PRESCRIPTION

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

ADMINISTRATION

If pain has been adequately controlled within the previous 24 hours, the nurse should administer a similar dose of diamorphine over the next 24 hours.

If the previous 24 hour dose has made the patient unduly drowsy etc, the nurse should use his/her discretion as to whether the dose to be administered for the next 24 hours can/should be reduced, within the prescribed dosage regime. If the minimum dose appears to have made the patient too drowsy, the on-call doctor should be contacted.

If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose.

INFORMATION TO PATIENTS and RELATIVES

Where patients are mentally capable of receiving such information, they must be told that an infusion of a painkiller (diamorphine) is being started and that the dose will be

adjusted if necessary to allow them to be as comfortable as possible without being unduly sedated.

When patients are unable to understand such information, by reason of either their physical or mental status, the decision that diamorphine is being, or about to be, administered should be communicated to their next-of-kin/relatives, again indicating that the aim is to make the patient as comfortable as possible and that the dose will be adjusted to keep the patient as comfortable as possible without being unduly sedated. If relatives express concern about the administration of diamorphine, despite the above discussion, the medical staff should be informed and the medical staff should make every effort to discuss the administration of diamorphine with the patient's next-of-kin/family. A resume of the discussion should be recorded in the patient's notes."

We can just take a moment to look at the Infusion and Pain Control Chart, which is attached to your document. That was, as it were, compiled by you as an illustration.
A Yes.

Q The next page is the Diamorphine Infusion and Pain Control Chart. So this was something which you were seeking to institute.
A Yes.

Q May I just ask you this, because it is obvious you stand by the content of that, because you have explained it in your own evidence. Was that something which actually did come into place? Do you remember?
A No, not in that form.

Code A: That may not matter. Sir, that is all I need to ask about those documents and if that would be a convenient moment for us to break, then may we do so?

THE CHAIRMAN: Yes. Thank you very much indeed, Code A. Doctor, we are going to break now and we will be returning at 9.30 tomorrow morning. Is that convenient to you?
A That is very convenient, thank you.

THE CHAIRMAN: Very well. I remind you that you remain on oath. Please do not discuss this case with anybody in the intervening period, nor allow anybody to address you on the subject. Thank you very much indeed. 9.30, ladies and gentlemen.

(The Panel adjourned until 9.30 a.m. on Wednesday, 1 July 2009)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 1 July 2009

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

Chairman: Code A, LLB JP

Panel Members: Code A

Legal Assessor: Code A

CASE OF:

Code A

(DAY SEVENTEEN)

Code A of counsel and Code A of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

Code A QC and Code A of counsel, instructed by the Medical Defence Union, appeared on behalf of Code A 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. Good morning, doctor, welcome back. Please take a seat. I remind you, of course, that you remain on oath and we broke yesterday when Code A was about to turn to the matter of individual patients.

Code A That is correct.

Code A, Recalled

B Cross-examined by Code A, Continued

Q Code A I am not going to trouble you with any matters relating to Patient E, Code A Code A whom you spoke about – the one contact you had with her. There is nothing I need to ask you by way of fleshing out what you said, so I am going to turn right away, if I may, to the position with regard to Patient I, Code A. I just want to deal first of all, please, with the sequence of events. I do not know whether you have at the beginning of that file a
C chronology?
A Yes.

Q I do not know whether you have the up to date one, the full one. Does your start with an entry on the 19 March?
A Yes.

D Q Then various bits in italic print?
A Yes.

Q Then I am sure we are looking at the same document. Wherever possible I am going to try to use this for assisting us getting through this quicker than we might otherwise do. Would you look, please, in that file at page 374, using those numbers that have a little dash either side. We can see there the notes you made on page 374.
E A Sorry, is this in the ---

Q Yes, sorry. I will indicate when we are going to the chronology. We need to actually look at the document itself.
A Yes, thank you.

Q You have already covered this.
F

> "A delightful 92 year old lady... She is still in a lot of pain which is the main barrier to mobilisation at present – could her analgesia be reviewed?"

A Yes.

Q Can we take that as being that you thought she perhaps needed to receive more
G analgesia than she was currently receiving?
A Yes.

Q Would you then look, please, at page 301, bearing in mind the date of your seeing her in hospital was 23 March.
A Yes.

H

Q You are writing there to Code A later on in the month, on the 26th – all right?
A Yes.

Q And you say in the first section of your letter that you had visited Code A at Haslar on 24 March. Now, maybe it is a mistake on the date, but it is one visit only that we are talking about?
A Yes.

Q So really it appears to be a typo in the letter, the 23 March. Your note says the 23rd?
A Oh, yes. I beg your pardon.

Q You see what I mean?
A I beg your pardon, yes. I understand what you mean.

Q I just want to be clear that it is not two visits. It is you seeing her once?
A That is correct.

Q It looks as if it is sensible to go on the date as being the 23rd? All right?
A Yes.

Q Could we go to the chronology that is at the front, if you would, and go to page 6. We can see the date, 23 March, is there but what is recorded in the history column, as it were, is from nursing notes and therefore not from your review. If we move on to page 8 in that same chronology, if you would, at the top, which appears to be in the section involving 24 March, we have the little note in summary form that I have just drawn your attention to. What we have to bear in mind – Sir, I am sure this can be corrected on a different version of this document – but we need to bear in mind that the chronology appears to be inaccurate. It should be the 23rd that you are seeing. It is not your fault, Code A, of course, so we can get it in context. We can just note, looking at the chronology, if you go back to the 23rd, page to page 6 of the chronology which is 23 March, to save you looking through all the documents to check these things we are assuming it is correct, on page 6 we can see that on the 23rd, half way down the page, she receives paracetamol.
A Yes.

Q The same amount that she had been on before. It does not look as if the hospital acted on your suggestion?
A Yes.

Q It appears, if you go over the page to page 8 again, that on the 24th she is still on 1 g paracetamol. They have not done anything about it and, over the page at page 9, again the same amount?
A Yes.

Q Is that perhaps an illustration of the kind of thing I was asking you about yesterday, about hospitals in this situation perhaps tolerating greater pain levels than you would in a continuing care ward?
A Yes, and certainly if one were wanting to attempt rehabilitation, it would be vitally important to get pain under control.

Q You indicated that where your letter is at page 301, if you go back to that which we looked at a moment or two ago, you talk about mobilisation not only in that document but elsewhere, but as I think you indicated to us in your evidence when you said "hopefully remobilisation" at the end, it would depend entirely on Haslar having checked out her post-operative condition to make sure she was suitable for transfer?
A Yes.

Q And you were indicating, although you did not spell it out in black and white, because one tries to look on things in the best light in reality that meant you had considerable doubts that she would get back on her feet?
A Yes. I had some doubts about whether... Yes.

Q I think the description you gave in the statement you made was "... meant I had considerable doubts"?
A Yes. That is correct.

Q What there is between the two may be debatable, but that is an expression you used in the statement to the police and obviously the concerns, you say, that the hip was very painful? Yes?
A Yes.

Q Can we go, please, to page 23 in so far as this patient is concerned?
A Is that the summary document or ---

Q I am sorry. It is my fault. The main file itself, page 23 – the document you looked at in the course of your evidence in chief. This is from the nurse, Code A, I think it is?
A Yes.

Q This is the transfer letter. You have already indicated to us that that was quite at variance with what you had found a couple of days before?
A Yes.

Q And you indicated that you would be very surprised if that lady could be properly described as "weight-bearing" unless she had, I think you said, great assistance?
A Yes.

Q That means – what – nurses supporting her?
A Yes. It would probably mean two nurses to support.

Q And a zimmer frame?
A A zimmer frame, possibly, yes.

Q Thank you. If you look back to the summary at the beginning of the file, I just want to use that as the quickest of dealing with the drug administration history. Perhaps you would turn up in the chronology document or history document, page 9, where we have the date of the transfer to Dryad. Do you see that?
A Yes.

Q Then over the page, the transfer having set out the position, you have Code A review. We have already looked at that. There she says, "Plan sort out analgesia."

A A Yes.

Q Obviously a sensible thing to do with the patient in this condition?
A Indeed.

Q The chronology goes on. If you look at page 11, there is a prescription for Oramorph by Code A and we can see the stages at which it was administered. I need not trouble you
B with the detail of that. Perfectly sensible course to take. Agreed?
A Yes.

Q Any time I ask you about a situation like this, when you were not the person who is actually dealing with the patient at the time, we have to bear in mind the most significant thing is the view of the person who actually is examining the patient, who has the patient there in front of them?
C A Yes.

Q Over the page to page 12, we can see that Oramorph is administered, together with co-dydramol – all right? In the top left section – Oramorph?
A Yes.

Q The particular drugs are given little bullet point or a bullet spot, as it were. The 28th,
D the next day, Oramorph and co-dydramol – all right?
A Yes.

Q Then over the page to page 13, in terms of analgesia, we are looking at the 29th, co-dydramol. She is not receiving Oramorph at that point. All right – on 29 March?
A Yes, yes.

E Q Over the page, page 14, co-dydramol, and then by the 31st, at the bottom of that section, Oramorph is administered again, and then there is co-dydramol and then MST. All right?
A Yes.

Q She is still in pain, as we can see on page 15 at the top. In a lot of pain. Again, nothing that you would criticise in terms of the opiates that were being administered at that
F stage?
A No.

Q But may I just ask you this in the light of something we heard from the witness? We have here a patient who has been treated on Dryad with co-dydramol, but also opiates in the sense of Oramorph and MST. All right?
A Yes.
G

Q Can I put it as bluntly as this? It would be complete nonsense to suggest that patients when they arrived at Dryad were immediately put on a syringe driver?
A As far as I am concerned that is complete nonsense.

Q We heard that said by a witness, and I would just like you to deal with that. On 1 April, looking at page 15, MST. Taking it pretty rapidly, page 16, MST on the 2nd, and the
H 3rd and on the 4th. All right?

A A Yes.

Q Then we come to the 6 April, when she is reviewed by Code A – all right?
A Yes.

Q Then over the page, page 18, on the 6th, MST – all right?
A Yes.

B

Q Then antibiotics are mentioned on the 7th, and we have the history of pain. The 7th, 8th and 9th on page 19, MST?
A Yes.

Q Your note, which we can see mentioned on page 18, which you dealt with in your evidence – your note of seeing her on 7 April?
C A Yes.

Q Asking for an x-ray to be taken?
A Yes.

Q As you said, there was clearly a continuing problem with the right hip. All right?
A Yes.

D

Q And you, of course, would be aware of the drug history up until that point. All right?
A Yes.

Q You had indicated that an x-ray should be taken. Would you look, please, at page 134 in the main body of the file?
A Yes.

E

Q If you look about half way down that page, dated 7 April, where it says, "[Seen by] Code A. For x-ray tomorrow at 1500 hours." It looks as though an x-ray had been arranged?
A It does.

Q I am going to go on the basis that an x-ray in fact, for whatever reason, was not taken. All right?
F A Yes.

Q I can only put this to you as a possible situation. The following day, if an x-ray had been arranged for the 8th, if the patient was unable to be moved safely or properly in terms of their care for x-ray, would it be proper to make a decision not to take an x-ray?
A I think that would depend on the whole situation at the time.

G Q Yes, but there might have been circumstances where, in the view of the nursing staff. The patient was not well enough to be moved to x-ray, or is that something we can rule out?
A I think that would be very unusual.

Q Thank you. Then can we look, please, at the drug chart at page 178 in that same main body of the file. Again, you have been asked about that and I am not going to go over that with you. We can see the various drugs that are set out, including morphine, MST and so on,

H

A and obviously in terms of seeing this patient on 7 April, you would have indicated if you had any concern at all about the drug administration up to that point. Right?
A Yes.

Q Then your next note is when you saw her on 12 April. That is on page 27, if we can turn to that, please. On 12 April:

B "Now v. drowsy ...
Diamorphine infusion established"

So when you saw her she was on the syringe driver. Correct?
A Yes.

Q Which had been commenced that day, and you took the decision, because she
C appeared to be very drowsy, that the appropriate thing to do was to reduce the diamorphine down to 40?
A Yes.

Q And you obviously had in mind the fact that it was a real possibility, if not a likelihood indeed, that pain would recur?
A Yes.

D

Q And that therefore if that did happen, the nursing staff should increase the dose to 60?
A Yes.

Q No doubt if it had continued, they would be justified in increasing it further?
A Yes.

E Q It is clear that the midazolam that the patient was also on, administered subcutaneously, was in fact increased, albeit not by an enormous amount, but it went up. I am not suggesting for a moment, Code A that that was something that you asked to be done. Indeed, Code A was not present when you saw this patient that day. She had been in the hospital in the morning, but this patient was seen by you in the afternoon. It appears that a nurse – and the initials, I think, are Code A initials – it looks as if the nurse got it wrong?
F A I did not know.

Q You did not ask for it to be done, and the dose in fact, midazolam, was put as the same as the diamorphine?
A Yes.

Q Which involved an increase. Can we just look, please, at page 174 in the same file. It
G is clear, obviously, that this is something you would have seen?
A Yes.

Q Indeed, it would be important for you to take note of it in terms of your examination of the patient, and your decision as to what was appropriate?
A Yes.

H

Q And it obviously is plain as a pikestaff that the diamorphine had been prescribed at the dose range 20-200?
A Yes.

Q That would have registered with you, would it not?
A I think that what... I just cannot remember. What it certainly registered with me is the patient was receiving 80 mg, which I felt was too much.

Q I fully appreciate that. We can see at 1640 in the section dealing with drug administration, that is when the dose was reduced.
A Yes.

Q Because Code A who I think is Code A, is the nurse doing that. Perhaps we can just take note of the point I made about midazolam. Lower down the page, midazolam was 20 and it was increased to 40, matching the dose which you prescribed for the diamorphine.
A Yes.

Q For whatever reason. You have told us about your approach as to how you would have established in terms of what she had been on, in terms of MST and how you would, as it were, take into account the amount that she had been on prior to the administration of diamorphine.
A Yes.

Q Which in fact was 45 in 24 hours. To make a direct comparison, a direct conversion with diamorphine, you would halve it, bringing you out at about 20 to 25, you have said, subcutaneously.
A Yes.

Q But because the patient's pain control needed to be greater, you therefore thought an appropriate initial dose in terms of the situation as you found it was 40. That is the process you adopted in working out the figure.
A Yes.

Q You have told the Panel that your reduction would have an effect on the patient, in other words, the reduction would come into play within about an hour.
A I emphasise that I am not an expert in pharmacology, but that is my understanding.

Q Obviously on that occasion, you did not ask what had happened with regard to the x-ray.
A No, I did not.

Q I am not criticising you for a moment, but just so we know. You did not say, "Why has this patient not had an x-ray?" Why not say on this occasion, "She should be given an x-ray, as I asked"? I am sorry if the answer is obvious, but would you like to deal with it? Why not say, "I did ask for an x-ray earlier. It does not appear to have been done. I think she should be x-rayed."
A I suspect that I felt at this stage this lady was terminally ill.

Q I would just like to ask you about that in general terms. Somebody in that state, why not refer them back to the Queen Alexandra? Again, the answer may be obvious, but I would like to hear you explain.
A Because I think this lady's prognosis was awful in terms of recovery at all and certainly functional recovery. I thought this lady's prognosis was awful, both in terms of her life and most certainly in terms of her ability to get back on her feet.

Q That leads me on to ask you something in more general terms now that we have discussed the condition of this patient. Where a patient on a continuing care ward is in such pain and distress that the administration of subcutaneous analgesia is justified and that subcutaneous analgesia involves a combination of diamorphine and midazolam, which is quite a common combination. Correct?
A Yes.

Q Those drugs are administered to deal with pain, distress, agitation – whatever one describes the symptoms as.
A That is correct.

Q The patient is on the palliative care route. We have seen that.
A Yes.

Q It may be very difficult to draw the line between palliative care and terminal care.
A This lady was terminally ill and needed palliation of her symptoms.

Q It is very difficult to say at precisely what time one is talking about terminal care, but people use different expressions. The patient continues to deteriorate. Let us assume that. Is it right for us to have this in mind? The patient's deterioration may be due simply to the patient's symptoms which brought about the pain, distress and agitation in the first place, their medical condition, to use that expression.
A It may be because someone was dying, rather than ...

Q Their condition is just getting worse.
A Yes.

Q It may be the deterioration is due in part to the effect of the subcutaneous analgesia.
A Yes.

Q That is something you have to live with in deciding what the best thing to do is.
A There sometimes is a balance to be struck between the dose and symptom control.

Q When the doctor treating the patient is faced with a situation of a patient continuing to deteriorate and the continued deterioration justifies an increase in the diamorphine and the midazolam, the doctor is aware that the administration of those drugs may well be playing a part in the deterioration.
A It certainly – yes.

Q But a doctor cannot decide precisely what is causing the deterioration: whether it is the patient's medical condition or that in combination with the analgesia without taking the patient off the analgesia and see what happens.
A That is correct.

Q Is that something you would seriously contemplate?
A Not in this situation. No, I would not normally contemplate doing that.

Q Again, I am sorry if the answer is obvious, but why not? Why not just say, "Well, I'm not sure whether the patient's condition is deteriorating entirely because of the medical condition or in part because of the administration of diamorphine and midazolam" Why not just take them off?
A I think what one has to look at is someone's prognosis. In other words, what is this patient's expectation of life, what sort of symptoms have they been experiencing up to date and to make a judgment about what is the most important issue to resolve. In other words, is someone at the end of their life and the overriding priority is to keep them comfortable or might they, by reversing the effects of opiates or whatever enable them to return to a more normal state?

Q What is the risk if you take somebody off a syringe driver?
A Worsening of the pain and agitation and distress.

Q Just in relation to this patient, before we leave the situation, you have told us what you recorded – we have seen it on page 27 – you have told us what your view was of the situation. I just want to check one thing with you, if I may. If you look at page 20 of the chronology? This is not an occasion when you saw the patient, but on 10 April, before you are seeing her on the 12th, on the night of the 10th, if that is right, she is described as having had a very poor night. Do you see that?
A Yes.

Q And:

"Appears to be leaning to left. Does not appear to be as well and experiencing difficulty in swallowing."

I am not going to read out the rest. She is not drinking, despite encouragement and help. She is on Oramorph at that time. That may well be an indication of some sort of cerebrovascular event.
A It could be.

Q Again, this is not a criticism of you. Are you able to remember whether you were aware of that when you did your ward round on the 12th and reviewed her?
A I really could not say.

Q If you had been aware of it, would that have been a further factor influencing your view as to what was appropriate in the circumstances?
A Yes.

Q You were asked questions about the cause of death. That is why I am making that point.
A I understand.

Q That is all I need to ask you about that patient. We can move on, please, to Patient J. We have the general picture set out in the chronology at the beginning of the file. It is a

chronology which is going to be updated; it is not as full as the other one which you were looking at, but it may be we can use that one to move on pretty quickly, because looking at the chronology on the first page, we can see that he was admitted to A&E on the first page on 6 August at QAH. If you turn over the page, if we look at 9 August, that is when you reviewed this patient. We have already looked at your notes. You remember this is the very large gentleman.

A Yes.

Q I am not going to ask you to look back at the notes, but just so we can see the history. There is a continuing history on QAH, "Reviewed on ward" and so on and so forth. On 13 August on page 3 of the chronology we see the planned transfer to Dryad. On the 15th, it is noted there is no bed available.

A Yes.

Q Another indication of the sort of pressure on Dryad. Correct?

A Yes.

Q On the 16th, there is no bed available. Code A from whom we will be hearing, saw him. Then if you look on page 4, on 23 August he was actually admitted on that date and you have covered that with us.

A Yes.

Q Looking on the chronology and moving over to page 5, he has been admitted on the 23rd, some medication, including paracetamol, is prescribed by a doctor other than Code A

A Yes. I think that was Code A

Q A blood sample was sent for analysis on the 24th.

A Yes.

Q Code A is prescribing temazepam on that day.

A Yes.

Q Then we see on 25 August a verbal message from Code A That is a doctor whose name you will recognise in Code A practice.

A Yes.

Q To withhold the clexane dose and review with Code A *mane*. In other words, the following day.

A Yes.

Q Would you just help us, please, with clexane? As I understand it, that is an anti-coagulant.

A That is right.

Q If a patient is bleeding – and we had better look at the notes just to see the sort of thing that was operating in this case. If you go to page 63, do you see the date of 25 August?

A Yes.

Q On that date, it is recorded in the summary that he is passing fresh blood PR – per rectum?

A A Yes.

Q Then:

"? Clexane. Verbal message from Code A to withhold 1800 dose and review with Code A mane. Also vomiting – metoclopramide 10 mg given IM … good effect.

B Would you just help us, please, with the significance of that? If the patient is passing fresh blood and it appears that Code A had received that information over the telephone, does that make sense?
A Yes.

Q The reason, if you could just explain.
A Because clexane is an anti-coagulant and, if not the cause of the bleeding, would C certainly make bleeding worse.

Q Then the administration in terms of vomiting of the other drug.
A Yes. Metoclopramide is an anti-emetic, in other words, an anti-nausea, anti-vomiting medication.

Q So that, so far as you can judge it looking the notes, makes sense too?
D A Yes.

Q Then if we could look, please, at page 174, looking at the top part of that page, we can see the two medications you have just been dealing with, or certainly one of them, the metoclopramide. We can see it is verbal, Code A, in the top left.
A Yes.

E Q Does there appear to be Code A signature lower down that page?
A I think it is overwritten. I think that is Code A signature.

Q What I am suggesting to you – again, you cannot possibly say, but just so we can have this picture in mind as we consider your seeing of this patient – it looks as if Code A probably came in in the evening. He must have been there to sign on the 25th. That would be consistent with him coming in, would it not?
F A He has signed it at some stage, presumably after 1755.

Q Given the verbal authorisation. It is consistent with him having actually come in perhaps later on that evening.
A Yes. It is consistent with him having visited the hospital and signed the drug chart.

Q Just while we are on that page, because we are going to come to your seeing G him on 1 November, we can see there diamorphine. I am sorry. That is in September so I need not trouble you with that. We will come back in terms of November later, the range that is there. Then would you look, please, at page 56? We can take up the picture in terms of Code A, page 56 at the top of the page, 26 August is when she calls to see him. All right?
A Yes.

H Q We have already dealt with this, "clammy unwell", and you have explained

A the significance of that, "suggest MI treat stat [diamorphine]". In other words, an instant dose of diamorphine, a single dose. Is that right?
A Yes.

Q "Oramorph overnight". Perfectly sensible so far as you can judge it ...
A Yes.

B Q ... in the circumstances. "Alternative possibly GI bleed but no ..."?
A Haematemesis.

Q The significance of haematemesis, please?
A Haematemesis means vomiting blood.

Q

C "Not well enough to transfer to acute unit
Keep comfortable
I am happy for nursing staff to confirm death"

We bear in mind, on the preceding page of that file, that Code A had admitted this patient on the 23rd. All right?
D A Yes.

Q We have the date. Code A, can we assume, should have seen the previous notes coming from the hospital?
A Should have seen? If ---

Q I appreciate you cannot say with confidence, but in the ordinary courses of events should have done. If we look back to the previous page, page 54, that is the
E hospital note by - I think it may be Code A?
A Yes.

Q On 20 August, he has put towards the end of his note, "Not for 555".
A Yes.

Q Meaning?
F A Not for cardiopulmonary resuscitation.

Q So in the ordinary course of events, if Code A had seen that, no doubt that would have a bearing on whether he made any decision that this patient should be referred back to the hospital?
A Yes.

G Q I appreciate the difficulty, Code A in you trying to deal with this when you had not actually seen the patient yourself, but we are trying to piece the picture together. We can see the situation, back on page 56, after what Code A had indicated, but, in her view, he was not well enough to transfer to an acute unit. He remained poorly, as the note made by her on the 28th. I need not trouble you with the next note. You, of course, then see him on 1 August. All right?
A 1 September.

H

Q I am sorry. I keep making the mistake - 1 September. It follows that you would have seen the previous history as recorded on that document?
A Yes.

Q Would have seen that Code A had been raising the possibility of GI bleed. All right?
A Yes.

Q If we go to page 174, the drug chart, when you saw him on 1 September it would have been apparent that he was on the syringe driver?
A Yes.

Q Again, it is the same point really, Code A, but I draw your attention to it: you would have seen that the diamorphine prescribed was the range 40-200?
A I can see that from the chart.

Q Because this is not an example of the rear part which you were dealing with yesterday, you would have been looking at the prescription position, because he is on the syringe driver; you would need to know, would you not?
A Yes. As I have said before, I cannot recollect, I have never seen this prescription, but, nevertheless, it was my responsibility to see it.

Q All right. I will not press you any further on that. I do not think I can get any further information on that. The view taken as to what was appropriate with regard to the treatment for this patient, back to page 56, would also depend on what you would have made of any results that had come through with regard to this patient. For example, the haemoglobin would have been available to you?
A I cannot say whether it would have been or not.

Q In the normal course of events it would have been?
A Yes.

Q We know that it had dropped so it would be an indication of the patient having bled quite significantly?
A Yes.

Q Once again, you did not query because you did not see anything wrong or incorrect about this patient being on the syringe driver by that stage?
A No, I felt this man was terminally ill and because of that I may not have looked or asked for haemoglobin results.

Q I think you have already indicated a number of factors that applied anyway with regard to this patient. Extremely unlikely to leave hospital terminally ill, as you have already indicated.

Q As you saw the history, and whatever other material was supplied to you, there was nothing which caused you to feel that Code A had acted inappropriately?
A No.

Q May I turn, please, then to Patient K, Code A. I think the first document to go to, please, in the file is at page 155. Do you have that?

A A Yes, I have.

Q Thank you. At the top of the page we can see, "[admitted to] Dryad", on 21 October. I am not going to read through all of that, but the plan:

"Get to know
Assess rehab potential",

B

- and so on -

"Probably for rest home in due course".

Then four days later you saw this patient, because that is the note you have already dealt with. Yes?

C A Yes.

Q As you have recorded about halfway through your note, "chronic renal failure"?

A Yes.

Q I want to ask you some questions relating to a view you have already expressed about the situation with regard to this patient and I am referring, Code A to evidence that you gave at the inquest. You may remember you were asked about this patient?

D A Yes.

Q We have the transcript. I just want to ask you about one or two matters arising from your evidence at the inquest. I think you indicated that although, of course, you are not a renal physician, you are not a nephrologist, you indicated that it was nonetheless clear to you that there is a long list of possibilities which could account for deterioration in renal function?

E A Yes.

Q We do not need to go through all of them, but that was the position. As you have already indicated, in terms of urinary tract infection that was an extremely common cause of deterioration in renal function ---

F A In elderly people, yes.

Q You have already covered that topic in the evidence you gave. The time that I think you saw her the position was, with regard to 25 October, if I can just deal with that. You were asked about why you had not referred this patient when you saw her on 25 October, why you had not referred her to a renal consultant, and you gave your reasons why. Do you remember?

G A Yes.

Q Again, I am going to take it shortly. You indicated that you felt from reading the notes, not from any personal recollection at the time, Code A was likely to have what is called a vascular dementia?

A Yes.

H Q A series of small little strokes and so on. Yes?

A A Yes.

Q In addition she had chronic renal failure. She had a very low albumen level in her blood?
A Yes.

Q Which you indicated was an extremely poor prognostic marker?
B A Yes.

Q Would you just explain that, please, why it makes the prognosis poorer?
A Albumen is a protein in blood and what we know is that in people with chronic illnesses the lower your albumen in general the worse your prognosis.

Q Your feeling was at that stage that because of the multiple problems and having excluded other physical causes, like urinary tract infection, it was unlikely C that anything more could be done from a renal perspective than had been done already?
A That is correct.

Q You made it clear again at that stage you are not a renal physician?
A That is correct.

D Q You made the general point:

> "It is not appropriate ... to refer everyone on to a specialist. One has to make judgments about what [a person's] prognosis is ..."

A Yes.

E Q In this case you felt that her prognosis was extremely poor and that was the reason why you thought it was not appropriate to refer this patient on to a nephrologist.
A That is correct.

Q I do not think I need to ask you any more detail because you were asked a number of questions about that at the inquest. For my learned friend's reference F point, that is day eleven, the inquest, page 33. There is another reference at day eleven, page 10.

Would you look, please, at page 156, the next page on, because, Code A there is just something about your further note I want to clarify with you. At the top of the page, we are now on 1 November, "Physically independent", and so on, you set out the position, you have already told us about it, and then the last two lines:

G

> "[Therefore] try home visit to see if functions better in own home."

What was the situation then? If you had indicated in your view on 25 October there were a number of problems which made the prognosis very poor, would you help us with what the realities were when you were saying, "[Therefore] try home visit"?
H A I cannot remember without going through the notes at what stage I would

A have made the judgment about Code A prognosis being so poor. I am not sure it was at that stage on the 25th. I think it was later but I would have to look through the file.

Q Yes. I think that was the context you were being asked in the inquest about the 25th. I will just double-check there but I am pretty sure that is right. (Pause) I think it was 25 October you were being asked about, because you were being
B asked about your note with regard to chronic renal failure, because you have already been asked by another advocate at the inquest whether you could have referred her to a consultant.
A Yes.

Q The coroner said:

C "In this case you didn't refer her on to a renal consultant. Why not?"

- and you gave those answers.

In that context, maybe you were meaning at a later stage?
A I think I may have been.

D Q At the time, on 1 November, it seemed a possibility that it might be worth trying a home visit?
A Yes.

Q Then if we move on to the next date in terms of the entries on page 156, 15 November, this is the "very aggressive", "very restless", and so on, note which you have, again, dealt with and asking Code A to see her and so on. You indicated if
E it was unclear whether the patient's distress was mental or physical then you might use an opiate ...
A Yes.

Q ... in circumstances you were presented with here. Can we look, please, at the position with regard to the drugs prescribed for this patient? I think the best page is to go to page 281, please. Do you see in relation to diamorphine on that page, it is 40-80?
F A That is correct.

Q That would be a reasonable range ---
A Yes.

Q --- in your view? Midazolam 20-80. We can see the administration of the diamorphine and the midazolam on the 19th. You were not prescribing that, but
G you were asked some questions about the fact that this lady had been on chlorpromazine, and it may be easier for you if we go back to the chronology in this case just to deal with this point. At the very beginning of the file there is another chronology. It will save you looking at different pages, I hope. Perhaps we can move on in the chronology, Code A to page 8. Do you have that?
A Yes, I have. Thank you.

H Q Looking at the 19th, that is, in fact, a Friday, Friday the 19th, when she was seen by Code A, she was prescribed and, indeed, it was administered

chlorpromazine, diamorphine, administered at 9.25 in the morning?
A Yes.

Q I just need to note the times because I am going to ask you something about that. Midazolam also at the same time, 9.25?
A Yes.

Q Chlorpromazine, would that have any bearing on what the appropriate amount of diamorphine or midazolam was to administer to the patient?
A Potentially in relation to midazolam.

Q Potentially because? If you would just explain why?
A They are both sedatives.

Q It has a sedating effect as well.
A. Yes.

Q If you look at the top of the page, on that same page, it in fact is the previous day, the 18th, the Thursday. Fentanyl was a 25 skin patch every three days, was administered at 9.15 in the morning?
A Yes.

Q If you can just take that on board in terms of what I am going to ask you. So the day before, fentanyl, 9.15 in the morning. The next day, as a result of matters which the Panel has already heard about, the drug prescription has changed. On the morning of Friday 19 November, is this generally right? The fentanyl would have just about reached its peak level?
A That would be my understanding, but to be absolutely sure I would have to check in the BNF.

Q I am not going to press you or suggest that you can give precise answers, but the fentanyl your understanding – just to follow through the point – is something that takes effect gradually?
A Yes.

Q The patch is put on, and is deliberately designed to provide to the patient ---
A Yes.

Q --- morphine ---
A --- a continuous low dose of opiate.

Q Yes. And over a 24-hour period, assuming the patch is still on, it gradually builds up?
A That is correct.

Q This is very, very general.
A Yes.

Q So that 24 hours after the patch has been put on, it has reached more or less ---
A Steady state.

Q And then it will decline?

A Yes.

Q In fact, a fentanyl 25 patch, as I understand it, means 40 mg in 24 hours. Does that make sense?
A The equivalence to ---

Q The equivalent to.... By the time the patient has reached peaked level, 24 hours later, they will have received 40 mg?
A I could not answer that.

Q I think, and I am sure you will heave a sigh of relief, Code A I think if that is as far as you can take it, I will not go through the remainder of the conversion that I was going to go through in terms of what the sensible prescription of diamorphine would have been to take over from the fentanyl. Or is that something you can ---
A No. Not really.

Q All right. You were asked about it by Code A I am not blaming him, and you gave an answer, but what you are really saying is, "I really can't sensibly answer as to what would be ---"?
A I do not have the expertise to answer that.

Code A: Then I am not going to press you on it. I am sorry it has taken so long, but that is all I need to ask you. Thank you.

THE CHAIRMAN: We will break here, Code A The witness has been on the stand for over an hour. We will come back in twenty minutes, please, ladies and gentlemen. Doctor, I remind you, you are on oath. Please do not discuss matters. The Panel Assistant will take you somewhere where you can get some refreshment.

THE WITNESS: Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone.

Code A: Sir, before I ask Code A any questions, may I start by mentioning that Code A Code A is at the back of the hearing room. He, of course, as an expert is in a different category to other witnesses. He is, I think, entitled to be present. He has also been receiving the transcripts of the hearing so he can comment, if necessary, on the evidence. I just thought I ought to mention that as a courtesy to the Panel.

THE CHAIRMAN: Thank you, Code A. You have no objection to that, Code A?

Code A: No.

THE CHAIRMAN: Thank you.

Re-examined by Code A

Q Code A, I have some general questions to ask you in re-examination. Then I want to ask you just a few questions – very few, I think – about each of the individual patients that Code A has gone through with you. When you began your evidence being cross-examined, you gave evidence that your understanding was that Code A spent a lot of her own time speaking to relatives, and she did a lot of counselling and that the nurses, I think, were fulsome in their praise of her?
A Yes.

Q Can I just ask where you information was coming from? You were going in one afternoon a week. Who primarily did you liaise with?
A That was from the nursing staff.

Q You say the nursing staff. I just want to see if we can tie that down a little bit. Was there any particular individual that you would tend to do your ward rounds with?
A No.

Q Not Code A?
A It could be any of the senior nursing staff.

Q Did you speak yourself to any of those relatives?
A I only remember during the course of the year speaking to, well, three or four sets of relatives.

Q Over the course of the year, did you say?
A Well, I think ... Over the course of a year, oh ... It is difficult to remember.

Q All right.
A But eight sets of relatives, perhaps. It is very difficult to ...

Q All right.
A Eight sets of relatives. It is very difficult to recollect.

Q All right. You were asked about the notation "happy for nursing staff to confirm death". You indicated that you would not expect Code A to talk to you before making that notation?
A That is correct.

Q But do we take it – and I think you have given us evidence already – that that is a notation effectively that the patient is expected to die in the relatively near future?
A I would anticipate... In general terms, yes.

Q In terms of a move to palliative care ---
A Could I just clarify that a little?

Q Yes.
A Obviously there may be some patients who are extremely frail and for whom one recognises that they are unlikely to improve in their condition, but death need not be---

A Q Absolutely ---
A --- perceived to be happening next week, not today or tomorrow.

Q If there was a decision, however, to move to a palliative care route, rather than a treatment route, do we take it that equally you would not expect to be consulted about that in relation to each individual patient?
A That is correct.

B

Q And how would you expect that to be written up in the notes?
A I would expect there to be a note to the effect that the care plan had changed from, if you like, trying to get someone back on their feet to trying to keep them comfortable.

Q Try to keep them comfortable. Or your notation, which we have just been looking at, I think, TLC?
C A Yes.

Q You were asked about Code A resignation in the year 2000 and you told the Panel that your understanding was that she would be replaced by, I think, a full time clinical assistant?
A She was.

D Q And ultimately did you say, I think, there were two and a half doctors? We understand what you mean by that – two and a half doctors looking after, did you say, 30 beds?
A Yes. That is the current position.

Q You knew, I think, in 199 that there was a police inquiry into one of the deaths on the ward?
E A On Daedalus Ward that was.

Q Yes.
A I was aware of that.

Q At the GWMH hospital?
A Yes.
F

Q Were you also aware of the CHI investigation?
A Yes.

Q Did those events, so far as you are aware, have any effect on staffing levels at the hospital ?
A Not that I am aware of.
G

Q Why did it change?
A I beg your pardon?

Q Why was there a change in the staffing levels?
A I am not aware that ---

H Q You just told us there was a change in staffing levels?

A A Yes, in terms of the medical staff.

Q Did you find out why management might have thought that was necessary? Do you know what the thinking behind it was?
A I think, certainly by that time, I had felt that the situation certainly from the point of view of medical cover was untenable. I had previously worked in Southampton where we had a GP, who was a clinical assistant, providing cover to our wards. Eventually the
B demands just outgrew the ability to keep pace. So I came to the view, as did my colleagues, that the model of cover we had just was not sustainable, just was not enough.

Q When did you come to that view?
A I think I came to that view during 1999, early 2000.

Q You also agreed with [Code A] when he suggested to you that missing notes were
C a common feature?
A On transfer.

Q Again, can I just ask you about your source of evidence about that. We have heard some evidence, for instance, from the nurse manager of Daedalus Ward, [Code A], who told us that they used to come late in 1 in 10 or 1 in 20 cases.
A I certainly remember that it was a recurring theme that notes were incomplete, X-rays
D were missing, et cetera.

Q Does that mean that they came but they came late, or they did not come at all?
A Usually came late.

Q Again, just dealing with the general questions, you said I think in answer to [Code A] that Oramorph was the first choice for strong opiates. Yes?
E A Yes. Yes.

Q I am not challenging that or doubting that. I am just seeking to clarify it with you. Co-codamol and co-dydramol – are they on the next level down?
A Yes.

Q In terms of the analgesic ladder?
F A Yes.

Q They are not opiates?
A They are.

Q They are opiates, but they are weaker opiates?
A Weaker opiates.
G

Q So is there perceived to be a jump between co-dydramol and co-codamol and that sort of drug, and an opiate-based drug? Sorry – a stronger opiate?
A Yes, but opiate... Morphine and diamorphine are stronger opiates.

Q Co-codamol and co-dydramol are drugs which I think are given relatively regularly by GPs?
H A Yes.

Q I just want to try to understand what your evidence is, and Code A spent a bit of time trying to understand, I think, what your evidence is, about these variable prescriptions. Do you still have one of the examples of the prescription sheets which you can open out?
A No.

Q Could I ask for you to be given one for a patient. Sir, we are just going to pass one to the witness, to use by way of example. (Sheet handed to the witness)
A Thank you.

Q Can you open it out?
A It is only the one sheet.

Q Can we get another one? (Sheet returned to counsel) I just want to understand when you were giving us evidence about the opened out sheets, and you were talking about a blue plastic folder that they came in.
A Yes.

THE CHAIRMAN: Code A, whilst we are looking for that ----

Code A: The example is Code A in the file.

THE CHAIRMAN: While we are looking for the document, I wonder, Code A, is there any chance that one of these blue plastic folders could be obtained?

Code A: Yes. I do not know if they still exist, but I will explore this with the witness. (Further sheet handed to the witness)
A Thank you.

Q Just fold that out. Which one do you have there? Is that Code A?
A Yes.

Q In our bundles we have in that particular file, just so we can try to follow the evidence, we have page 368A. That is marked "Prescription Sheet" with a big "B" in the corner. That is the front page, is it?
A That is the front page.

Q And there are occasions, I think, when you were saying, effectively you only looked at one side of the sheet?
A That is right.

Q Would that be the same side of the sheet with prescription sheet B on it?
A No.

Q It would be the other side?
A It would be the other side.

Q Can you just help us in relation to this patient, what sheets there are on the other side? Can you just go from left to right?

A A On the reverse sheet, first page on the left is the "Daily Review Prescription" sheet. The next page is for "Nursing Use Only".

Q Could you slow down? Sorry. "Daily Review Prescription", and in that version that you are looking at, does it start with diamorphine 20-200?
A Yes, it does.

B Q And the first date is the 19th?
A Yes.

Q So that is on the far left hand – that is 368E. That is the left hand panel, as it were. What is the middle panel?
A It is headed "For Nursing Use Only – Exceptions To Prescribed Orders".

C Q That is on page 368F. And the last one?
A Is "Portsmouth Healthcare Trust Prescription Sheet" with a "B" in the top right hand corner.

Q That is our front sheet, in fact?
A Yes.

D Q So that is the right hand pane. And on the other side, does it start with Oramorph?
A Yes.

Q So that is in fact our page 368B. Would you regard that as the front or the back of the sheet? Perhaps it does not matter. The next middle panel, does that have digoxin?
A Yes.

E Q That is our page 368C. Is the far right-hand side blank?
A Yes.

Q This sheet, you say, would have been opened out.
A Yes.

Q And it would have been in a blue plastic folder.
F A Yes.

Q It slips into the folder from the side or the top and it is then attached where?
A It has a sort of hook on it and it sits on the bottom of the bed, the bed rail end.

Q I am sorry if these seem such obvious questions, but in order to write on the sheet, you have to take the sheet out of the folder.
G A Yes. Or you can partially pull it out to write on it.

Q How would you write on it?
A It is retained by a strip of cellophane along the top and a strip of cellophane along the bottom and there is a split in the cellophane at the join lines, so you can just pull the page out like that. That is my recollection.

H

Q Is there any regularity about which side faces you? If you are standing at the foot of the bed, which side do you say would be facing you?
A As you approach the patient?

Q These sheets were at the foot of the patient's bed.
A Yes.

Q They are in clear blue plastic folders.
A They are a blue plastic folder retained by clear cellophane.

Q They are attached to the bottom of the ---
A They hook over the rail at the bottom of the bed.

Q Which side of the sheet would normally be facing outwards?
A This side here, which is Oramorph and the regular prescriptions.

Q If you wanted to look at the back of the prescription sheet, you would probably have to take it out of the folder, would you not?
A Yes.

Q Did you regularly or irregularly review prescriptions?
A I thought that on most occasions I did review prescriptions.

Q Which prescriptions did you think you were reviewing?
A I would certainly open the chart like this and look to see what was being prescribed.

Q How would you know whether a patient was on a syringe driver or not?
A Well, usually it would be pretty obvious when one approached the bedside.

Q Why?
A Because you could see the syringe driver.

Q Where?
A It would usually be on a bedside table or locker.

Q Were syringe drivers ever put under the pillow of a patient that you can recall?
A I cannot recall. It might even be on top of the bed.

Q It is just that we have heard some evidence about that. The other way, I suppose, of telling if a patient is on a syringe driver is if you did look at the chart.
A Yes.

Q You cannot help us as to how often you looked at the back of the prescription sheet.
A If a patient were on a syringe driver, I would look at this. Sometimes I recollect that Code A actually wrote syringe drivers on this part of the chart, but if it was not in that part of the chart, then I would take it out and look at what was on the reverse side. That would be my normal practice.

Q If a patient was on a syringe driver, but it was under the covers or under a pillow, would you still, do you think, have realised if a patient was a syringe driver?

A A Absolutely. The nursing staff would have reported it to me.

Q So that would have caused you, would it, to have looked at what was going into the syringe driver?
A On most occasions it would have done, yes. It should have done.

Q It seems to follow from that – and I think you have already given this evidence – that
B you must have seen these prescriptions.
A Yes.

Q But did nothing about it.
A I certainly do not recollect them and I did not do anything in particular about Code A Code A

C Q Do you know if the same system is used now, the blue plastic folders?
A No, it is not.

Q Do you still work ---
A I am not working on Dryad Ward any longer.

Q I appreciate that, but you are still working in a hospital environment.
D A Yes, but not in a ward environment at the moment. I am not usually in a ward environment.

Q You were shown a defence document. The first document I think you were shown is the document we have marked D4. At the bottom of this note, which is entitled "Learning Points from the Code A Complaint" dated 27 October 1999, we can see it is an agreed protocol that Code A clinical assistant, writes up diamorphine for syringe drivers with
E doses ranging between 20 and 200 mg a day.
A Yes.

Q I just want to understand your evidence about this. Were you then aware of any such protocol?
A I was not aware of any such protocol.

F Q If you had been aware of any such protocol, would you have done anything about it, do you think? Would it have disturbed you in any way, or would you have been content with it?
A I think it would depend on what the content of the protocol was.

Q If there was a protocol which indicated that when a syringe driver with diamorphine in it was being started, it would be appropriate for the clinical assistant to write up a
G prescription for a dose range of between 20 and 200 mg of diamorphine, would you have thought that was acceptable, or not?
A I think it depends on your interpretation of what is being – because it says "doses ranging between". So what I interpreted by that was that it could be a dose of 20 to 40, 20 to 80 and not just 20 to 200.

Q I understand. So you would say that is ambiguous?
H A Yes.

Q The next document that you were shown, D5, is your document. You wrote this up, did you? You devised this.
A Yes.

Q In December 1999.
A That is correct.

Q First of all, can you help the Panel why this was written up?
A As I said yesterday, I think the principal reason was in relation to the Code A complaint, where we had had an independent medical review from a consultant in Southampton, Dr ---

Q I am not going to ask you to go any further than that. That is why you ---
A Yes. She commented on the wide prescribing range.

Q Did this in fact come into effect, this protocol?
A Not as laid out.

Q What was changed about it?
A What was an acceptable prescription range. This is a draft document prepared by me. I have previously said that I was not an expert in palliative care. My understanding certainly in relation to smaller doses of diamorphine was that the correct approach was to double the dose if pain had not been controlled. So I prepared this document on the basis of that. That document was then circulated for comment to members of the Medicine Prescribing Committee, which reflected a lot of disciplines, including palliative care, and I immediately got feedback from consultants in palliative care, saying that what I had suggested would not be an appropriate ...

Q Before you devised this document, did you actually take any advice, or was it really a draft?
A It was a draft to start a discussion.

Q You not being an expert in palliative care, where were you taking your basis of knowledge from for even starting this document?
A I suppose it was my belief that it was appropriate to double the dose.

Q Where had you got that from?
A Just my early experience in Southampton, but it was very limited.

Q Then you took advice and the advice that you received was that this would be wrong.
A That is correct.

Q And so it was changed.
A Yes.

Q Do you remember what it was changed to?
A I think, as is now the conventional wisdom, the wisdom is that if pain has not been controlled by the current dose, then it is permissible to increase the dose by up to 50 per cent the following day.

Q Under the heading "Prescription" – and again, we now I think appreciate that this was written without the benefit of advice – you write:

"Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 20-80, 60-240 mg ..."

Did that also get changed?
A Oh, yes.

Q Because you appreciated it was wrong?
A Yes.

Q The very last line:

"If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the pervious 24 hours dose."

All of that again – I know it follows from what you have just said – presumably was changed.
A Yes.

Q And the table that follows on the next page is not how it was eventually published?
A That is correct.

Q We can put that away. Can we just now look relatively briefly at the individual patients you have been asked about? The first was Code A. I think the first thing I want to do is to clear up what I think has been thought to be an error in the chronology. If you have a look at these original notes. (Same handed) In our chronology, I am looking at page 6. This is Patient I. This is a very minor point perhaps, but I think it may be important to get it right. If we go to pages 373 and 374 and the chronology at page 6, do you see an entry for 24 March, "Ward round MMS"?
A Yes.

Q Then:

"Skin very thin and fragile lower legs
Needs to elevate"

That is not your ward round. Then underneath that, do we see a note saying:

"Dear Code A

Many thanks for reviewing this pleasant 92 year old lady ..."

A Yes.

Q Over the page, that note continues:

A "She has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult."

Then we have a note from you dated apparently 23 March.
A Yes.

Q And then over the page from that, we have a note dated 25 March.
B A Yes.

Q Do you think you have got that date right, or do you think you may have made a mistake?
A I honestly have no idea. Given that it was the 24th, yes, I think it must be a mistake on my part. I am sorry.

C Q It looks, does it not, as though it must be the 24th?
A Yes.

Q It may just be worth us making a notation on the record itself at page 374. Indeed, when you wrote your letter at page 301, you wrote about seeing the patient on 24 March.
A I did, yes.

D Q So that would seem to be consistent.
A Yes.

Q If we stay with the clinical records, this was the lady for whom you recommended an x-ray.
A That is correct.

E Q It does not look as though that x-ray was ever performed.
A That is correct.

Q I think you confirmed this to Code A that it would not be for nursing staff to take that sort of decision.
A About whether someone should have an x-ray or not?

F Q Yes.
A No, it should be medical staff.

Q Once a doctor has written that a patient should have an x-ray, nurses have quite a lot of power but they would not normally have the power to overrule that direction?
A Not normally.

G Q It is right to say that that request for an x-ray does not appear to have been followed up by anybody.
A That is correct.

Q That decision, that direction, recommendation, call it what you will, took place on 7 April 1999. Yes?
H A Yes.

Q It is in the clinical notes, I think, at page 27. Can we take it that if you are asking for an x-ray at that stage you are still regarding this patient as poorly but treatable?
A Potentially treatable.

Q Had you taken a decision at that stage that, in fact, this patient was for purely palliative care?
A I do not think so.

Q By the time you next come to see her, or at least there is a note to that effect on 12 April. Yes?
A Yes.

Q You describe her as being, "Now [very] drowsy".
A Yes.

Q No x-ray has been taken and she has been started, by the time you see her, on a high dose of diamorphine via syringe driver.
A She was on 20 mg BD of MST prior to that.

Q Yes, she was.
A Her pain had not been controlled by that dose. I think we worked through the conversion factors, and the conversion yesterday, in my understanding, was at that time to halve the dose of morphine to convert to diamorphine and my limited understanding at that time in palliative care would have been to double the dose to get the pain under control.

Q Yes. I am sorry. All I asked you was that on 12 April when you next came to see her she was now very drowsy.
A Yes.

Q You did not review your previous decision about an x-ray. Did you just not notice that or did you, by this stage, form a different view?
A I cannot remember, but my feeling was that on 7 April when I last saw her I felt that this lady's prognosis was extremely poor in terms of functional recovery and, indeed, of life. It is likely that this lady had a deep-seated wound infection. The British Orthopaedic Association produced a booklet in 2007 which talked about complications related to fractured neck of femur.

Code A: Yes. Can we just stop there for a moment? That is not knowledge that you would have had in 1999.

Code A: (Speaking off microphone)

Code A: I want to know what your thinking was in 1999.

Code A: Sir, with respect, I wonder if the witness could just finish what he was saying by way of explanation? Then if he has not answered the question, he can be asked to deal with it.

THE CHAIRMAN: Code A, let the witness finish and then you can ask your question.

Code A: (To the witness) What were you going to tell us about something published in 2007?

A What I was going to say was the overall mortality from fractured neck of femur is about 25% a year. If you have a complication such as deep-seated wound infection the death rate approaches 50% and that booklet specifically says that few of those who recover will ever walk again, and that certainly has been my experience over the years of dealing with patients where the operation for a fractured neck of femur, that there have been complications.

Q I want to go back to your state of mind on 12 April 1999.
A Yes.

Q You record that the patient was, "Now [very] drowsy".
A Yes.

Q Can we take it that you would then have looked at the prescription sheet to discover why?
A Yes.

Q You found that the patient was on a high dose of diamorphine.
A Yes.

Q Which you reduced by half.
A Yes.

Q Was the fact that the patient was now on a syringe driver relevant to your decision as to whether it would be worth pursuing an x-ray, as you had advised five days before?
A I do not think so.

Q What had changed?
A I felt this lady was now terminally unwell. There was constant reference throughout her notes, in the nursing records in particular, to this lady being in pain and my view was that this lady had gone through three weeks of real suffering where the pain had never really been properly controlled and I felt her outlook was pretty hopeless and the overriding priority by that stage should be to keep her comfortable.

Q At the time that you saw her, the time of this review, we can take it, I think, that you could not speak to the patient, or if you could speak to her she could not answer you?
A That is correct.

Q Because she was not rousable?
A That is correct.

Q Did you consider then that whether you made the decision or not a decision had been made to treat this patient palliatively?
A I think that was the correct decision.

Q I did not ask you that. I asked you whether you thought that decision had

A been made.
A Yes.

Q Thank you. You were also asked, and I think this was as a generality - it was put to you, I think, you cannot find out what will happen to a patient unless you take them off opiates.
A That is correct.

B

Q I just want to explore that with you for a moment. If you have a patient who is unconscious, unrousable, you are not going to be able to find out what is going on with the patient in terms of their sensation, et cetera.
A That is right.

Q Why cannot you simply reduce the opiates until they become rousable?
C A I did reduce the opiates.

Q I understand that, but the answer you gave to Code A was you cannot find out what will happen without taking the patient off opiates. Is there a distinction between taking them off opiates and reducing the opiates?
A Yes, there is.

D Q You can, presumably, reduce the opiates?
A Yes, or stop them.

Q You spoke early on in your cross-examination about the experience of the nurses?
A Yes.

E Q Your impression was that they were, in general, no doubt, very experienced nurses.
A That is correct.

Q Did you know what their training had been in the use of either syringe drivers or opiates?
A No.

F Q In this case we know that a nurse called Code A decided, after your intervention to half the dose of diamorphine, to double up on the midazolam.
A Yes.

Code A: Which I think you described yesterday as astonishing.

Code A: Sir, with respect, my friend cannot put that she made a
G decision to double up because he does not know why she did. It may be a mistake.

THE CHAIRMAN: Yes. Code A, all we can say is that she did double up.

Code A: I accept that correction. (To the witness) We know that she did it. Yes?
A Yes.

H Q You describe that, as I think you said yesterday, as astonishing?

A A Yes, given what I had found.

Q If that were a deliberate decision, it would, in your view, have been quite wrong?
A Yes.

Q If it is a mistake, is it a serious mistake?
B A Yes.

Q You were asked about indications that this patient had had a CVA?
A Yes.

Q We know that the patient was leaning to the left.
A Yes.

C

Q Was that what you took to be the prime indicator of the CVA?
A From that note it is possible the patient could have had a CVA.

Q Yes, well, all sorts of things could have happened.
A Yes, it could.

D Q The fact that the patient was leaning to the left, did you take that as being a possible indicator that she had had a CVA?
A A possible indicator.

Q Yes. This patient had a painful right hip. Might that cause a patient to lean to the left?
A Indeed it might, but it had not been commented on before.

E Q No. I want to move on then, please, to Patient J. I have not very much to ask you about that, but you commented on the earlier annotation, "not for 555".
A Yes.

Q You indicated, as I understood it, and I want your help about this, that that would potentially indicate non-referral back to hospital for treatment. Is that what you were saying?
F A What it would indicate is that that decision, I think, would indicate that one would have concerns about their overall prognosis.

Q One has to be careful, of course. This is an annotation made by another doctor.
A Yes.

G Q At a particular point in that patient's illness.
A Yes.

Q Are you saying that once "555" is written into somebody's notes, that every doctor thereafter is likely to follow that and that it may have an effect on their future treatment, not just for resuscitation but for other treatments as well?
A Decisions about CPR are complex decisions and decisions about the
H appropriateness of being for resuscitation or not can be a fluid one. In other words, there will clearly be patients who have incurable illnesses who are likely to

A die and their resuscitation status will not change. On the other hand, there are patients who may be extremely ill at a point in time and they will be deemed inappropriate at that time for resuscitation, but when they improve it is appropriate to review their resuscitation status and change it if that seems appropriate.

Q So far as other treatment is concerned, and this patient may be a good example, it seems he had a GI bleed?
B A That is correct.

Q The fact that "not for 555", or not for resus, whatever is written in the notes, is written into his notes is or is not an indication that his gastrointestinal bleed should not be treated?
A It is not an indication that it should not be treated but it may not be appropriate. It depends on the ---

C Q That would be for the doctor ---
A Reassessing.

Q It would require, would it, a reassessment?
A Yes.

D Q If we go to the clinical notes at page 56 and the page before, page 55, he had been seen by Code A Yes?
A Yes.

Q I think among other things, it seems as if it was he who prescribed Clexane. Yes?

E Q I am not going to go through the notes, but I think the evidence will probably demonstrate that he did. Then on 26 August the patient is seen by Code A and she decides he is not well enough to transfer to?
A Acute unit.

Q Then we see these two notations:

F "Keep comfortable
I am happy for nursing staff to confirm death"

A Yes.

Q Is that an indication at that stage, on 26 August, that the patient was for treatment or for palliative care?
A For palliative care.

G Q The decision to treat a 67 year old man, as I think this patient was ---
A Yes.

Q --- for palliative care would require what sort of assessment?
A It would require an assessment of what the underlying prognosis for this gentleman would be and the seriousness of the illness which had developed and, therefore, will it be appropriate to actively manage or not.
H

Q We know that on 30 August syringe driver was started, so by the time you see him on 1 September you found him to be, "Rather drowsy, but comfortable".
A Yes.

Q We see:

"Remains confused
For TLC ..."

So that is another annotation that this patient is for palliative care?
A Yes.

Q At the time that you made that notation did you take it that that was already the course that this patient was on?
A Yes.

Q Finally, I do not think we need to turn up any notes for Patient K, I just want to ask you about your understanding of fentanyl – what a 25 microgram patch means. What is your understanding of what a 25 microgram fentanyl patch would convert to? Let us take it 24 hours into its life, as it were.
A Right. Could I say that I think there has been a change in the *British National Formulary* about what the equivalence in morphine or the fentanyl patch has been between 1999 and now.

Q Right.
A I would have to reference ---

Q You said to Code A, and I did not catch quite what you said, I think you said it is the equivalent of 40 mg?
A No. Code A put that to me.

Q That was being suggested to you?
A Yes.

Q I thought you accepted that, or you ---
A No. I said I could not be sure.

THE CHAIRMAN: Code A, perhaps the witness could finish the answer he started a moment ago when he said "I would have to have reference to..." and then you interrupted him.

THE WITNESS: To a *British National Formulary* before 1999, and a current one. I think ---

Code A: I was not ignoring that. I was just about to take the witness to it, but I wanted to know what your evidence was before you referred to the *BNF*. Are you saying that you would not have been sure what the equivalence was?
A Not without looking at the *British National Formulary*.

Q I am not criticising you for that for a moment, but I just wanted to understand what your evidence was. Would you take out Panel bundle 1, which is to your left, and turn up tab 3 and go to page 12. Just to help you, this is a *BNF* for September 1998. Yes? So we are going back to at least the right ---

A I cannot see a date on it, but ---

Q If you look at the first page, you probably can.

A Thank you.

Q Yes? Okay. Then if you go to our page 12 – it is page 201 within the book – do you have that? Look at the page numbers with a line outside, the far right hand side at the bottom of the page.

A Yes.

Q The heading is "Fentanyl"?

A Yes.

Q We can see that the contra-indications and side-effects are those for morphine salts?

A Yes.

Q We can see under "Administration":

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

That is because the effects of the patch wear on?

A Yes.

Q Is that the brand name, "Durogesic"?

A Yes.

Q But it is fentanyl by a brand name. If we look underneath that, do you see "Administration"?

A Yes.

Q In rather small writing. It tell us doctors where to put a patch. Then do you see these words:

> "Patients who have not previously received a strong opioid analgesic, initial dose, one '25/micrograms/hour' patch replaced after 72 hours; patients who have received a strong opioid analgesic, initial dose based on previous 24-hour opioid requirement (oral morphine sulphate 90 mg over 24 hours + one '25 micrograms/hour' patch...".

A Yes.

Q So that gives us the conversion, I think. It is the equivalent of giving somebody 90 mg of Oramorph?

A Yes.

Code A: That is all that I ask you.

THE CHAIRMAN: Thank you, Code A we come to the stage now where the barristers have completed their questions, at least for the moment, and it falls to the Panel to consider whether they have any questions, then, to ask them of you.

We have already taken the opportunity as a Panel in the last break to discuss, Code A and Code A, what sort of time scale we would need before we would be ready to put our questions. I can tell you for the time that we have now reached, that we would not be ready to put any questions to the doctor before lunch.

It is now ten to twelve. We would need all of that time to have any prospect for one o'clock. What I am going to say is that we will not be in a position to put questions before two o'clock. I very much hope that at two o'clock we will be in such a position. We will take a shorter lunch to try to ensure that. Clearly the doctor has given some important testimony and it is very important the Panel consider carefully those questions they would wish to ask of him now so that we do not find ourselves having to ask him to come back on another occasion.

Doctor, I am afraid that means that you are now going to be released this side of lunch, other than, of course, you are free now to go and take a longer lunch. Could you please be back here for two o'clock? What will happen is that the Panel will put their questions, and I hope they will be shorter than they would have been if we did not take the time; there will not be a repetition, I hope, of questions. When we have asked our questions of you, the final hurdle is that then the barristers are entitled to ask any questions which might have arisen out of our questions. That, then, will be it. If you would return at two o'clock I would be most grateful. I remind you that you remain on oath. You should not discuss the case with anybody and you should not allow anybody to talk to you about the case.

THE WITNESS: Thank you.

THE CHAIRMAN: Thank you very much. Two o'clock, please, ladies and gentlemen.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Doctor, I sorry that we have kept you out for so long. As you will appreciate, your testimony raised a lot of issues that are of particular interest to the Panel. If it sweetens the pill slightly, I think as a result of our discussions, we will now be asking fewer questions than we would have been if we had just gone straight into questions from the Panel.

THE WITNESS: Thank you very much.

THE CHAIRMAN: We are going to start with questions from Code A, who is a lay member of the Panel.

Questioned by THE PANEL

Code A: I think some of my questions might reflect that I am a lay member, so would you bear with that. I would like to first have a look at Code A. I understand you

to say that there was some difference between when you assessed this lady and when she was actually admitted to the Dryad ward and there was some incongruency in between the letter from Haslar to Dryad and what the lady was actually like. When I actually looked at these two, your initial assessment and the letter from them, I actually had difficulty in seeing that incongruency – that there was not a consistency there. Does that make sense? Obviously not.

A You are saying there was not an inconsistency between ---

Q That is right. That is what I understood you to say. It was not entirely consistent between how this patient appeared when she got to Dryad Ward and when you saw her, and the letter from Haslar to Dryad?

A There would appear to be an inconsistency between my assessment when I saw Code A in the Haslar Hospital and the letter which accompanied Code A from Haslar Hospital. That is Code A, I think, who wrote that letter.

Q Right. Could we just explore that inconsistency a little bit because when I looked at it, I thought, "I can see there is a lot of consistency actually there, rather than the inconsistency", so I think I have the letter on page 23 in bundle I. That was the letter from the ward. I have a feeling – I think if we go to 301, that was your actual letter. Am I right? I am not very good with these references.

A Shall I ---

Q You see. I can see that what you are saying, the main problems are the pain in the right hip ---

A Yes.

Q -- and a swollen right thigh, and even a limited range of passive movement. When you actually saw her you were saying that there was a limited amount of movement. In a way, they are actually saying here that she can only move aided with two nurses and a zimmer frame. They are also saying there is not a lot of movement there, are they not?

A Yes. Perhaps it might be important to say there is a difference between active movement and passive moment.

Q Right?

A So when I saw this lady, I would deduct from my letter that she was not capable of lifting her leg of her own volition because of the pain.

Q Right?

A And when I saw her, even passive moment – that was me lifting her leg for her – even a limited range of movement, that was very painful for her. I find it just a little bit surprising that in the transfer letter from Haslar it says that she is now mobile from bed to chair with two nurses, when I found that even just lifting her leg a little of the bed was extremely painful.

Q Painful for her. So that might be around this whole acceptance of pain, et cetera. That could be an explanation or --- ?

A Sorry?

Q It may well be that whatever the pain, this person was got out of bed and ---

A Yes. I am not disputing ----

Q Okay. There could be a lot of explanations for that. That takes me one path, but I am under the impression that she was very with-it?
A Compos mentis, yes.

Q A compos mentis, quite with-it lady, so she was actually coming to Dryad for treatment in terms of mobilisation. She was not a palliative care?
A Not at that stage.

Q Can I then take you to Code A assessment on page 27?
A Sorry? Dr --- ?

Q I can see that Code A assessment here on page 27 is consistent with yours, that you want the plan to sort out the analgesia?
A Yes.

Q Okay. But this also tells me that this lady is not continent.
A Yes.

Q And my understanding was that this lady was continent but had some accidents – incontinence of urine because of the immobility, the lack of getting out of bed. We have heard from another witness that that can actually be quite transient. It is not necessarily a symptom of old age, of the systems breaking down.
A The lack of continence.

Q The lack of continence in this particular lady.
A I think if someone were having what you describe as "accidents", I describe that as not being continent.

Q Right, okay. A lot of your patients are actually palliative?
A Yes.

Q Who are incontinent?
A Yes.

Q Then this lady was different, in that it was occasional, not continuous?
A Yes. It is certainly recognised that if you are immobile, you are more likely to be incontinent.

Q Because you cannot get to the bedpan, or whatever else?
A That is right.

Q Absolutely. But how would this initial assessment by Code A enable me to understand those differences in this lady, to another lady who is coming in for palliative care?
A In Code A assessment she says that Code A is not weight-bearing.

Q Yes?
A So that clearly could be an influence on her continence.

Q Yes. Yes?

A I think recording someone is being incontinent is just recording a fact. It is not making a prognosis or indicating that someone should only be for palliative care or whether she is for active care. I do not think it is saying that.

Q Right. Okay. But in this is suggesting to me or to the nurses that there is a treatment programme here that we may have to look at?
A What is in it is Code A statement "Try and sort out analgesia".

B

Q That is right; that is right. But you have already indicated in your letter that you are not entirely satisfied that there is not actually – excuse me if I get this wrong – an orthopaedic problem. It is not actually a problem with the operation.
A I asked for some reassurance in my letter that all was well orthopaedically with Code A hip, and there is an entry from the orthopaedic surgeon the day after I saw her which does not make any reference to that. I find that not to be an unusual experience and
C I have tended to work from the basis that if it is in the notes, if they have said nothing, then they are happy with how things are orthopaedically.

Q Right, okay. But the pain continues in the hip?
A Yes.

Q What is the risk from this of actually the focus becoming on the analgesia and actually
D controlling the pain through analgesia rather than looking at whether there is another problem?
A Yes. Normally one would expect pain after a hip replacement, and that the pain would gradually ease with time.

Q Absolutely. That is right.
A If that does not appear to be the pattern, that is clearly the stage at which one should
E be thinking about or further assessing what is actually going wrong with this lady's hip.

Q Right?
A I think the question for me is, at what stage following the operation does one make that assessment, and that may be different for different doctors. Some may have a much earlier threshold for investigating than others. That is just human behaviour.

F Q So when you are looking at an initial assessment like this and you are setting out something for the nurses, what else might you expect to see in there that tells you there has to be a period of review? You are saying that really, when you are dealing with it it might be a matter of a period ---
A --- of time.

Q --- and see how the pain is decreasing?
G A I think what one would expect to see is a progress report, in terms of, is the pain settling and is the patient now starting to mobilise and if not, then initiating further investigation. But I think the overriding priority at the time of transfer was pain control.

Q That is fine, but you see the reason why I am asking questions around this is, when we actually get to the 6 April this patient is, I understand, seen by Code A and Code A addresses the analgesia and increasing the dosage. Okay?
H A Yes.

Q But does not actually address what is causing that pain not to be going away?
A Yes. Well ---

Q So it indicates a certain mind-set, or perhaps does it indicate that certain mind-set, that the focus is more on the analgesia rather than it is that this patient is in here for mobilised treatment, et cetera?
A I saw the patient the following day and felt that investigation was appropriate.

Q That is right.
A As I have said before, I think we have different thresholds for at which time we should do that, but I would have thought that by that time it was appropriate to investigate, because the pain was not settling.

Q But it is arguable that the same pattern is then progressed because the patient does not go for the x-ray? As far as we know, nothing is actioned. The patient does not go for the x-ray and then, of course, by the time you next see the patient the patient is then on the syringe driver?
A Yes.

Q And is drowsy, and unrousable?
A Yes.

Q And so dehydrated because they are not getting fluid, et cetera.
A Well ---

Q So has that focus on the analgesia prevented any addressing the treatment plan?
A I do no think so. Certainly from my perspective, when I saw this lady on the 7th, I was clearly concerned about what was going on in her right hip. Without going into all the detail, I think that the most likely thing is that she had a deep-seated wound infection.

Q Infection – yes.
A What can one do about that is then the next question. An x-ray is the first step in that. An x-ray may show absolutely nothing. Either way, one would then consider, "Is this lady well enough to refer back to an orthopaedic opinion?" What I would say is that if this lady did have a deep-seated infection, the consequences of that are fairly awful, in terms that it usually requires going back to theatre. This is already a lady who was very frail, so there would be risks simply from the anaesthetic. Also, the operation that is carried out leaves someone with considerable shortening of the leg and that can often make mobilisation very difficult. We know that developing a deep-seated wound infection carries a very poor outlook, so even with referral onto the orthopaedic surgeon, I would have been very pessimistic about this lady's prospects for surviving, let alone for walking.

Q But the alternative to that is to accept that the patient is just going to relapse into death, is it not? Move towards death?
A Unfortunately we recognise that is a complication of ---

Q That is assessing the risks, is it not? I am not certain how.... I can see what you want to initiate here – the x-ray ?
A Yes.

Q But I am not certain how those risks were actually assessed by Code A and by the nursing team?
A There is no record of that having been done that I can see.

Q So you come in after, and find out that the x-ray has not been ---
A --- done.

Q And that the patient has moved to being on a syringe driver and unrousable and imminent death is near. What should we have expected a reasonably competent consultant to actually have initiated at that point to ensure the protection of patients?
A When I saw her on 12 April?

Q Yes?
A I think it is to look at what has happened and to review what has happened to this lady up until that point.

Q Right?
A I have outlined what I felt the likely prognosis would be and then to make a decision about do we actively intervene, or do we treat this lady palliatively? I believe that is what I did.

Q I am not certain that you actually did make the decision to treat palliatively, the patient is already on the syringe driver and ---
A To continue the treatment.

Q There was no alternative, was there, at that point? You are saying once they are on a syringe driver you do not actually take – and he is unrousable – you do not take people off that?
A It would be unusual to do that.

Q That is right.
A But this lady, having had her operation on something like 19 March and three weeks later she is still in severe pain and, in fact, if anything in more pain that she was at the start.

Q Exactly. That is ---
A That indicates to me a very poor prognosis.

Q Is not the pain because the cause of it had not been addressed again?
A What I have said, even if ... I just think that the odds were really stacked against a good recovery for this poor lady.

Q I can hear that, yes, but I am not certain as to how that balancing act was actually carried out. Then, if you say there was a review at the end – a review of this lady's decline and the failure to take up the x-ray – I am not certain what the outcome of that review actually was?
A I felt by that time the x-ray had become irrelevant.

Q Obviously, yes.

A That is why I did not pursue it, because I felt this lady's prognosis was so poor that it was just right to treat her palliatively because she had been, as far as I can see, in a lot of pain since day one, and in increasing pain.

Q Yes. Yes. Okay.
A But the outcome is from trying to... It is a very difficult complication to manage – deep-seated wound infection after fractured neck of femur. The outcomes are extremely poor. I mentioned earlier some of the figures that are associated with that. Those are figures, if you like, across the board. This lady was 92, so her outcome is likely to be worse than the average outcome simply because of her age.

Q Yes, yes. But having heard from an earlier consultant giving us evidence, there is certainly the view that you would move to looking to actually rule out whether or not further surgery was necessary or further treatment of the hip would have been necessary?
A I can only speak from my experience, which is that such patients do very badly and, as I said, there is a document the British Orthopaedic Association published just two years ago which affirms that.

Q Can I move on then slightly, and look with you around palliative care. What does a good assessment – what should a good assessment – in relation to palliative care look like? What would you expect to see in there?
A First of all, what is the patient's diagnosis and, resulting from that, what is their prognosis for quality of life, et cetera. That is going to be the starting point.

Q Yes?
A Then, if a patient develops an intercurrent illness, depending on the severity of that, whether it is appropriate to treat that or not in the context of someone with a poor prognosis. In that situation, I think that often we are aiming to relieve symptoms rather than looking to curing or to treating very serious illness arising in someone who already had a poor prognosis.

Q Right, right. So in a case like Code A, is that what you would have expected to have seen here? This lady moves from coming in for mobilisation treatment and we see here drift – if I use that word – or move into not just palliative care but end of life care. Where is that? What assessment?
A As I have said, the patient with fractured neck of femur is in an extremely serious condition. We know that across the board, with all patients with fractured neck of femur, there is a 25 per cent mortality rate at one year. So although someone may appear to be fit, well and going to have a simple operation, it is a marker of poor outcomes. It is not infrequent to see people who have previously been well who die from complications of fractured neck of femur.

Q But when I read the guidelines about palliative care, it talks about bringing together all the relevant people to decide on the prognosis, the outcome. Why would you not have sought the view of a consultant from the acute ward or someone who deals with the orthopaedic side to actually come and review this lady?
A That was the thinking behind asking for the x-ray, to try and find out what is happening, with a view to them seeking orthopaedic review, because the first thing an orthopaedic surgeon would ask me, if I had referred a patient to him, is, "Well, have you re-x-rayed the hip?"

Q But that did not happen here.
A No, it did not happen.

Q It went from one to the other without that detailed assessment, this person's prognosis was so poor, moving into palliative care. In fact, we moved from the one to the end of life care.
A Yes. I am sure that was an appropriate ...

Q Also when I look at the palliative care guidelines, it advises that you have to take account of the fact that to constantly make sure that the drugs are not making the patient worse than the actual cause or problem for the patient. So how did you see that the controls were put in so that constantly was being reviewed within palliative care?
A There is nursing documentation to support the fact that this lady was really in pain for almost the entire length of her stay in hospital, both Haslar and at the War Memorial Hospital. Drug charts and the nursing documentation show that Code A was needing increasing doses of diamorphine to try and control her pain. Now, in most situations, when one is aiming for palliation, one does manage to – what one is aiming to achieve is pain control and someone being alert, conscious, but sometimes it is not possible to achieve that and the level of pain control or sedation needed to control patients' symptoms is such that it makes them drowsy. I wish it were thus that one could always palliate and leave people alert and orientated, but sometimes unfortunately it just does not happen.

Code A: I will leave it there. Thank you very much.

THE CHAIRMAN: Code A is also a lay member of the Panel.

Code A: Good afternoon. If I could turn you back to Patient I, page 27. You had seen this lady prior to entry on to the ward.
A Yes. I saw her in Haslar Hospital.

Q You had known that she was in pain then.
A Yes.

Q Just before we go any further, on page 27, I think it is Code A note, can you tell me what date that is? I thought it was the 26th.
A I think it is.

Q It is the 26th. Yours is the 7th.
A Yes.

Q If you turn back to page 23, can you tell me where the date is there, because I am struggling to find that. I cannot see a date. Can you?
A No, I cannot see a date.

Q But it talks about "she was admitted on the 19th".

THE CHAIRMAN: It has just been pointed out to me on page 23, above the extension number, there is the number 260399. There are no full stops or slashes, but it looks like a date.

THE WITNESS: It looks like a date.

Code A: So that was written on the same day as this.
A Yes.

Q 26.3.99 is a Tuesday and you see the patient the following week on the Wednesday.
A Yes.

Q You have said that she is still in a lot of pain.
A Yes.

Q But you still think on the 7th there is still reason to look at it positively, because you want him to do an x-ray.
A I think I would have been looking at it negatively.

Q But you want him to do an x-ray, you want him to find out the cause, et cetera, et cetera.
A Yes.

Q I should think that is more of a positive than a negative, but fair enough. If those types of things had taken place on the 26th ----
A I do not think it would have been appropriate to do it at that stage. This comes back to the question of at what stage, if someone is in continuing pain, does one then start investigating. Some people will mobilise on day two after a fractured neck of femur, some very elderly ladies. Some people may take ten days, two weeks to really get going, simply because of pain. So it is unpredictable.

Q But you have told us that when you first saw this lady, the mobility, you showed us lifting her leg with your hands and she was in a lot of pain.
A Yes.

Q So surely the closer you are to trying to reverse the problem, nearer to the actual operation would give a better prognosis of the final outcome, would it?
A I think the other thing to say is that x-raying someone in this condition often does not tell you very much. The x-ray can be completely normal with a deep-seated hip infection. The longer time goes by, the more likely the x-ray is to become abnormal. What an x-ray could tell us was the collapse of the head of the femur, that the femur had dislocated. I think that both of these are much less likely than a deep- seated wound infection. To come back to your question, it is a matter of judgment at what stage you think it is appropriate to investigate. I would not be thinking of x-raying someone let us say if they were still in pain after a week after their first neck of femur. I would still be thinking that this could still be natural recovery.

Q It would still follow that the closer from the operation that you identified, for instance, the infection, the more chance you have of stopping that infection getting bigger, curing that infection quicker.
A My guess would be yes, is the answer to that. I am not an orthopaedic surgeon, but often these deep-seated wound infections are extremely difficult to treat.

Q I see no note from the 26th to the 7th within this. There is no record of any deterioration or action being taken. You go to the nursing notes and I have tried to read through those and it talks about "still in pain", "still in pain", "still in pain", but no-one is trying to find out what the cause is. I am right in thinking that you visit once a week.
A That is right.

Q But Code A visits every day.
A That is right.

Q And there is no record.
A That is right.

Q Then on the 7th you instigate a plan of some sort with regard to x-ray.
A Yes.

Q Then you visit again the following Monday, which is the 12th, and nothing has been done.
A There are records in the nursing notes about some (inaudible) which has recurred. I acknowledge that there is not anything written. In an ideal world, one would have wanted that to be happening.

Q You see, earlier in your evidence you said that they knew more about it than you and you thought that the nursing staff and Code A you had the utmost confidence in them and those types of things.
A Yes.

Q Yet here we have a situation where you actually instigated a plan and nothing has been done, nothing is carried out. I am not from your industry, but in my industry, somebody would be wanting to know why.
A On my ward round, I would be gathering information from the nursing staff about what had happened since ...

Q Because you would not be able to take it from here, would you?
A No, I would not. Definitely not.

Q So there is something amiss with the recording. I am moving away from that now, doctor. Could I just take you to page 169? It is the front page of the concertina sheet, the drug sheet. If you go down two-thirds of the page, under 9:

> "Put date prescription needs to be reviewed in 'review' box of regular prescription section."

If you turn to page 174, I think that sheet is all Code A signature and there is no review date.
A No, there is not.

Q On any of it. This is Patient F and there is no review date on any of those. Surely a review date is exactly what it says.
A Yes.

Q Therefore if there is no review date, these prescriptions are never-ending.
A There should be a review date.

Q Can you remember bringing that to ---
A No, I cannot remember.

Q Do you think that is an ideal situation, to have no review date?
A No.

Q One of the allegations against Code A is that she did not keep clear and accurate and contemporaneous notes on a number of things and one of them is the drug regime.
A Yes.

Q Would you say that that is a failing on Code A part?
A Yes. There is clear instruction on the prescription sheet to complete a review date.

Q Initially you told us – correct me if I am wrong – that you thought that Code A and Code A had more experience in the use of these opiates.
A They did have more practical experience of using them.

Q I think you also said that if you had come to something outside the normal, you would have referred to the BNF.
A Yes.

Q Where they may have more experience than you, in 1999 you were a consultant.
A Yes.

Q You were a very experienced person in your field.
A Yes.

Q You have said to us that if you would have seen the prescriptions for 20 to 200, that wide range, you would have done something about that.
A Yes. It was my responsibility to do something about it.

Q When you saw that – and you reduced one from 80 to 40.
A I did not recollect seeing prescriptions for 20 to 200 mg until the police interviewed me and produced a prescription sheet which demonstrated that.

Q With the greatest of respect, doctor, I have difficulty accepting that, because you told me that the sheets are there, you are reviewing the patients, you are on a ward round with people that you say have more experience in this than you and, before you can make a judgment, you must review all the facts.
A I accept that I must have looked at this prescription, but I have no recollection of it. I should have done something about it. I fully recognise that.

Code A: Thank you very much indeed. That is all.

THE CHAIRMAN: I am going to introduce Code A, who is also a lay member of the Panel.

A Code A: Good afternoon. My question is around your supervisory role in relation to Code A and also in relation to the nursing staff. Earlier on in your evidence, you gave examples, quite a few examples, of situations where you would not have expected Code A to consult with you.
A Yes.

Q What my question is is whether you can give me some idea of the extent of your
B knowledge of the amount of discretion that Code A and the nursing staff had in their day-to-day work. For example, in relation to the syringe drivers, we have heard evidence about syringe drivers being prescribed without a specific start date. Were you aware of that?
A I am not aware of it being without a specific start date.

Q No incident at all of that?
A Do you mean that it was not recorded on the ...
C
Q That there would not be a specific date as to when it would commence.
A I think I said that in our palliative care ward today we do admit some patients who may not be immediately in need of opiates, but I think I described the sort of patient who is perhaps recovering from a very serious operation, is very frail and one was not sure whether this person was going to get better or whether they might in fact continue to decline. In that situation, we would write up prescriptions in advance. In other words, the prescription would
D be dated, but there would be no start date on it.

Q Are you talking about via syringe drivers?
A Yes.

Q So you would consider that appropriate?
A What I cannot be sure of, because I do not work in the palliative care ward, is whether
E that is a syringe driver or whether – I think that is written up as Oramorph, such and such a dose, three to four-hourly as required. That is from memory of what we do on a palliative care ward today, but I do not work there, so I cannot ....

Q If that were the position would you consider it appropriate for a syringe driver without a specific start date? That level of discretion, would you consider that appropriate?
F A I think it would come back to the clinical condition of the patient. In other words, if it was someone who was very frail, let us say might be having difficulties in eating and swallowing, one might in these circumstances consider it appropriate to be considering subcutaneous drugs rather than oral drugs but I am not sure of whether a syringe driver would be appropriate at that stage.

Q Is that because, do you think, of the risk involved in that way of
G management?
A Syringe drivers are applied when patients are no longer able to swallow or where you feel that a patient would be caused a lot of distress by repeated injections.

Q Are there risks involved? I am not sure I understand what you are saying.
A I do not think there is any greater risk than giving orally. It is just I think we
H should be giving drugs orally where we possibly can.

Q Let us suppose there was a syringe driver prescription without a specific start date. Would you consider that that would be operating in the patient's best interests, working within that format?
A It would depend on the individual patient and their circumstances.

Q You saying it could be in the patient's best interests?
A I think it could be, if, again, the situation is someone who is very frail, having difficulties swallowing, or let us say a very thin skin and you knew that repeated injections were likely to be painful, then in these circumstances it might be appropriate to prescribe a syringe driver.

Q Yes, but my question does not really focus around prescribing syringe drivers *per se*, it is about the flexibility regarding the commencement, if you see what I mean? There is a slight difference.
A I think if you reasonably anticipate that the patient may become distressed within the next few days then I think it is reasonable to prescribe in an anticipatory way.

Q What about from the nursing staff's point of view? We have heard that some nursing staff, they have actually told us that they have the flexibility to initiate in certain circumstances the syringe drivers. How do you see that?
A I am sorry. Could you repeat that?

Q The nursing staff could initiate the syringe drivers off their own volition, without having to consult with Code A or any other doctor.
A I cannot say I was aware of that.

Q If that were the case, what would be your view on that?
A I think it would depend on the individual situation. If Code A had assessed the patient and felt that a syringe driver might become appropriate because she is not available, I do not feel it is unreasonable for nursing staff to commence that syringe driver because she is immediately available.

Q I think you said earlier on in your testimony that you were not really aware of the level of training that the nursing staff had had.
A No, I was not.

Q So even taking that into consideration you would still consider it appropriate?
A When I came onto Dryad ward the nursing staff seemed to be very au fait with syringe drivers and I made the assumption that they knew how to manage this, but I did not enquire as to what the specific training was.

Q Do you think there were any potential risks, that way of operating?
A Administration of opiates has to be undertaken by two qualified nurses and so I think that there was some safeguards in that. There was not one individual nurse could go to the drug cupboard and look at the prescription and just decide off her own back what was the appropriate - so there had to be two nurses as far as controlled drugs were concerned.

Q Again, would that way of operating be in the patient's best interests?
A In terms of relieving a patient's pain and distress yes, I think it would be,

given that there was not a doctor immediately available on site.

Q Are there any situations where you think it may not be in the patient's best interests?
A I cannot.

THE CHAIRMAN: You are looking a little tired. Would you like to take a break now before we continue?

THE WITNESS: No, I am fine, thank you.

THE CHAIRMAN: You are quite sure about that?

THE WITNESS: Yes, thank you.

THE CHAIRMAN: If at any time you do feel it is all getting a bit much and you need a few minutes to get yourself together, please just say so. This is your testimony and we will take it at your pace.

THE WITNESS: Thank you very much.

THE CHAIRMAN: I am going to pass you now to Code A, who is a medical member of the Panel.

Code A: Can I just take you back briefly to the same case that both of my colleagues opposite each other talked about, and this is Code A, that is Patient I?
A Yes.

Q The first question to a geriatrician is this: does age in itself matter?
A No. It should not be a barrier to receiving treatment if treatment is deemed to be appropriate.

Q Code A, said a witness, was a very independent old lady of 92 who drove her car until she was 90, and this poor old lady was pulled over walking her dog.
A Yes.

Q Fractured her neck of femur. It is an important context. Do you agree?
A I did.

Q Let me then go, just leaving that aside, to the issue that you raised in your note. You were clearly concerned that there might be an orthopaedic problem.
A Yes.

Q Both before she left Haslar ...
A Yes.

Q ... and later when you saw her, I do not know, about a week after she came into Dryad.
A Yes.

Q You noted shortening.
A Yes.

Q I think I heard you say to Code A that you thought this was due to deep-seated infection?
A Yes.

Q About which you would be very pessimistic in terms of outcome?
A Yes.

Q But could there be another explanation of shortening? What would a junior doctor think if you said, "Shortening of the leg, doctor, what do you think?"
A The other diagnostic possibilities would be dislocation of a hip. That could produce shortening.

Q For the lay members, is that something that is remediable?
A Yes, it is, but I think it is unlikely in this clinical context, because usually when a hip is dislocated and there is a sudden increase in pain and not the gradual increase in pain which seems to have happened. Also this lady had been seen, I think, by the physiotherapist who did not report any concern with the hip, and physiotherapists are often quite good at picking up orthopaedic problems. The other possibility is that her femoral head had collapsed as a result, because just osteoporotic and soft and metal work, and, again, that presents a major challenge from an orthopaedic perspective to sort that.

Q Indeed, the orthopaedic surgeon who independently gave us his witness on that said that there was a chance in osteoporotic old people that the metal work might come apart.
A Yes.

Q Is that potentially remediable?
A My understanding is that when you have metal work in place it is extremely difficult to eradicate infection and that the only chance of getting that infection to resolve is actually to remove the metal work.

Q What we seem to be agreed about is that when there is shortening there are different possibilities and there is, perhaps, some potential for treatment?
A Yes.

Q You say that was not going through your mind, that you were being pessimistic, not optimistic, I think you said to Code A?
A Yes.

Q So Code A, who was very independent, pulled over by a dog, might she not have had the chance of an orthopaedic opinion?
A As I said, when I requested the x-ray that was at the back of my mind, because the first thing an orthopaedic surgeon would ask is, "Have you x-rayed the hip", but I would still come back to my view that even though this was an independent fit lady beforehand, her prognosis at this stage when I saw her on the 7th I think was looking distinctly guarded.

Q That is to say the least, is it not, but is that not because nothing has been

done? I am sorry, I am probably repeating on what my colleagues have said, but is that not because nothing has been done?
A Having seen such patients in the past, my experience is my patients do extremely badly.

Q We will leave it there. Just going back to the general situation. You came to Dryad and there was you and there was Code A and her staff and there was Code A, the clinical assistant, daily, Monday to Friday. I think you mentioned a senior registrar?
A Yes, Code A occasionally.

Q So there was a registrar on occasion. So if Code A needed advice, on a day-to-day basis if she needed someone to refer to with a problem, would she go to you?
A Yes.

Q There would not be another way she could go to your registrar, for instance?
A No, that would be unlikely.

Q How available were you?
A I may not always have been immediately available but Code A would be able, if she was not able to contact me directly, to leave a message with my secretary and I would try to get back to her.

Q So there was a contact point that could easily be used?
A Yes.

Q Forgive me for asking this question: were you amenable to being contacted?
A Well, I would like to think so.

Q Glad to be contacted?
A Yes.

Q Would the staff have known that?
A I think so, yes.

Q Did they ever?
A I think I remember a couple of occasions. Well, I certainly remember being down seeing relatives of an evening at the request of staff, either Code A or the nursing staff. I think I recollect being there on a weekend once when I was not on call to sort out a problem. So I would like to think that - I think it is really important that consultants are available.

Q Thank you very much for that. Let us think about Patient J, Code A Code A was this very obese gentleman who came from - I have forgotten now. I think it was the QA?
A Queen Alexandra Hospital, yes.

Q He came for a chance at remobilisation.
A Yes.

Q I think there was somebody, it might have been you, who said there was a

A good assessment on the day of admission and that was by Code A?
A I am not sure. I do not think it was me that said it, but there was a good assessment by Code A

Q That was the kind of note you would expect a hospital doctor to make?
A Yes.

B Q He started this gentleman on Clexane.
A I would have to ---

Q Okay. We will take our time on that one. It should be page 55, I think, in J.
A I am sorry.

Q It is 55. It has "54" in bold.
C A Yes. I am just trying to find the reference to Clexane. I have the prescription sheet on page 173.

Code A: Good.

Code A: Clexane is mentioned on page 172.

Code A: Page 172. (To the witness) I do not recognise that as Code A writing.
D A No, I think that is Code A signature.

Q I think we established that earlier. So he started Code A on Clexane. Would it be a reasonable assumption then that starting him on Clexane, which is to prevent problems ...
A Yes.
E

Q ... firmly does not put this gentleman in the end of life category at this stage?
A Yes, that is fair comment.

Q So he is still for mobilisation, if it is possible.
A If it is possible, yes.

F Q Then the next day he has, "Fresh blood [per rectum]".
A Yes.

Q As a physician, what would you take that to mean?
A He was having bleeding from his gastrointestinal tract. Probably the lower part of the gastrointestinal tract. Is that what you?

G Q Fresh red blood could come from the lower. Could it come from the upper GI tract?
A If it was a very profuse bleed my understanding is it could, but I think that is unlikely.

Q But it could?
A I would prefer to defer to a gastroenterologist on that particular question.

H Q I am asking you as a general physician geriatrician.

A I think someone would have to be having a very severe gastric bleed before that would happen.

Q It could be a severe GI bleed?
A My feeling is ---

Q Put it at that level. It could be?
A It could be.

Q What would you expect a nurse to do if she saw that in the bed? If it was in your ward in QA, what would you expect a nurse to do?
A Call the doctor.

Q Why?
A Because gastrointestinal bleeding is a serious condition.

Q What do you expect the doctor to do?
A Make a judgment about what treatment is felt - well, to examine the patient and make a judgment as to what treatment is felt to be appropriate.

Q The doctor having thought it was a GI bleed of some significance, what would you expect that doctor to do before he then left that patient?
A I think it depends on the individual patient, but in normal circumstances one would expect someone to check a blood count, check pulse, blood pressure, et cetera, and ask, perhaps, for blood to be cross-matched.

Q Would it be unreasonable to expect a junior doctor to put up a drip?
A Oh yes, yes.

Q It would not be unreasonable?
A It would not be unreasonable.

Q What would you expect a houseman then to do? Sorry – we call them something else now. F1, or something, is it not?
A Much the same. Much the same.

Q Yes. But what else would you expect them to do?
A Call a senior.

Q Yes. Why?
A Because that would represent a significant change in someone's condition which they might potentially not be able to deal with on their own.

Q It is a serious situation? A potentially serious situation?
A Yes.

Q This did not happen?
A No.

Q That is not good.

A I think that in this situation what one has to look at is what was this patient's prognosis, outcome, what was wrong with them, and this man clearly had very significant medical problems in that he was immobile. It was unlikely that he would ever regain his mobility. He had extensive pressure sores in his sacrum and the back of his legs. This man was never in my view going to get out of a bed. He is never going to mobilise again, and I think his life expectancy was extremely poor. In that context ---

B Q Wait a moment. He had been sent because there was some potential for mobilisation?
A I would disagree with that, fundamentally.

Q Okay.
A As I say, he had no prospect of rehabilitation.

Q Let us backtrack a moment. Let us stick to where we were going, in a ward in the
C QA. If a man had an acute bleed, a sixty-something year old man had an acute bleed and he was in for something else, is there some potential for assessment at a reasonable risk?
A I think what we are coming down to is, what is this man's prognosis ---

Q No, no. You said that. But is there some potential ---
A Yes. There is potential for assessment ---

D

Q At a reasonable risk?
A There is potential to intervene.

Q And if he was in the QA might he have had an endoscopy?
A He might have had.

E Q If he had not, if he had not had an endoscopy in the QA under your care, what would be written in the notes?
A Just ask me again.

Q See if I can put it a different way. If somebody had decided – if you had decided –
that this man, who is not in Dryad, is in the QA, and you see him on your ward round the next day?
F A Yes.

Q If you decided that he was not for endoscopy ---
A Yes.

Q --- what would you have done?
A I would have written in the notes.
G

Q How much would you have written?
A I would have written the reasons why I thought that he should not be for endoscopy.

Q Why would you have written why he should not?
A So that other people who followed on would see that and would know that that was the plan of care.
H

Q You would be very careful to write down the reasons, because it is a big decision, is it not?
A Yes.

Q Apart from covering your own back, there are many other ramifications?
A It is a big decision.

Q And that did not happen either?
A No.

Q So I am still left with that same problem. Why is a 67-year old man, although he has multiple problems, why is he not given the chance of a reasonably easy investigation and, through that investigation, therapeutic endoscopy to tie off a blood vessel, to put adrenalin round a blood vessel that is bleeding?
A Because I think the important thing is, "What is this man's prognosis" and in the light of the events that are happening to this gentleman, how appropriate or otherwise is it to intervene.

Q But you are not there?
A No.

Q Somebody else is there?
A Yes.

Q Somebody else is making those decisions?
A Yes.

Q On an intercurrent event?
A Yes.

Q In the progress of this man of 60-something?
A Yes.

Q Do you not think it might have been reasonable for somebody to telephone you and say, "What should we do here"?
A I had confidence in Code A and her decision making.

Q So you are happy that your patient did not get the chance?
A In the nursing record, and speaking to the nursing staff ---

Q Are you content with that not being in the record? Are you content that your patient did not get the chance?
A Yes, in this situation I am.

Q Are you content that the decision – a major decision – that you would have written in the notes if it was in the QA was not taken to you?
A Yes. Code A was a very experienced doctor and she had been in that role for eleven years.

Q I am sorry, in what role?

A A In her clinical assistant.

Q In what kind of a ward?
A Rehabilitation and continuing care ward. She was also an experienced GP.

Q On a what kind of ward?
A Continuing care.

B

Q Continuing care ward?
A Yes.

Q That was changing?
A That was changing. She was also a very experienced GP. She could have encountered this problem in her general practice.

C

Q Okay. I am going to move to a totally different area very briefly. That touches upon that last interchange we had there. Patients were now coming. The situation was changing. This continuing care ward was becoming a place to which patients were sent by orthopaedic surgeons post-op and by others for some... We know that the chance of mobilisation was not good because the staff were not there to do it. There were no physios and so on.
A Yes.

D

Q But that was what was happening?
A Yes.

Q Do you think it is possible that such patients, that this team was not used to dealing with, might have been reclassified in their minds into continuing care patients and not given the management that was meant for them?
E A When my colleagues and I saw patients on the acute wards, potentially to be transferred to our wards, we would in general write the diagnosis, what the prognosis would be and a management plan.

Q "We" being?
A The consultants. Sorry; if I was asked to see someone, have a word, and my colleagues were asked to see someone on the orthopaedic wards in Queen Alexandra
F Hospital, there was always a letter written to the patient's general practitioner after every such ward consultation.

Q So they did not get to Dryad except through your hands?
A That is right. So when we started with the bed pressures and there were fewer continuing care patients, what happened was, if you like, the waiting list for Dryad Ward would evaporate at times, but there would still be a waiting list of patients for transfer to
G Daedalus Ward. What would happen is that one of the secretaries who maintained the waiting list would then take the names of the top two or three patients out of the waiting list, board, along with an accompanying letter, speak to a consultant who was available in the offices, and say, "We have an empty bed in Dryad Ward. There are these patients here who are on the waiting list for Daedalus. Do you think they might be suitable for transfer to Dryad Ward given the circumstances that exist?" And so, if I were there, I would look through that and try and identify the most suitable, in other words, the patient who was not
H like to need intensive rehabilitation.

Q Yes. But nevertheless, you and your colleagues have formulated a plan by writing something down before the transfer?
A Yes.

Q And that might be, as we have seen, to give them a chance for remobilisation, and so on?
A Yes.

Q But we have not seen in the cases that we have dealt with today "for continuing care"?
A No.

Q So I come back to that. Do you think that the nursing staff, or the team in general in Dryad, might perhaps have taken a more pessimistic view, despite what you have written?
A They could have done. But to me, I think the staff in Dryad Ward were aware of the pressures, and certainly Code A did speak to me about the pressures on the ward, and I made it clear that what we were trying to do was transfer the most suitable patients, and the reasons for them being transferred. Then a letter from me and my colleagues would always or should have accompanied the patient.

Q Were you aware at any time that some of your nursing staff had used the word "dumping" when talking about such patients?
A I was not specifically aware, but in the context of Dryad Ward, certainly often ... I think what would sometimes happen is that between the time of assessment and transfer to Dryad Ward, which might be up to three weeks sometimes, a patient's condition could have changed and we were left with a problem that was not that which was in the referral letter.

Q I think we all understand that, but the pejorative word "dumping" has connotations, does it not? About the way people think about the patients coming to you?
A You mean in the sense that if people feel they have been dumped, they might not want to behave as they should do? I am not quite clear what you are suggesting.

Q Let me turn your question back to you. What do you think?

THE LEGAL ASSESSOR: Could I just intervene here? If the witness is not aware of the word "dumping" being used, my advice is, it is pointless to ask him what it means. His view to what it means is no different from anybody else.

THE CHAIRMAN: Yes, I think that must be right. If the position, doctor, is that you were not aware of nurses using the word "dumping" or "dumped" in relation to patients who were incoming onto the ward, then there is really no value in exploring that particular point further with you, so we will desist.

THE WITNESS: Thank you.

Code A: Then finally, and again very briefly, touching on opiates. You said that you are not an expert?
A No.

Q And that Code A and the nursing staff were much more experienced in the practical use of drivers and diamorphine?
A Yes.

Q With sedatives. But it would not be unreasonable to say, would it, that opiates such as Oramorph and MST are pretty much ordinary drugs to most physicians?
A Yes.

Q And we have been looking at some of the doses, and I think that you were fairly happy with the doses of Oramorph, for instance, that were being used?
A In particular situations.

Q I think that you said that in 1999 you were not aware of the existence of any guidelines or protocols for the use of opiates or sedatives in the unit?
A That is right.

Q But that there was the *BNF* if you needed a reference?
A Yes.

Q I am just wondering if you are aware of what the *BNF* says about opiates in the elderly?
A I have certainly read it in the past and at various times in the past when I felt it has been appropriate to do so.

Q Can you tell us what your understanding of that is, or rather what your understanding in 1999 was?
A I could not tell you what the *BNF* said in 1999 about prescribing opiates in the elderly, but in general the theme was exercising more caution in elderly patients.

Q Would it surprise you to see that it says that in the elderly, perhaps you should start at 50 per cent of the dose in another adult?
A That does not surprise me.

Q That does not surprise you?
A No.

Code A Thank you very much, Code A

THE CHAIRMAN: Thank you, doctor. I am very conscious of the fact you have been on the stand now for one hour and twenty minutes. Would you like to take a break before you move on to questions from myself?
A I feel fine, thank you.

THE CHAIRMAN: I am encouraged to hear that you feel fine. There are, I think, at least one or two persons in the room who would appreciate at least a comfort break. I am going to say five minutes for a comfort break. Then we will resume, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back. Doctor, the good news is you really are coming towards the end now, and I am the last member of the Panel. I am afraid I am a lay member too, with all the difficulties that that throws up. What I am going to attempt to do is to pull together the picture that I think you have been presenting in the course of your evidence.

I should start by saying, I absolutely understand that at the time that you went onto Dryad in 1999 the situation was in a state of flux, and clearly from what you have told us there were a number of elements that were far from satisfactory. It was very much a matter of all parties doing the best they could in the circumstances they were faced with, and with the resources that were available to them. I understand that. What I want to do is to make sure that I have understood clearly exactly what that means in terms of what the situation was. We start off with the fact that it was a ward that was going through change. I think you told us yesterday that it had been effectively a continuing care ward, and you said that at that time that meant not so much strain on the medical staff, but considerable strain on the nursing staff.

I think you said that the change that came, bringing on to the ward persons who were not simply for continuing care, but for whom additional elements of care were required, such as various therapies, I think you said that the significance of that was that it actually increased the strain and pressure on the nursing staff who were required to do even more than had already been the case?
A Yes.

Q In those circumstances we had a consultant, yourself, who was coming onto the ward once a week to do a full ward round, and I am not sure whether you said you would see every patient or only those that you were asked to see?
A No. I saw every patient.

Q Every patient. So we have a situation where there is a consultant coming on once a week for a ward round. We have a clinical assistant, a GP from a local practice, who is coming in Monday to Friday, every day, and we have heard certainly in the mornings, very often in the afternoons and even in the evenings as well, in your view going above and beyond what you might expect for one individual?
A Yes.

Q And you have nursing staff. You have told us candidly that you were not aware of all of the training that they would have had, in particular with regard to the use of syringe drivers?
A That is correct.

Q But you were confident that not only did you have a first class doctor on the ward, but you also had good and experienced nursing staff?
A Yes.

Q Your view was that the doctor and, to some extent even, the nursing staff had more experience of some of the areas of activity that would be required on this ward than you had hitherto had?
A Yes.

Q You have also candidly accept that notwithstanding that, you were the consultant and to that extent you ultimately were responsible for what went on on that ward?

A A Yes.

Q Part of your duty of care was to ensure that on your weekly ward rounds you properly inspected the notes. That would be the clinical notes?
A Yes.

Q And the nursing notes?
B A No, I would not normally look at the nursing notes.

Q You would not normally look at the nursing notes?
A Because there is usually a member of the nursing staff on hand who is able to tell me what was happening. There might be occasions when I did have to conduct a ward round for a short period on my own and I might then look at the records if the nurse was not available.

C Q So there you were, with a doctor in whom you had great confidence and, so far as you were aware, a doctor in whom all the nursing staff also had great confidence.
A Yes.

Q You have told us that they were fulsome in their praise of this doctor.
A Yes.

D Q You have also helped us to understand the system that had developed on this ward to cope with the particular pressures that the ward faced.
A Yes.

Q You have told us that this was a ward where the clinical assistant would write up variable doses on some prescriptions.
A Yes.

E Q You explained the rationale behind that. In broad terms, you were happy with that.
A Yes.

Q We were shown exhibit D4, which was, you may recall, the memorandum dated 27 October 1999 headed "Learning Points from the Code A Complaint".
A Yes.

F Q This of course was a document that would have been produced at a time when all of the patients with whom we are concerned in this case, with the exception I think of Patient K, Code A, were actually dead.
A Yes.

Q As it happens, the document refers to what was called "an agreed protocol" that you
G tell us at the time you were not aware of.
A I was not aware of any protocol.

Q But that document tells us that there was an agreed protocol that specifically allowed Code A to write up diamorphine for a syringe driver with doses ranging between 20 and 200 mg a day.
A Yes.

H

A Q You have told us there may be some potential for misunderstanding within that phrase, but be that as it may, so far as you were concerned, (a) you did not know that there was such an agreement.
A That is correct.

Q And (b) you had, until it was pointed out to you some years later, no recollection of ever having seen doses of that large a range.
B A That is correct.

Q It was pointed out to you by Code A yesterday that these kinds of ranges were not limited to the one example that had been brought to your attention some years ago.
A That is correct.

Q In fact, there were many.
C A There were three I think in total.

Q That is something we can refer to the records on in due course. Your understanding at the moment is that there were three of those?
A Yes.

Q None of those you recollect having seen?
D A That is correct.

Q Although you accept that you must have seen them?
A I accept that I must have seen two of them.

Q But it did not necessarily register in your mind at the time that this was rather a wide range?
E A That is correct. I do not recollect that wide range. What I was saying was, the third one, when I was explaining the blue fold-over drug chart, I accept it was my responsibility to look at the reverse side, but because the patient was not on a syringe driver, I may well not have looked at that chart.

Q What is clear about the agreed protocol that is referred to in this document is that it only extends to the issue of the variable dose. It says nothing about the sort of circumstances
F alluded to by Code A where you have the doctor writing up a prescription for the mixture of opiates to be delivered by syringe driver without a start date being recorded on the prescription.
A Did you say that it does not record a start date?

Q The document says nothing about a start date.
A No, it does not.
G

Q So far as you were aware, whenever a syringe driver with this mixture of opiates was prescribed, there would always have been a start date recorded in the note of the prescription.
A Yes.

Q If there had not been and you had seen it, that is something that would have excited comment from you?
H

A That would usually be something that would be picked up by the nursing staff, because nursing staff are not allowed to administer against a prescription that has not been signed and dated, with the exception of verbal orders, for which there is a separate policy.

Q But of course in the event that ---

Code A Sir, I am sorry to interrupt, but it should be made clear to the witness that these were signed and dated. There was not a signed date, but a signed and dated prescription.

THE CHAIRMAN: Thank you for pointing that out. (To the witness) As Code A has said, we are not talking about a prescription that is not dated in terms of when it has been written, but rather, an open-dated prescription. If I can put it in this way to you. It is very crude language, as you might expect from a layman. We have been given to understand from a number of witnesses now that the process of being on a syringe driver with the sort of mixtures of opiates that we have been talking about is in effect a one-way street, end of life regime, that will not go on for very long. Once you have started, in effect, within the context of this ward, there was no going back; it was death.

A I think that would often be the case, if one was clear that someone's symptoms were for palliation.

Q Can you recall a single instance in your year on Dryad Ward where a patient was put on to a mix of opiates on syringe driver who did not die?

A No, I cannot.

Q So on the one hand we all understand and agree that that is the end game. When you start on that, that is death. But that is an action. Somebody has to start you on that particular road.

A Yes.

Q Before you get to there, somebody in effect has to sign the death warrant, somebody has to prescribe that.

A Someone has to make a decision that this patient is for palliation.

Q And they are going to indicate that, in terms of the syringe driver, by prescribing the syringe driver with the opiates.

A In the first instance, one would expect that to be recorded in the medical notes, that someone's symptoms was for palliation.

Q But even if they did not use some of the words we have heard and I know you have agreed with today: "Make comfortable", "TLC" and so on, these are all euphemisms for a change of status to palliative care, end of life, the patient is going to die.

A Yes.

Q One of the ways in which we can see that decision illustrated is when a patient is actually prescribed that mixture of drugs to be delivered in that manner, but there are two stages to the process. There is the writing-up of the prescription and then there is the administration of the prescription.

A Yes.

Q You have been asked about the dangers and the risks that are attendant upon a situation where the prescription is written out, but where no start date is indicated on the prescription.
A Yes.

Q Do you accept that the principal risk there is that, for whatever reason, a patient might be administered at an earlier stage than would be appropriate?
A Yes.

Q That must be the risk. So the situation that we have on this ward is that you have nursing staff who ultimately are going to be the persons who will in effect press the button, set up the syringe driver and administer the prescription from which there is no return.
A Yes.

Q We have heard evidence that under the system that developed – and clearly it developed long before you had come on to the ward and was in place when you arrived – it was possible for nursing staff of their own volition to decide, "Now the time has come. We will administer the syringe driver and the drugs therein and therefore ultimately end the life of this patient."
A Can you just repeat that for me?

Q You came into the ward at a time when this structure was in place.
A Yes.

Q The structure was one which enabled nursing staff, not qualified doctors, nursing staff of their own volition, without a doctor telling them, "Do this now", to administer the syringe driver and the mixture of opiates therein.
A I would have expected the nursing staff to have contacted the doctor, but in the event that a patient was in distress and a doctor was immediately available, in that situation, that is the situation I would have envisaged, not it happening as a routine without consultation with Code A

Q Do you see the risk that is attendant in a ward where we know nursing staff are under great pressure? Do you see the risk in such a situation for putting into the discretion of the nursing staff as to when administration should happen?

THE LEGAL ASSESSOR: Chairman, may I interrupt here? It is simply to advise the Panel that a warning should be given in relation to self-incrimination. This specific line of questioning, it seems to me, raises the question of a link between the action or inaction of Code A the consultant on the ward, and the fatal outcome for the patients. The reason I mention it is that a suggestion has been made that the nurses were effectively put in charge, were given a discretion.

I advise at this stage that Code A should be warned that he is entitled to claim privilege against self-incrimination in respect of any evidence he gives which might be relied upon in a criminal prosecution either to decide to prosecute or to establish his guilt.

In other words, in less legal words, if Code A is asked questions which are directed towards or are clearly relevant to his possible guilt of a criminal charge, he should be told that he is not obliged to answer that question. I advise that we have now reached that point and he

should be warned that he need not respond to any question, not just this specific question, if the answer may tend clearly to incriminate him.

I do emphasise that my intervention is made simply because of the line of questioning being pursued. It implies no view on my part whatsoever as to Code A culpability or otherwise and neither does it imply any criticism of the line of the Panel's questioning.

THE CHAIRMAN: Thank you very much, Legal Assessor. I of course fully accept the advice. I want to check to see that the doctor understands the advice that I have just been given by the Legal Assessor.

THE WITNESS: That I would not wish to answer these questions without having ---

THE CHAIRMAN: Let me say a little bit further. First of all, this is not the first time that this warning has been given in this case and it may not be the last time, but it is absolutely the right of any individual who comes before us not to answer any questions which they feel might in the answering put them in a position where they themselves could find themselves answerable in a criminal court. As the Legal Assessor says, because the line of questioning could have that effect, it does not mean that it is delivered in an attempt to point a finger, but it is absolutely your right, and you should be aware of it, that you do not need to answer any question which you feel could in the answering put you in a position where you could be brought before a court of criminal law.

THE WITNESS: Thank you.

THE CHAIRMAN: I will continue with such questions as I have, on the understanding that at any time, if there is any question you do not want to answer, you simply say, "I do not wish to answer that" and it will not go on.

The point that I had reached was that at the time you came into this ward, there was already existing a situation in which nursing staff were able of their own volition to determine when to administer the syringe driver with the opiates on board, where, and only where, the prescription itself was open in terms of start date. That was the situation when you arrived.

A Yes.

Q Was that a situation that you were aware of?

A That the staff could start it at any time?

Q If they had a prescription which did not have a start date.

A My view, as I said before, is that I would have expected them to have consulted Code A before taking that step.

Q I understand that, but the question was directed to your state of knowledge only. At the time that you came on to the ward, did you know, were you aware that in the circumstances outlined, they could of their own volition start the syringe driver?

A I am not really sure that I was aware of that.

Q Is the first that you have heard of this during the course of this hearing, or have you heard of this at an earlier stage?

A I just do not know.

Q Very well. You cannot be expected to remember everything. Even sometimes very significant points can go by the board. You have told us, however, that you had great confidence in both Code A and indeed the nursing staff.
A Yes.

Q You were asked some questions by Code A about whether that confidence in Code A and the nursing staff was shared by all members of the nursing staff.
A As far as I am aware, it was.

Q We have seen – you have not up to this point – another defence document that has been put in. I am referring to exhibits D1 and D2. There was in fact in 1999 and 2000 a difficulty involving one particular nurse, Code A, concerning problems that she had with Code A and Code A. Are you aware of that, or were you aware at the time?
A I think I can remember Code A

Q She was complaining that she was being harassed by Code A and Code A
A I think, now you have mentioned it, I was aware of that, but I am not sure I was aware of any details surrounding that.

Q Were you aware that one of the areas of difficulty, if I can put it neutrally, between the three parties was the prescribing of opiates, in particular in relation to syringe drivers?
A I do not think that I was aware of that.

Q We will put that into the camp of something that you were not aware of at the time that you were on this ward.
A I do not think so.

Q Very well. So the picture we have is that whilst you had great confidence in the doctor and the nursing staff, your belief was that the nursing staff, because of the fulsome praise that had been communicated to you by at least some, was indeed unanimous.
A My recollection was of all of the nursing staff being full of praise for Code A

Q Going on to things that you were or were not aware of at the time that you were on the ward, we have also been shown, and I think you have seen, exhibit D5 which was headed, "PROTOCOL FOR PRESCRIPTION AND ADMINISTRATION OF DIAMORPHINE BY SUBCUTANEOUS INFUSION". That document, in fact, was written by yourself.
A Yes.

Q It was written in December of 1999.
A Yes.

Q By which time all of the patients with whom we are currently concerned were dead.
A Yes.

Q It is also the draft of a protocol but that draft was never brought into being. It was changed.
A That is correct.

Q The reason it was changed was because a number of the points contained within it, namely those which dealt with the upward progression of doses, was, in fact, ill-conceived.
A Yes.

Q Wrong.
A Yes.

Q That was information that while being wrong does accurately reflect what you understood to be the medical clinical position at the time?
A Can you just repeat that again?

Q Yes. Although you have accepted that there were elements within your draft that are wrong, it is your evidence, is it, that you nonetheless at the time believed them to be right?
A With a caveat that in terms of the doubling up of dose, my experience had been that was much lower doses than are in that document, so this document was used as, if you like, a starter for ten for other people to comment on.

Q One of the reasons why you did not object when you saw on the prescription notes, one of the reasons why you did not object to these rapid successions of doubling up was because you actually believed that that was the correct and appropriate way to act?
A That is correct.

Q But you were wrong.
A I was wrong.

Q Had you referred to the current *British National Formulary*, current at that time, at the time you were on the ward, you would have known that?
A I would have to go back to the *British National Formulary* and look.

Q You will recall that, very briefly, Code A ran through the list of areas that were covered at the time within the *British National Formulary.*
A I am sorry. Could you repeat that?

Q You are aware that when Code A was asking questions of you he did take you, albeit quite fast, through the main subject areas that were covered by the *British National Formulary* in terms of dosage for opiates.
A Yes.

Q Very well. It is just a matter of establishing that clear picture of what you did know and what you did not know. So far as this is concerned, what you knew turns out in some cases to have been ill conceived but does explain why you might not have questioned the doctor or nursing staff when you saw examples of that wrong action.
A Yes.

Q Because you too took the view that it was correct and appropriate. We have looked at some length at the case of Patient I, the unfortunate Code A. I think you said that the odds were stacked against a good recovery for this poor lady?
A That was my view at the time.

Q Yes. The timing is quite important there because, of course, that phrase might apply at different stages in her progression through the system, but what we have clearly established, I believe, is, first of all, that you had written up a note on 7 April indicating that you wanted this patient to be x-rayed?
A Yes.

Q We have heard already from another consultant that when a consultant says that something should be done in terms of action to be taken forward, this is not a suggestion or a request. The consultant told us that she expected that it would be done.
A Yes.

Q Is that the same with you, the way you operate?
A Yes.

Q This was not a fanciful suggestion, this was an order.
A Yes.

Q So far as we are able to tell now, looking at the documents that are before us, it was an order that was not followed?
A Yes.

Q You gave the order on 7 April. We have already heard that within these clinical notes there was no further entry until 12 April and that entry was made by yourself?
A Yes.

Q You came back, you presumably looked at the clinical notes and saw what you had previously ordered?
A Yes.

Q You quickly realised that nothing had been done about it?
A Yes.

Q Did you cause enquiries to be made at that point as to how it was that an instruction given by yourself had not been carried out?
A No, I do not remember enquiring.

Q If you had enquired, would it be reasonable to assume that whatever you had learned you would have noted on the clinical notes?
A Yes.

Q May we take it then that by the total absence of any information there you may not have enquired at all?
A It is certainly possible.

Q I have looked at the note that you have made and I wonder if you can help me. It almost appears to me as if it may have been made into stages in terms of time, because the first part of it reads, "Now [very] drowsy", and we know, of course, that by this stage the poor lady was already on the syringe driver, she had been put on to that the day before, and so was on that final journey, but when you

wrote, "Now [very] drowsy", that would imply to me that, although sleepy, the patient was still conscious. You should have a look at it. It is on page 27 of bundle I.
A Yes.

Q Where you have written, "Now [very] drowsy", would it be reasonable for me to assume that by that you meant the patient was conscious?
A Yes, they would still be responding in some way.

Q Yes. The reason I ask is because you deal with that point and you indicate that there should be the reduction in the diamorphine. Presumably, to make her able to be more responsive. I think you told us you felt it was clear from your examination that she was over-sedated?
A Yes.

Q We then have the next paragraph, as it were, "Able to move hips without pain", which is clear enough, "but [patient] not rousable!", with an exclamation mark.

Q What did you mean by that and what is the significance of the exclamation mark?
A I think it meant that she had been over-sedated.

Q If the patient was not rousable, would that be an indication that at the time you wrote that she was unconscious, or, merely, you could not get her out of the state of drowsiness to get any sensible response?
A I cannot say.

Q No. Unfortunately, neither can I, which is why I was asking for help, because on the face of it it appears to me that there may have been a gap in time between the writing of the first and the second.
A I would not have thought so.

Q Very well. The purpose of the exclamation mark was really to make the point then that you may have cured the pain, but if the patient is non-rousable then they are clearly over-sedated?
A Yes.

Q You have told us what the danger of over-sedation is.
A Yes.

Q That it can depress the respiratory system to the point that the patient stops breathing altogether and dies.
A Yes.

Q That is why you reduced that dose?
A Yes.

Q Here is an example where you do note a prescription level, you do apply your oversight as a consultant to look at that, question it and say that is not appropriate, it is causing this patient to be over-sedated, and you give an order that that be reduced.

A Yes.

Q We heard that, unfortunately, one of the nurses, and she was named, Code A Code A, unfortunately, for whatever reason, and it was made very clear to us by Code A that we have no information as to what that reason might have been, but the fact is that that nurse, when she made up the replacement syringe driver, whilst following your instruction to reduce the dose of diamorphine, for one reason or another, doubled the dose of - I am sorry, you will have to read it for me.
A Midazolam.

Q Yes, midazolam, and I think you told us that that astonished you?
A Yes.

Q Because the consequence of that increase in dose did what?
A It could lead to further over-sedation.

Q With the potential consequence of?
A Respiratory depression and death.

Q Indeed, we see that the very next entry in the clinical notes refers to the very next day, early in the morning, in fact, at 1.15, the patient in fact died?
A Yes.

Q You told us that part of the rationale here was pain and you certainly, on 7 April, have noted pain. You recorded, "Still in a lot of pain".
A Yes.

Q There are no other clinical entries before your own on 12 April where you have indicated fairly clearly, in that final paragraph I referred you to, "Able to move hips without pain". So, presumably, that was you manipulating the hips?
A Yes.

Q I think you told us in extreme circumstances, where a patient is unrousable, you would do something that would trigger the pain mechanism to see whether the patient was capable of experiencing pain.
A Yes.

Q You moved that patient's hitherto painful hips without response.
A Yes.

Q You said that you did not routinely read the nursing notes. Had you done so, would it surprise you to learn that on 11 April, that is, the day when the instruction was given by Code A to commence syringe driver, that the nurse on duty ---

Code A Sir, I am sorry to interrupt. I do not think that is right. The syringe driver was commenced on the morning of 12 April at eight o'clock, or nine o'clock.

THE CHAIRMAN: I think I said when the instruction was given and the notes, if you would like to refer to page 134, would indicate that the instruction was given on 11 April.

Code A: No, we dealt with this.

Code A: This is Code A. I think that is first thing on the Monday morning is what she said. Code A gave evidence about, "[seen by] Code A to commence syringe driver", and she said that, in her view, was given on the morning of the 12th, and if you look at the administration of it, it was indeed on the morning.

THE CHAIRMAN: I am looking at the note on page 134 and the last date entry is 11 April 1999.

Code A: Yes.

THE CHAIRMAN: Are you telling me that that note, down to but not including the final line, is not the note of Code A?

Code A: That is right. The final line is that she – it is very difficult because there are a couple of squiggles, but the last line is her and her alone, above that it is not her, and she indicated in her evidence that that was, "[seen by] Code A", meant not seen at night but seen on the morning when she, in other words, was going off duty.

THE CHAIRMAN: Seen on the morning of?

Code A: Of Monday the 12th, and she said first thing Monday morning. The drug chart shows that the diamorphine was administered subcutaneously on the morning of the 12th and I think the time is, off the top of my head, eight o'clock.

Code A: It is page 174.

Code A: Thank you.

THE CHAIRMAN: Thank you. (To the witness) So far as the nursing note on 11 April is concerned, the nurse had noted there, "Code A denies pain when left alone". It is fair to say went on to write, "but complains when moved at all". Does that sound, at that point in time, whenever it was actually written, different to the position on 7 April, "still in a lot of pain"?
A I could not say for sure.

Q Very well. In any event, the next entry in the nursing notes, which, as you have told us, you would not have seen, so you would not have known this anyway, is that, "[seen by] Code A, to commence syringe driver", we know that it was commenced and the next item in the nursing note for also 12 April was seen by yourself and then your instruction to reduce. When we look at the progression of actions over that period, you are coming in on the 12th and saying, "reduce that dose because the patient is over-sedated", that does being reduced but, unhappily and for whatever reason, the midazolam being doubled at the same time, with the same potential consequence of over-sedation which leads to depression of the respiratory system which can therefore lead to death, and we find that the next morning, at 1.15, the patient died peacefully.

A You were asked by Code A about the entry in the death certificate and when he asked you, you indicated that you could not see, from what was in front of you at this point, how there could have been a recorded course of death as cerebrovascular accident. Would this be the reality of the situation: this patient died as a result of over-sedation?
A I do not feel qualified to comment on that.

B Q Who would be qualified to comment on that?
A Someone who has experience in clinical pharmacology.

Q So you, as a consultant, you are not a junior doctor who is just starting out, you have been attending deaths on numerous occasions: it is not within your area of expertise?

C A As I remember, the change in the syringe driver was at 15.40 or 16.40. I cannot remember the exact time, and Code A died eight, nine hours later. I would have thought that if it had been the midazolam – the midazolam which had been responsible for it – it would have happened at an earlier stage. But I am not an expert on that.

D Q For the backdrop that we have is difficult situations all round; the ward is changing in its focus; there are patients being sent to the ward who do not fit the traditional profile and who require an even higher element of nursing. There is, besides yourself coming in once a week, Code A whom you see, I think you said, at best once a fortnight ---
A Yes.

Q --- because she was not always able to attend these fortnightly ward round?
A Yes.

E Q A situation in which you give instructions which are not followed? It is a situation ---
A You are talking about the X-ray?

Q For example, yes.
A That is the only example I can think of where something I asked to be done does not appear to have been done.

F Q The only example that you can think of of a time that you have asked for something to be done on that ward and it was not done was that time?
A As far as I can recollect.

Q If we were to look through the notes, just of the few patients that we have before us and look to see what are the things that you have asked to be done, on every occasion we are going to see they were in fact done?
G A Without going through them again, but that is certainly my feeling.

Q You said this was a ward where you had great confidence not only in the doctor, but also in the nursing staff. You have told us that certainly on this occasion you had not given the instruction for the midazolam to be increased, but yet that happened?
A But .... I do not see how I can be responsible for ----

H

THE LEGAL ASSESSOR: May I assist here? I think it is important that the witness is asked questions to which he can properly respond. I understand, of course, that the Panel has questions to ask him but there is a danger of matters that in a sense have been recited to the witness and for the witness then to be asked for his comments. My advice to the Panel is that he should be asked relatively open questions which he is able to answer one way or the other.

THE CHAIRMAN: Thank you, Legal Assessor. I am almost there in any event. (To the witness) On this ward you have told us about your confidence in the nurses. Were you aware, or are you aware, that there were times when bank staff would be working on the ward, particularly at night?

A I cannot say that I was aware of bank staff being used more on Dryad Ward than any other ward that I happened to come across.

Q No. And indeed, it is a common feature, sadly, in hospitals up and down the country today and, indeed, at that time, that shortfalls in staffing are routinely made up by the use of bank nurses. What is the disadvantage of bank nurses?

A People whom one does not know, one does not know what experience they have, et cetera.

Q Yes, indeed. We have heard evidence that it is entirely feasible that on occasions that might be no regular nursing staff on of a night; that it could be that you would have two bank nurses.

A I was not aware of that.

Q Does that affect your view of the degree of risk?

A Oh yes. It has to.

Q Knowing the things that you do know now, but you did not know then, as well as the things that you clearly did know then, was this ward a safe place for patients to transfer into?

THE LEGAL ASSESSOR: My advice to the Panel, Code A, is that that is too wide and ambiguous a question to put to this witness. Many people would say that hospitals are inherently unsafe places for one reason or another. No doubt many people would far rather be ill almost anywhere else other than in a hospital. My advice to the Panel is that that is not a question to which this witness can give a sensible, concise and clear reply.

THE CHAIRMAN: Was it more dangerous than the average ward in the average hospital?

A I would have said I would have been happy for my mother to be admitted to that ward than many other wards that I have had occasion to visit over the years.

THE CHAIRMAN: That is something for us to ponder on. Thank you very much indeed, Doctor. That completes the questions from the Panel. If you can bear it, I am now going to ask the members of the Bar if they have questions arising out of the Panel questions. Perhaps I could also ask for an indication from each of you as to how long that might be.

Code A: I do have questions. 20 minutes, perhaps.

THE CHAIRMAN: Thank you. Code A?

Code A: I would have thought I have slightly less than that, but I certainly do have questions.

THE CHAIRMAN: Doctor, there are a number of points. You have been on the stand for a very considerable amount of time now, and normally we take the view that a witness should not be asked to remain on the stand without a break for more than an hour at a time, and you have gone well beyond that point. It is also the end of a long day. The indications are that there is a fair amount of questions still to come – something in the region of half an hour to three-quarters of an hour, I would guess.

We are in your hands, really, here because you know what your commitments are for tomorrow and whether it would be really very difficult for you to come back to us tomorrow or whether it would be less difficult. Could I ask you, would you be available to come first thing tomorrow morning?

THE WITNESS: I could, but I feel I would prefer to carry on. I will leave it to you, Chairman.

THE CHAIRMAN: Code A?

Code A: I am genuinely slightly concerned for the witness. He has had a very long afternoon. He has been cautioned, which must add to the stress, and sometimes witnesses are very loathe to indicate that they are not up to answering questions. I wholly understand he may rather finish tonight, but if we are going to go on tonight I think he should have a break, if I may say that.

THE CHAIRMAN: I think that is absolutely right. Code A do you have any observations?

Code A: I do not, sir.

THE CHAIRMAN: We can go one of two ways, Code A. Either we can take a break now and come back at it again a little bit later, or we can stop for today and ask you to come back tomorrow morning. If it would assist, we could no doubt start a little earlier than normal with the intention, therefore, of getting you away earlier. As you know, I have myself on a number of occasions asked you whether you were feeling okay, and I have certainly had the impression on a number of occasions that you were tired. It really is absolutely wrong to press a witness for difficult answers to difficult questions at a time when they are tired.

THE WITNESS: Thank you.

THE CHAIRMAN: I think the Panel are indicating to me a preference for tomorrow morning. Very well. Would it assist you if we were to say nine o'clock or would you be happy with a nine thirty start?

THE WITNESS: I do not have hotel accommodation booked for tonight, so if I am going to go home – I can travel up in the morning.

Code A: May I just indicate that we will obviously speak to the witness, purely about that, but we can certainly arrange accommodation for him very locally if that would help him.

THE WITNESS: Can I think about that?

THE CHAIRMAN: Yes. Reflect on that, but the offer is there. We are most grateful, Code A. What I will say at this stage is that we will break now and we will resume at 9.30 tomorrow morning. I am very sorry that we have kept you for so long, and I do hope that you will be away reasonably soon tomorrow. Meanwhile you do remain on oath. That means, therefore, please do not discuss this case with anybody, nor allow anybody to discuss it with you, though there will be representatives of the GMC talking to you in a moment about accommodation should you wish them to arrange it.

THE WITNESS: Thank you.

THE CHAIRMAN: Thank you very much. Thank you, ladies and gentlemen.

(The Panel adjourned until Thursday 2 July 2009 at 9.30 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 2 July 2009

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

Chairman: Code A LLB JP

Panel Members: Code A

Legal Assessor: Code A

CASE OF:

Code A

(DAY EIGHTEEN)

Code A of counsel and Code A of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

Code A QC and Code A of counsel, instructed by the Medical Defence Union, appeared on behalf of Code A, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning, everyone. Before the witness is called the Legal Assessor wishes to address the Panel in open session.

THE LEGAL ASSESSOR: Thank you, Code A The position is this, that I would like at the earliest opportunity to give the Panel some formal legal advice on the proper ambit of Panel questioning of witnesses. It would be my preference to give that advice as soon as I can. I am, of course, aware that Code A is outside, has been waiting for some time and would no doubt like to complete his evidence. It may equally be the case that counsel would wish to know what that advice is before the matter goes any further. So I raise it at this point, I am content to give my advice at this point, but I am in the hands of counsel and, of course, the Chairman as to whether now is the appropriate time to give that advice.

THE CHAIRMAN: Gentlemen, the position is that we are here half an hour earlier today at the specific request of the witness, who very kindly agreed to stay over last night so that counsel could have an opportunity to ask their questions of him. Mindful of that, it would be my preference that we allow the witness to answer his questions and get on his way. However, as the learned Legal Assessor has said, it is also very much a matter for counsel. If counsel feel that in some way it would assist them to hear his advice before they ask their questions of this witness then, of course, you need only say so and we will hear his advice before the questions. Code A

Code A: I think for my part, if there are no more Panel questions of this witness then I would be quite content to continue with the witness at this stage, and then perhaps when he has finished you could hear the legal advice so that you can assess it and formulate, as it were, upon it before we hear the next witness.

THE CHAIRMAN: Yes. Code A

Code A: Sir, in the abstract one would want to know the advice now, but I think in view of the circumstances with this particular witness and the reasons that you have just dealt with yourself, it would be appropriate, provided there are no more questions from the Panel for him, that we continue with his evidence and deal with the question of the advice, whatever it may be, later.

THE CHAIRMAN: Very well. As I indicated yesterday, the Panel questions are complete, so we will now call the witness, allow counsel to ask their questions and when the witness leaves then we will hear from the Legal Assessor more fully. So if we can have the witness, please.

Code A, Recalled
Further cross-examined by Code A

Q Code A, as you will appreciate from what was said yesterday, I have some further questions for you arising out of the matters raised with you by the Panel. May I just deal with one general issue, first of all? You were asked questions about the decision made by a doctor, nursing staff and maybe with relatives, the decision that a patient should go on to the palliative care route leading on to a terminal phase of the patient's life.
A Yes.

Q You gave evidence about the fact that the administration of subcutaneous analgesia with patients of this type, subcutaneous analgesia involving diamorphine and midazolam, that that really meant, barring miracles, the patient would come to the end of their life on the

A syringe driver, to use that expression.
A I would say so, yes.

Q That was the reality?
A Yes.

Q And something that had to be faced?
B A Yes.

Q No doubt, a difficult decision for those involved in palliative care?
A Yes.

Q Because of the consequences?
A Yes.

C Q But if the subcutaneous analgesia was not administered the alternative was that the patient would be suffering unnecessary pain and distress.
A Could be, yes.

Q Is that not ---
A If someone was in pain and distress and received nothing then, clearly, they would continue being in pain and distress.
D Q Would that be in accordance with medical ethics to allow a patient to suffer like that?
A No, not at all.

Q You have already given your evidence about the cases you were asked to consider that we are focussing on in this hearing that, in your view, there was, as it were, a proper course of treatment followed. Bearing in mind that approach, what do you say to anybody who would describe that as signing a patient's death warrant?
E A I think sometimes very unpleasant realities have to be faced.

Q I am dealing with the expression. What do you say to someone describing that as signing a patient's death warrant? Is that the sort of expression you would use?
A No, not at all.

Q Is that the sort of expression you would use with relatives?
F A Not at all.

Q Can you explain why not? Why not say, "We've signed this patient's death warrant"?
A Because I think that would be inhumane.

Q Any other reason?
A It is not true either. One would be relieving symptoms.

G Q Thank you. Another general matter. You were asked about evidence that the Panel has heard from a particular nurse with regard to a complaint that she made in respect of Code A Code A, just setting the context, and you indicated that that rang a bell with you.
A Yes.

H Q But you did not know the details and it was, of course, a complaint alleging harassment. Did you know that same nurse, when she gave evidence here - because this was

asked of you in the context of the general good repute in which Code A was held and the cohesion of the nursing staff - had said that in her view, this is the nurse who complained, that she found Code A to be an excellent nurse? Do you know she had said that?
A No.

Q Did you know that that same nurse had said she found that Code A was a good and experienced doctor and somebody who was caring about her patients?
A I did not know that.

Q Or that in her view, this was the nurse who complained, Code A was always aiming for the best for her patients?
A I did not know that.

Q That is your view of the doctor as well, is it not?
A Yes.

Q I want to ask you, please, again about another general matter to do with what has been described as anticipatory prescribing.
A Yes.

Q When we talk about anticipatory prescribing, is this right in terms of your understanding: it occurs in a case when a doctor's view that although the patient may not immediately need the medication it is sensible and in accordance with good medical practice to write up a prescription before the need manifests itself?
A Yes.

Q That might apply to a range of medications but can also apply to prescribing, before the patient needs it, diamorphine and midazolam?
A Yes.

Q You indicated that not only was that something which occurred in respect of Dryad Ward, it was something which occurred in respect of Queen Alexandra Hospital?
A Yes.

Q The decision to do that, that is writing up the prescription before it is necessary to administer the drugs, is in the best interests of the patient to avoid them suffering unnecessarily?
A Yes.

Q Maybe the doctor is not there immediately in order to authorise the use of a syringe driver, whatever it might be?
A Yes.

Q In those circumstances a nurse would be entitled to make a decision to start the use of a syringe driver, subject to the fact that he or she should check with the doctor first?
A Yes.

Q As you have told this hearing, you were aware that in relation to patients on Dryad Ward, Code A would on occasion prescribe subcutaneous analgesia, write out the prescription, before the patient actually needed it?
A Yes.

Q Your understanding was that if the situation, that is the need for the administration of the subcutaneous analgesia, arose when the doctor was not available, and no other doctor was immediately available, the nurse would ordinarily seek authorisation from the doctor?
A Yes.

Q By contacting by telephone or whatever it might be?
A Yes.

Q But if that contact was not possible, in terms of it being established, the nurse could go ahead and commence the use of the syringe driver?
A Yes.

Q Again, in the interests of the patient?
A Yes.

Q That being your understanding of what the situation was, and I appreciate you were never contacted specifically to be asked about this, it would be your understanding, would it not, that the doctor, in this case [Code A], would be seeing the patient, in any event, pretty soon afterwards?
A Yes.

Q Unless, of course, it was a long weekend or something of that kind. Right?
A Yes.

Q But the nurse would also have available to him or her the ability to contact an on-call doctor if they could not actually get hold of [Code A]?
A Yes.

Q I think you should know in the light of questions that have been asked that it is not suggested on behalf of the GMC, in any one of the twelve cases this Panel is considering, a nurse without proper authorisation or in some improper way started subcutaneous analgesia. It is right that you should know that.
A Thank you.

Q Indeed, we have heard from one nurse, curiously enough, the nurse who made a complaint about [Code A], that on an occasion when she actually commenced the use of the syringe driver, although it was not noted down, she felt sure she would have contacted [Code A] to get authorisation.
A Thank you.

Q In the circumstances that people were faced with on Dryad Ward, with patients of the kind we are dealing with, did that seem to you to be a perfectly sensible and proper system to use?
A Yes.

Q You have also indicated, I think this was your understanding, that, in any event, for the administration of a controlled drug in circumstances where the doctor is not immediately there, the nurses would ordinarily act in pairs. There would be two of them?
A That is a requirement.

Q Yes. You were asked about a situation, again, there is no instance in the twelve cases the Panel are examining of this having happened, but you were asked about the possibility of

perhaps being back staff only available. They would always have access to a night sister if it was at night, would they not?
A Yes.

Q There would be a senior, properly qualified nurse. Correct?
A That would be my understanding.

Q The key to it is this, is it not: the decision is, first of all, is it in the patient's best interest to have subcutaneous analgesia administered?
A Yes.

Q To elevate/prevent pain, distress, agitation, whatever it might be?
A Yes.

Q The second question is who is actually going to do it physically?
A Yes.

Q That is what actually arises in practice?
A Yes.

Q It is not a case of the doctor himself or herself setting up the syringe driver. That is done by experienced nurses?
A Yes.

Q They actually carry out the process?
A Yes.

Q The doctor need not necessarily be there when they actually do that?
A That is correct.

Q I am going to ask you about, I think, only two of the patients you were asked questions about by the Panel. I want to go back, please, to the case of the patient Code A, Patient I, if we may. You were asked questions about the plan with regard to this patient. Just to remind ourselves, when the patient was admitted, if we look at page 27 again, a page we have looked at many times, in fact, I think it is actually open in front of you now, page 27, we can see what Code A wrote in terms of a plan, "sort out analgesia". All right?
A Yes.

Q Of course, to see what the plan was one also has to look further in terms of nursing notes and the care plans.
A Yes.

Q Because some questions were asked as to what had or had not happened, had anything been done and what the care plan was. Would you look, please, at page 96 in that same file? This is part of the nursing care plan that came into being with regard to this patient. Correct?
A Yes.

Q At the top is the date of her admission:

"Code A is experiencing a lot of pain on movement.

Desired Outcome To eliminate pain if possible and keep Code A

comfortable, which should facilitate easier movement and mobilisation."

Does that make sense to you?
A Yes.

Q

"Nursing Action: Give prescribed analgesia and monitor effect
Position comfortably
Seek advice from physiotherapist regarding moving and mobilising"

A Yes.

Q Again, just what you would expect in the case of this patient?
A Yes.

Q We might as well just follow this through to prevent you having come back to it, because there is another point I want to make through your evidence to see whether it is a proper point when we look at this part of the history. The following day she was having regular Oramorph but was still in pain.
A Yes.

Q Obviously, somebody has to do something about that at some stage?
A Yes.

Q Next day:

"Has been vomiting with Oramorph. Advised by Code A to stop Oramorph".

Does that make sense to you?
A Yes.

Q "Is now having metaclorpramide"

Is that three times daily?
A Yes.

Q "and codydramorl. Vomited this afternoon".
A Yes.

Q Again, over the page,

"After using the commode. Refused supper."

Next day, 29 March: "Please review pain relief this morning." Running on to 31st.

"now commenced at 10 mg MST (twice a day) Walked with physiotherapist this am but in a lot of pain".

I am drawing your attention to that because you mentioned, do you remember, when you were asking about what you thought the situation might very well be with this patient and her

hip; you said that the physiotherapist you would have expected would have noticed or observed something. Would you just indicate as to what the significance of that was as to whether something had gone wrong with the operation in terms of the problem with the metal, as it were, in the hip, and you told us the nature of those problems, or whether it be something else.

A Could you just repeat that, please?

Q Yes. You mentioned in your evidence that you would have thought, and I may not have got the most precise note of it, my words, that with a catastrophic failure of the actual hip and metal work – and I am sorry to use that inelegant expression – you would have expected the physiotherapist would have noticed something?

A I certainly felt that if there had been a sudden dislocation of the hip, one would have expected a sudden increase in pain. Likewise, the head of the femur may suddenly disintegrate or gradually disintegrate.

Q So was that something you would expect a physiotherapist to ---

A A physiotherapist would certainly notice if there was sudden change for the worse.

Q Following through this note,

"She walked with the physiotherapist this am but in a lot of pain. Physio demonstrated how to get Code A from chair and"

– can you read that?

A "and onto gutter frame".

Q "Support round waist and hip/bottom level and ask Code A to push herself up to standing position".

Again a perfectly sensible course of action?

A Yes.

Q Then the next note is:

"Oramorph .... given for pain with not too much effect".

Then the following day, 1 April,

"Seen by the physiotherapist. To remain on bed during day over Easter holiday – to walk with ---"

A "...gutter frame once/twice a day".

Q Sorry, it is my ignorance, gutter frame, is that the same thing as a Zimmer frame?

A It is one which has arm supports; it is a higher frame.

Q So still trying to mobilise this lady?

A Yes.

Q "See Code A report.

A

Still having pain on movement."

The next day, if we follow it through, 3 April,

"Still continuing to complain of pain on movement."

B The MST increased on 8th. I am going to come back to the next entry in a moment about the X-ray? All right?
A Yes.

Q That deals with the picture with regard to the plan and the activity and, looking at it, does that seem to be a perfectly sensible way of proceeding?
A Yes.

C

Q You were also asked by one of the members of the Panel about the fact that really nothing was done after her admission. I am paraphrasing. There did not appear to be any sign of anything really being done after her admission. I have drawn your attention to what happened in terms of the nursing care plan and what happened there. Would you look please in the same file in relation to material which shows what was done after her admission? Would you look at page 43? It is in fact the following page from Code A admission
D note. We have there the biochemistry report from the Portsmouth Pathology Service.
A Yes.

Q There is a group of them there. I would like you to look through them, They go on from page 43 to the next page, 45, next page 47, next page 51, next page 57, 59 and 61. It is a collection of these documents. Does that show that in fact, in terms of seeking to treat this lady, proper tests were carried out and the results sought?
E A Yes.

Q Just in general, and we can look at each one individually if necessary?
A Yes.

Q On 26th, again, does that seem to be a sensible and proper course of action for a doctor in Code A position to ask for, to get results to try to discover what the right way
F of treating this lady was?
A Yes.

Q And in particular, very importantly, the question of infection?
A Yes.

Q You have told us already in your evidence about the devastating effect that deep-
G seated infection can have in respect of an operation of this kind. Is that right?
A Yes.

Q We can look through these reports and we can see in relation to the pages, at page 51 for example, when the report date was on a particular test; over at page 57, the date the report was made. Code A, the orthopaedic surgeon, referred to this in his evidence, so the Panel have already seen it, and in relation to the particular antibiotics and so on that were used, the
H date that was reported was 9 April. Right?

A A Yes.

Q And over on page 59, date reported was 8th; that is in relation to the findings of those tests, and similarly on page 61, "date reported", 8 April. It is right to say, is it not, that things were being done, and perfectly proper things, in terms of seeking to treat this lady as best as possible?
A Yes.

B

Q I would like to deal with just one further point in relation to something you were asked about. Do you remember you were asked in relation to I think in her case it is page 169. One of the members of the Panel was asking questions about the review box, do you remember?
A Yes.

C Q If we go to 169, we can see that on the front of these prescription sheets there was written, certainly at the time we are concerned with in relation to this patient, which is 1999, that there was at item 9 of the front sheet:

> "Put date prescription needs to be reviewed in 'review' box of regular Prescription Section."

D A Yes.

Q If we move on to page 174, we can see, in relation to his particular patient, prescriptions written by Code A and the review date, the little box on the left hand side in the middle of that left hand column is not marked.
A That is correct.

E Q And indeed I think in just about every one of the relevant patients that is the case. Were you aware of the fact that the request on these forms to tick or to put in the review date on the box only came in after a certain period of time? I am not expecting you to remember but I have got to put that to you because I am suggesting that it is clear that certainly in the early stages of some of these patients – I am not able to identify every one – and certainly in the case of Code A, Patient A, and Code A, Patient B, the particular form in use did not have provision for that. I other words, it did not say and did not provide a review F date box, but you would not be aware of that because you started in 1999. Is that correct?
A Correct.

Q But, in any event, in the normal course of events, the doctor himself or herself would be reviewing the prescriptions when they saw the patient?
A Yes.

G Q Perhaps we can see how this particular feature was not confined to Dryad Ward, the failure to fill in the box. I am sorry one has to go to a different file but can we look at the file relating to Patient H just to observe the point? I would like you to look, to assist us, at page 110. That page relates to Patient H and this is a regular prescription sheet from the Queen Alexandra, all right? So it is not Gosport War Memorial; it is QAH. If we look at that, just by way of example, we can see that on the forms then applicable there was a box to put review date in but it is not filled in.
H A That is correct.

Q So perhaps it is not very surprising to find that was not something that people did?
A Might I add that on reflection about this I think the purpose of this and the use for which it was really intended was for use of a short-term prescription like antibiotics to make sure that that review actually did occur and nursing staff had alerted the doctor to that.

Q Doctor, I think you may well be right because I think there was another example, maybe with Patient H, where there is in a hospital document one review date filled in for a medication of precisely that kind, for penicillin I think it was, but we can check that later. That is really the purpose of that particular provision?
A I think so.

Q I am also told, and we can check it later but you would not necessarily know, that the Haslar did not on its forms have provision for a review date. I want to follow through please, still with Patient I, the question of what happened in terms of X-ray or no X-ray. For this we need to go back to page 27 where we have two entries by you when you saw her on 7 April and 12 April?
A Yes.

Q And, as we have seen more than once, on 7 April you wrote with regard to this lady,

"For X-ray, right hip as movement still quite painful – also, about 2" shortening right leg."

A Yes.

Q It is not suggested that Code A was with you in relation to that ward round when, amongst the other patients you looked at, you looked at this lady. In the ordinary course of events when a consultant such as yourself wanted a patient X-rayed, you record the fact that you wanted that done?
A Yes.

Q I want to ask you about what actually would have happened. If the clinical assistant is not with you, some form has got to be completed, has it not?
A Yes.

Q Would it normally be you as a consultant doing the ward round, if that is something you wanted to happen, who would fill in the form?
A I think in this situation if Code A were not present, it would probably have been me who completed the form.

Q I am not suggesting for a minute you will be bale to recall but in the ordinary course of events you would have expected that you would have filled in a form?
A Yes.

Q If not you and not Code A perhaps the ward sister or whoever was going round the ward with you might or might not?
A No.

Q So if it is not Code A it has got to be you?

A A Yes.

Q And the form, without going into all the detail, what is the form in effect saying? What are you asking or showing or dealing with ?
A Requesting an X-ray of the right hip in this case.

Q So you set out what part of the body needs to be X-rayed?
B A Yes.

Q Anything else on the form?
A And provide clinical details such as "patient sustained fractured neck of femur on such a date; dynamic hip screw inserted, still in pain. Query infection. Query dislocation".

Q Thank you. To give the person who is taking the X-ray an indication as to what it is
C that should be scrutinised?
A Yes.

Q And who is the intended recipient of the form, first of all ? Who does that go to?
A It is the X-ray department.

Q So it goes to the x-ray department. There was no radiologist on duty at Gosport War
D Memorial Hospital, was there?
A Not at all times, no.

Q But there was an X-ray department?
A Yes.

Q So requests for X-rays would go there?
E A Yes.

Q And at some stage a radiologist, is this right, would take the X-ray?
A It would probably be a radiographer who took the X-ray.

Q I am getting expressions wrong, sorry. A radiographer would actually take the X-ray?
F A Yes.

Q There it is; it has been taken. What happens in the ordinary course of events next?
A A radiologist would review the X-ray and produce a report or the X-rya might be sent to the ward.

Q Let us take the first of the circumstances first. The radiologist looks and he will have
G the consultant's form indicating what it is he is meant to be looking for?
A Yes.

Q Supposing he finds nothing of any significance so far as he can detect: what does he do with his findings?
A He would dictate a report, which would be subsequently typed up and which would then find its way to the ward.
H

Q That would happen if things had moved in that particular way?
A Yes.

Q Whatever he had done in terms of making a report, that would find its way in due course to the ward?
A It should do?

Q Or to you?
A To the ward.

Q And ordinarily speaking when a consultant had asked for an X-ray without saying that it was urgent or anything of that kind but pointing out what the purpose was, how long would that process take?
A At that time I could not say but I certainly do not think it would be a same-day service.

Q I was going to put to you that it certainly would not be the same day and quite commonly you might not see the X-ray result until your next ward round?
A That would be correct.

Q So in this lady's case it might well have been that the X-ray result would not have come through to you until 12 April?
A That is correct.

Q Because what appears to be the case is that you did not indicate in your request for the X-ray that it needed to be carried out expeditiously?
A There is no record of my having asked for that.

Q No, but if you had thought that it was necessary to have the X-ray result that day or the following day, you could have said so?
A Yes.

Q Indeed, it would have been possible for you to have asked that the lady be X-rayed that very afternoon?
A Yes.

Q You would have the power to do that, assuming it was possible?
A Yes, assuming ether was an appointment.

Q In those circumstances when it appears you have not indicated that there was any urgency about this X-ray, it may be – we will look at some other entries – that in fact there was an X-ray which had been taken but it was not something you asked to see on 12 April?
A That is correct.

Q Is this right, or is this fair, Code A when you saw the patient on 12 April the x-ray result, if there was one, was not something that was in the forefront of your mind?
A No.

Q It is quite possible, therefore, that you did not ask for an x-ray or what the result was?
A That is perfectly possible.

THE CHAIRMAN: Code A, I do apologise for interrupting. You took us earlier to a page that I think might short circuit this enquiry.

Code A: I am coming to that.

THE CHAIRMAN: Very well.

Code A: I am doing these things deliberately in a certain way to get the general picture and then we are going to look at what the records show. Thank you.

(To the witness) Indeed, it is not an uncommon feature, in relation to hospital records and x-rays, for x-rays to go missing and to not make their way to the proper recipient?
A That is correct.

Q In relation to the history in this case, so far as we can piece it together, we have your request, order, whatever we like to call it, you are saying, "I want an x-ray done". All right?
A Yes.

Q I am not saying, "I want it done expeditiously", and anticipating at the time that you would see the x-ray next on your next ward round?
A Yes.

Q Then might we move, please, to page 134? On page 134, we are now on the summary, on 7 April there is a note made by, I think, Code A, that may be wrong, but made by a nurse, recording the fact that you had seen the patient. Right?
A Yes.

Q 7 April, "For x-ray tomorrow". Not just no time but x-ray at a particular time, at 1500 hours, then to commence and so on and so forth. In the ordinary course of events, and I appreciate, Code A, you did not make this note, that rather looks as if an x-ray had been arranged, does it not?
A Yes.

Q Arranged for a specific time the next day?
A Yes.

Q In the ordinary course of events, somebody, a member of the nursing staff, assuming Code A was not there, would have to be arranging with the x-ray department for this to be done?
A Yes.

Q They would have contact the x-ray department and fix an appointment time. All right?
A Yes.

Q We can see in that same note, after the commencement of a drug, just to follow it on, "To be reviewed on Monday" what does that suggest to you? Not what the plan was, but that the x-ray be reviewed on your next ward round?
A I could not say whether it was in relation to the x-ray or the commencement of flupenthixol or whether it is to review the whole picture.

Q It is consistent with the nurse understanding that the x-ray was to be reviewed on

A Monday, is it?
A Yes.

Q All right. That would make sense because that would be your next ward round?
A Yes.

Q I appreciate you cannot say for certain because you are not the person who wrote the
B note.
A Yes.

Q I would like you to look, please, again, trying to follow this through, to page 98. If the 12th was a Monday, we are on the Friday, I think. 9 April, towards the bottom of the page.
A Yes.

C Q Which would be, if the plan had been carried out, the day after the x-ray was taken, "To remain on bed rest until Code A sees x-ray of hip". All right?
A Yes.

Q Again, you are not the author of the note but it would not make much sense unless an x-ray had been taken, would it? "To remain on bed rest until Code A sees x-ray of hip".
A It does not give me a sense of whether the x-ray has been done or not.

D Q What would be the sense of writing it - I appreciate it is not you - if there was not any x-ray at all?
A It may have been relayed from the ward round that this lady was to have an x-ray of her right hip and that she was to stay on bed rest until that reported.

Q We have seen what the nursing staff recorded when she was due to have an x-ray. On 7 April, two days before this, apparently an x-ray has been arranged for the 8th.
E A Yes.

Q Now we are on the 9th, it makes sense, does it not, that there was an x-ray? You cannot know but ---
A I cannot know.

Q No.
F A I cannot know.

Q That is all I am going to ask you about that. I think that is probably as far as we can take it, having looked at what was said. I am now going to ask you about another aspect of this same patient, still on page 27, and your note of your ward round on the 12th, if you go back to that. Page 27, your round on Monday 12 April, "Now [very] drowsy", and then that next word. I am sorry.
G A "(since DIAMORPHINE ..."

Q "(since DIAMORPHINE infusion established)". I am sorry. I should have my own note about that.

"Reduce to 40 mg ...
- if pain recurs, [increase] to 60 mg.

H

Able to move hips, [without] pain but [patient] not rousable"

A patient who is not rousable, and I am not going to worry about quite what degree that was because some of your note suggests that, certainly, you were able to have some movement without pain was recorded, a patient may become unrousable for more than one reason?
A Yes.

Q A patient in this sort of situation?
A Yes.

Q They may be unrousable because they are, in fact, in a terminal phase ...
A Yes.

Q ... of their lives. The fact that they are unrousable may be affected by the fact that they are on subcutaneous analgesia?
A Yes.

Q It may be?
A Yes.

Q It may be a combination of the two?
A Yes.

Q The fact that a patient is not rousable does not necessarily mean they are oversedated?
A Not necessarily.

Q I appreciate, Code A and I am not criticising you for a moment, you took the view this patient may be oversedated that dose of diamorphine. Yes?
A Yes.

Q I am not criticising your decision for a moment. You thought if that is the cause the sensible approach is to reduce the diamorphine.
A Yes.

Q I am not suggesting for a moment you suggested that the midazolam should go up. All right?
A Yes.

Q The patient, as we know, in relation to page 27, died at 1.15 the following morning.
A Yes.

Q You were asked about, as it were, whether the death resulted from the oversedation of the midazolam.
A Yes.

Q In the sense that the midazolam had been put up from 20 to 40.
A Yes.

Q The fact of the matter is one simply cannot say, can one?
A I could not say.

Q No. Indeed, nobody can say because nobody knows precisely what the effect on this

patient was of any added midazolam?
A Yes.

Q All that we can say with confidence, whether it is a clinical pharmacologist or anybody else, you included, is that the increase of midazolam would have had a sedative effect?
A Yes.

Q More of a sedative effect than, in your view, would have been appropriate?
A Yes.

Q In your judgment, bearing in mind what happened in this case, it may be well be the case that this patient died as a result of the deterioration in her medical condition?
A Yes.

Q Coupled with the effect of diamorphine and midazolam?
A Yes.

Q Which played which role in relation to the cause of death it is impossible for anybody to say.
A Yes.

Q Just on that point in terms of drowsiness and whether a patient is rousable or not and the significance of that in relation to subcutaneous analgesia, would you look, please, back to page 134 in respect of this same patient? Code A, I appreciate moving around pages and dates and that sort of activity it is sometimes difficult to follow the thread, but we keep in mind that this lady had no subcutaneous analgesia administered until the morning of 12 April, the day you saw her. All right?
A All right.

Q Do not worry to look anywhere else, just bear in mind when I ask you about this note. The first time she has it is the morning, I think it is around about nine o'clock in the morning, of the 12th. Yes?
A Yes.

Q Let us at what the picture was the day before, before she is on any form of subcutaneous analgesia. There is an entry on the summary by a nurse, dated 11 April. Do you see that?
A Yes.

Q It has "Code A" written beside it.
A Yes.

Q

"Nephew telephoned at 19.10"

- so seven ten in the evening -

"as Code A condition has deteriorated since this afternoon. She is very drowsy. Unrousable at times. Refusing food and drink and asking to be left alone. Site round wound in right hip looks red and inflamed and

A feels hot. Asked about her pain Code A denies pain when left alone but complains when moved at all. Syringe driver possibility discussed with nephew. He is anxious that Code A be kept as comfortable as possible. He will telephone ward later this evening."

So I have gone through the whole note. All right?
A Yes.

B Q We note, in relation to what is said about the site round the wound in the right hip, again, is that consistent with infection taking its toll?
A It is certainly consistent with a superficial wound infection and, quite possibly, a deep wound infection.

C Q You cannot tell a deep-seated wound, but certainly superficial. Can we sensibly regard the entry in this way: there is a good example of a patient being very drowsy and unrousable at times which has nothing to do so with the administration of subcutaneous analgesia?
A That is correct.

Q Again, is that, perhaps, an indication, you are not the person who saw her on that afternoon or evening, an indication of the dying process?
A Yes.

D Q We must bear in mind in relation to that as well, to cover the whole picture, that at this stage she was receiving, on the 11th, a total of Oramorph 5 mg and MST two 20 mg doses administered. All right?
A Yes.

Code A: Code A, thank very much.

E THE CHAIRMAN: Thank you, doctor. Now it is Code A

Code A: I am terribly sorry. I do apologise. I need to ask something about Code A. I am afraid I omitted to do so.

THE CHAIRMAN: Yes, of course. We go back to Code A

F Code A: I am sorry, Code A, but it is considerably fewer questions about Code A Code A than with regard to Code A. This is Patient J. I will just take that file. First of all, this, please, with regard to Clexane, would you go to page 172? Just reminding ourselves, this patient was admitted to Dryad on 23 August. All right?
A Yes.

G Q We can see on page 172, although the date is a little unclear, a record of Clexane. All right?
A Yes.

Q "Passing Fresh Blood PR", per rectum, and we have already dealt with that. Right?
A Yes.

H Q Then on page 173, the next page, one can see the Clexane recorded there and then, as it were, stopping. All right?

A A Yes.

Q If we go back to page 55, we can see there the note by Code A on 23 August. All right?
A Yes.

Q When, at that stage, Clexane is continuing and we know that, in due course, the
B Clexane was stopped perfectly appropriately, as you have indicated, as a result of the ...
A Bleed.

Q Can we just note before we move on, page 182, that is from Queen Alexandra. All right? It is not Gosport War Memorial Hospital.
A Yes.

C Q We can see there, I simply draw your attention so we can take the fact, that he was on Clexane at QAH for really some time. On this particular sheet, he starts it on what appears to be 6 August, so he has quite a long history of being on Clexane.
A Yes.

Q Code A has helpfully reminded me of the thing that was in my head when you talked about review dates. It is on this sheet. If you look towards the bottom, you can see
D penicillin B has a start date of 11 August and review date of 13 August, but for the other drugs on that page, there is no review date. Does that tie in with what you said you would expect in relation to these review days?
A Yes.

Q I am not going to ask you to go over the situation with regard to Code A. You have covered it very fully in your evidence, but there is one further thing I just need to ask
E you about, please. This is on page 63 of the notes. If you would look at the date of 25 August, about a third of the way down the page, you were asked about this by one of the members of the Panel:

"Passing fresh blood PR [per rectum]
? Clexane"

F Obviously the nurse had taken action in terms of getting in touch with Code A
A Yes.

Q As you would expect. As I think you indicated, in such a situation you would expect a nurse to seek the advice of a doctor.
A Yes.

G Q Then – and I really assure you this is my last question, Code A – something you said about midazolam. I appreciate you are not an expert, but you indicated that in terms of the death of Code A, when you were asked about midazolam, you said that in your view, if her death had anything to do with midazolam, you would have expected it to have its effect earlier. Do you remember saying that?
A I would have expected it to have an effect within two to three hours.

H Q I appreciate when we hear that from you ---
A I am not an expert.

Q I am not pressing you on it. You said, "I am not an expert, but that in my view is the sort of time period I would estimate it would take its effect, if it was playing that part."
A Yes.

Code A Thank you very much.

THE CHAIRMAN: Code A the witness has now been on the stand for approximately an hour, so I think we will take a short break. Doctor, I am sorry to prolong the agony, but we will take a break now for 15 minutes. You will be taken somewhere where I hope you can get some refreshment. I remind you that you remain on oath. Please do not discuss the case with anyone, nor allow anyone to discuss it with you. Thank you very much. 15 minutes, please, ladies and gentlemen.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Code A

Further re-examined by Code A

Q Code A I am going to start with just some general questions and then a few questions about Patient I and then I hope we are finished. You were asked by members of the Panel about the starting of the syringe driver and whether it was appropriate for a nurse to be able to do that if she thought it was necessary for the patient.
A Yes.

Q Code A has asked you about that as well. My understanding of your evidence is that there is nothing wrong with the nurse doing that and the nurse being equipped to do that if it is necessary to control the patient's pain. Is that a fair summary of your evidence?
A Yes.

Q You have also accepted I think that the starting of a syringe driver in these circumstances, with these patients, with these drugs, would be a significant, probably a very significant, event in the patient's life.
A Yes.

Q Because, however one wants to couch it, it is an end of life event.
A Yes.

Q Does your answer pertain to a nurse of any level of training: state registered nurses, enrolled nurses, bank nurses? Is your answer the same for all?
A Any qualified nurse.

Q Any qualified nurse. Does a syringe driver provide immediate relief from pain? Does the inception of a syringe driver in fact provide immediate relief from pain?
A I would have thought that you would start to see some relief within 15 to 30 minutes.

Q If a patient is in immediate pain, which I think is something that is called breakthrough pain, if they are already on analgesia, are there other ways that a patient's pain could more immediately be controlled?

A A Did you say if they are on oral drugs?

Q If they are already on analgesia and a patient has breakthrough pain, are there other ways of providing pain relief immediately to the patient?
A One could give it in exceptional circumstances by intravenous injection.

Q Why do you say in exceptional circumstances? More exceptional than using a
B syringe driver?
A What I am thinking about is, say, a patient who is having a heart attack, who is in severe pain. That sort of situation.

Q Let us ignore a heart attack for a moment. A nurse is with the patient, the patient appears to be in pain. The patient is already on morphine in some form, MST, say.
A The dose could be increased.
C
Q Would that be as effective in the short-term as using a syringe driver?
A I think it would probably take longer. Oral drugs generally take longer to have an effect than subcutaneous drugs.

Q If a single injection of diamorphine is used, is that an appropriate method of dealing with immediate pain, or not?
D A Yes.

Q You were responsible for referring patients to the GWMH on occasion.
A On occasion, yes.

Q On occasion, did you refer patients to the GWMH, whether Dryad or Daedalus Wards, who required rehabilitation or remobilisation?
E A Yes.

Q When you did that, were you doing it expecting that efforts would be made to rehabilitate and remobilise the patient?
A Yes.

Q You were not doing it merely tongue-in-cheek, as it were?
F A No. In the interim, though, a patient's condition may have changed between my assessment and them actually being admitted to Dryad or Daedalus Wards.

Q But you appear to have had the advantage, which some others might not have done, of both being at the QAH and also seeing what the process was like at the GWMH.
A Yes.

G Q From what you have said, can we take it you would not have referred patients for rehabilitation if you had not thought it was going to happen?
A That is correct.

Q We have seen in some of the notes that we have just been looking at that whatever the staffing levels of physiotherapy were like, there was clearly physiotherapy at work on Dryad Ward.
H

A There was. What I could not be sure of at this distance in time is whether – my feeling was when I started on the ward that there was no routine physiotherapy at all.

Q Did you do anything to change that?
A That was not important if patients were being admitted there for continuing care, but as the nature of patients changed and we were transferring some patients who needed physiotherapeutic input, I remember having a meeting with managers to discuss how could we do that.

Q What was the answer?
A As I remember, I think the physiotherapy department in particular said that they would be unable to provide physiotherapy on a sort of continuing basis, but would be prepared to undertake assessments of patients with a view to giving guidance to nursing staff as to how to move them, mobilise, et cetera.

Q We were looking at an example of that a little earlier I think: how to get a patient out of safely and things of that nature.
A Yes.

Q I want to go back, I am afraid, to Patient I. You have spent a long time looking at these notes. Could you take up your bundle I, please? This is Code A of course. Could you go to a note you are becoming extremely with, I expect, at page 27? This is your note in the middle of the page of 7 April.
A Yes.

Q Leading up to this visit by you, the patient had apparently – and although there is no note in the clinical records, there is a note about this in the nursing records – this patient had been seen by Code A
A Yes.

Q And the MST had been increased. You have made a note of that, "MST [up]" and then what follows after the arrow?
A "Increased to 20 mg bd".

Q So that is 20 mg twice a day?
A Yes.

Q Then you suggest adding another antibiotic.
A No, it is not an antibiotic. It is a sedative, a tranquilliser.

Q What is it called?
A Flupenthixol.

Q The pain that you describe the patient being in, did you at this stage have any diagnosis for that? What was causing this patient's pain?
A I think, given that I have noted there has been a two-inch of shortening of the right hip and that I requested an x-ray, my concern would be, why was Code A still in so much pain?

Q A deep-seated infection, bearing in mind the two-inch shortening of the leg, would or would not be your primary diagnosis? What was your primary diagnosis?
A I think this lady had a deep-seated wound infection.

Q How is that going to cause a two-inch shortening of the leg?
A I think it is recorded after the operation that this lady had a lot of swelling in her leg, a wound haematoma. We know that wound haematomas are likely to become infected, but it is also possible that the head of the femur could have crumbled, either associated with infection or on its own.

Q I am sorry? You would have associated it with infection or – ?
A The head of the femur could also have crumbled and that would cause shortening.

Q Or conceivably there could be some displacement within the ball of the hip, where the operation has actually taken place?
A Yes. The metalwork may have pushed through.

Q When you next attended on 12 April, it does not look as if you saw any x-ray.
A It does not look as if I did.

Q If you had, would you have made a note about it, about what the x-ray revealed?
A I would have thought so, if I had seen it, yes.

Q Because here was a patient presumably still with a two-inch shortening of the right leg.
A Yes.

Q That had not been fixed.
A No.

Q That could only be fixed presumably if she went back to orthopaedics.
A Yes. Well, potentially fixed.

Q You found a patient who was very drowsy with a diamorphine infusion established. When you found that nothing appeared to have happened, or you certainly did not see an x-ray report or an x-ray, did you take that up with anybody?
A Well, I cannot remember, but my feeling would be that at this stage I thought this lady was terminally unwell and that following that up was pointless.

Q You had directed an x-ray to be taken.
A Yes.

Q There was no sign, as far as we can see, that an x-ray had been taken, that you knew of.
A That is correct, yes.

Q Would you have thought – I appreciate you probably cannot remember specifically now – but would you have thought it would be appropriate to take that up with Code A
A I do not think that in this situation it would have crossed my mind to do it, because I felt that this lady was terminally ill and the utility of an x-ray was nil.

Q Would it have concerned you that no x-ray report was available to you?
A If I had been aware that the x-ray had not been done, then I would have wanted to know why that had not happened.

Q Who would you have asked?
A I would have asked the nursing staff.

Q I want you to have reference, please, to two pages: page 134 and page 98. Page 98 perhaps first, at the bottom of which we see that on 11 April the patient was given an extra dose of Oramorph in the morning at 7.15.
A Yes.

Q The patient is already I think on 40 mg of MST, which is the slow-acting, slow-release morphine.
A Yes.

Q We see on page 134 that the patient is described as being "very drowsy, unrousable at times".
A Yes.

Q Can you help the Panel with this? Is the MST likely to be having that sort of effect upon her?
A It could be.

Q When you came to reduce Code A prescription from 80 down to 40, that was still in effect a doubling of the dose that she had been on, was it not?
A Yes.

Q Bearing in mind that she was already very drowsy and unrousable at times, can you explain your thinking?
A Because there has been constant reference throughout this lady's admission to her being in pain. In the note of 11 April, it does say that whenever Code A was moved, she was continuing to be in pain, despite being drowsy, and therefore to attend to her basic nursing needs, in my view she required more analgesia.

Q When you reduced the dose, as you did, is that something that you would have spoken to Code A about?
A I should have spoken to Code A about it but I do not recollect doing so.

Q Can you help us as to why you would not approach Code A about that sort of thing?
A I would only see Code A once a fortnight. I was very busy and I suspect that by the next time I came round I had forgotten about that episode.

Q May I ask you this in that context? Did you have any reluctance to approach Code A?
A No.

Q On that theme, you were asked by Code A about your supervisory role.

A

A Yes.

Q You were, in a sense, in a supervisory role, were you?
A Oh, yes.

Q Was Code A in a training post?
A No.

B

Q I want to just look at the issue of the blood tests. Can we go to page 43, please? It is just to clear up a potential ambiguity. This is a document which shows that the specimen date, if we look at the bottom left hand corner, was 26 March.
A Yes.

Q And that in fact is the date of transfer from QAH to Dryad Ward for this patient?
C A Yes.

Q Can you confirm or otherwise that this, nevertheless, would have been a report ordered from the Gosport War Memorial Hospital?
A Yes, I think I can. In the top right hand corner underneath "Accredited Laboratory", there are two boxes, one a hospital number and the other is report destination which has GWM and GWDR and that is the code for Dryad Ward at Gosport War Memorial Hospital.

D

Q GWM would be presumably Gosport War Memorial and GWR Dryad?
A Yes.

Q To the left of that we see "Requesting Clinician Code A" and we see that all the way through the rest of the reports as well but does that actually mean that you were the requesting clinician or would it be done under your name?
E A It was done under my name.

Q You are the expert in this; we are not. Was there anything either in these blood reports or from the clinical records that you can discover that apart from having a possible infection at the area of the hip, this patient had a general blood infection?
A Is there anything to indicate that on this?

F Q Yes?
A No is the straight answer to that.

Q You were asked by Code A most recently about the effect of the increase in the midazolam?
A Yes.

G Q I just want to ask you this: if it was not that which caused the patient's death, what are you saying this patient died of?
A I think she died of the complications of a fractured neck of femur; in other words, a deep-seated wound infection.

Q A local deep-seated wound infection
A Yes, in the right hi.

H

Code A: That is all that I ask. Thank you.

THE CHAIRMAN: Thank you, Code A

Doctor, I am delighted to be able to tell you that that brings your testimony to an end. It is a very important part of our work to try to build up a clear picture of situations that occurred sometimes years before, certainly in this case. It is impossible for us to do it without the assistance of witnesses such as yourself who are prepared to come before us, subject themselves to long hours of questioning and give us their own individual testimony. We appreciate that it is a stressful experience and in your case, with the amount of time involved, particularly gruelling, and we are most grateful to you for your patience in sticking with the process. Thank you very much indeed, Doctor. You are free to go.

(The witness withdrew)

THE CHAIRMAN: I think we will now hear from the Legal Assessor.

THE LEGAL ASSESSOR: Thank you, Code A

I now formally advise as to the questioning of witnesses by a panel. It will have become apparent to the Panel I am sure that all counsel in this case are very experienced and able. Each knows what his case is; each asks of a witness those questions he needs to ask in order to seek to establish his case. Counsel know more about the facts surrounding this case than we do or ever will, given the wealth of background material which exists and which they have gone through.

The primary role of a panel is to make fair and reasoned decisions based on the complete evidence and submissions presented to it by counsel. It is of course entirely for the Panel to decide what it makes of the completed evidence when it goes into camera to begin its deliberations.

It is proper that a panel may, after a witness has been examined by counsel, ask succinct factual and open questions to clarify the evidence of that witness. When a panel asks such questions, it should bear in mind the following. Firstly, a panel is acting in a judicial capacity. It should ask any questions in a fair, impartial and judicial spirit. Those questions, as I have previously advised, should be asked in an open manner, just as the Panel has requested of the defence in this case. It is inappropriate for a panel in effect to give evidence through questioning. It is inappropriate for panel questioning to take the form of a persistent and prolonged line of cross-examination, which might be interpreted as being intended to support a point of view already held by a panellist. It is inappropriate for the form of a panel's questioning to disclose what might appear to be a fixed point of view in a panellist's mind. Such an impression might be given by the tone of the questioning, by the use of leading questions or by accompanying comments, such as "I have difficulty in accepting that". It is inappropriate for a panel's questions to take the form of an extensive and lengthy recitation of a witness' evidence back to that witness, followed by an invitation to that witness to agree with the panellist's interpretation of it.

In conclusion, a panel must bear in mind at all times its absolute judicial duty to act fairly and impartially. It must keep an open mind about the evidence until it begins its deliberations and it must make it apparent to all that that is what it is doing.

I have before today advised the Panel as to the way in which questions should be asked. It is not appropriate for a Legal Assessor to intervene repeatedly thereafter in order to provide advice already given. Of course, a panel does not have to accept my advice. A panel is the judge of both fact and law but Code A and most importantly Code A are entitled to know at this stage whether this Panel accepts my advice or not, and I advise as follows.

Counsel should be asked whether they dissent from or wish to add to what I have said. The Panel should go into camera now to discuss the implications of this advice and to specifically decide whether or not to accept it. Having done so, the Panel then should come back into open session. If the Panel has concluded that it accepts my advice and will abide by it, it should announce that fact. If, as it is perfectly entitled to do, the Panel declines to follow any part of my advice, it should announce that fact and give reasons.

Mr Chairman, that is my advice to the Panel.

THE CHAIRMAN: Thank you very much indeed, Legal Assessor.

Code A do you have any observations on the advice just tendered?

Code A I have nothing,

Code A I do not.

THE CHAIRMAN: The Panel will now accede to the advice of the Legal Assessor and go into *camera* to consider what he has said. We will call you back as soon as we are able.

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

STRANGERS HAVING BEEN READMITTED

DETERMINATION

THE CHAIRMAN: Welcome back, everybody. I should say, before I go on to deal with the matter of the advice just given, that the Panel are very conscious, Code A of the house-keeping concerns that you will have. There is a witness waiting to come before us now who was here yesterday, there is a specific window of time booked for video link evidence to be presented later in the afternoon and it is for that reason that I am going to attempt to respond to the very detailed and helpful advice from our Legal Assessor in an extemporary fashion rather than taking time to reduce it into writing and then read it to the parties.

I should say at the outset that the Panel entirely accepts the advice of the Legal Assessor. We have taken the opportunity to have that advice printed off for us so that each of us have our own individual copy and that has enabled us to study the advice with greater care and accuracy than would have been possible just by referring to our own notes and it also gives us a helpful template for the future. The hope is that each and every one of us will use it to assist us when we are formulating potential questions in our own mind as to whether the question is appropriate or whether the form of that question is appropriate and, if not, to

attempt to make the necessary changes, even to the extent that that might mean not asking the question at all.

In particular, the Legal Assessor in his advice drew our attention to certain matters that a panel should bear in mind when asking questions and the first was that it should ask any questions in a fair, impartial and judicial spirit, and I would like to say here and now it is the intention of this Panel always to do just that. This is not a Panel of professional questioners and there may be times when the form in which a question is put is less than ideal, but behind it we would wish all parties to feel that whilst our questions may at times be probing and sometimes demanding, they are, nevertheless, coming from a spirit of enquiry.

We are required in this case in particular to look at the situation as it was on two wards a number of years ago so that we can form a view in respect of matters, prescriptions, that have already been admitted as to whether the actions in prescribing those was, for example, inappropriate or not in the best interests of the patient and to do that requires us to have a clear, or as clear as we can get it, view of customs, practice and the general flavour of how things actually worked on the individual wards.

We, as I say, recognise and accept that, nonetheless, the way in which we ask those probing questions should always not only be in a fair, impartial and judicial spirit, but so far as it is possible not give an impression to the contrary. We fully accept that it is not appropriate for a Panel member, in effect, to give evidence through questioning. It is sometimes objected to in counsel's so it would be quite wrong for it to be permissible in Panel members'. Those who wish to give evidence should go on the witness stand and that is something that we fully accept and endorse.

The Legal Assessor has advised us that it is inappropriate for Panel questioning to take a form which might be interpreted as being intended to support a point of view already held by a panellist. That is something that we endorse absolutely. It may be from time to time that when particularly challenging or probing questions are put that they will inevitably be put from a particular point of view, but it should be absolutely clear to all parties that no member of this Panel has at this stage made a decision in terms of having a fixed point of view. Rather, we are enquiring and what we very much hope is that at the end of the process it will be seen that all parties are subject to the same level of probing and challenge and that it is absolutely not reserved for one particular side or another. That would be absolutely wrong and, as I have indicated, it would not be an accurate reflection of the views of this Panel.

The next point is really somewhat similar in that the advice was it is inappropriate for the form of questioning to disclose what might appear to be a fixed point of view in the panellist's mind. Particular reference was drawn to the use of accompanying comments such as, "I have difficulty in accepting that", and that is a comment that was used yesterday. Again, the Panel fully accept and endorse that and we will each of us make efforts to ensure that so far as we are able we avoid the use of such phrases.

Finally, the Legal Assessor advised us that it was inappropriate for Panel's questions to take the form of extensive and lengthy recitation of a witness's evidence with an invitation to the witness to agree. We have to absolutely endorse that. It has been a matter of criticism when counsel has engaged in that particular practice and we take it on board. We need to be very careful in our own questioning to ensure that we do not go in that direction.

The Legal Assessor advised in conclusion that a Panel must bear in mind at all times its absolute judicial duty to act fairly and impartially. It must keep an open mind about the

evidence and it must make it apparent to all that that is what it is doing. In so far as any of the questions that we may have asked so far have not made it apparent that the Panel retains an open and enquiring mind, then I can only apologise and assure all of you that this Panel is still very much engaged in active enquiry and no minds have been made up. We are hearing evidence from one particular side at the moment and it would be wholly inappropriate to reach conclusions before we have heard all of the evidence from both sides and it is our intention to do just that.

I should say that the Panel would also invite counsel to continue with the practice that they have adopted with members of the Panel and with each other throughout, in that if anybody at any point asks a question, or starts to ask a question, which somebody find objectionable they should do exactly what they have so far done and that is object, and I hope in every case so far where a Panel's question has been objected to, that objection has been listened to, taken account of and, where appropriate, the line of questioning has desisted. We wish to make it very clear that we do rely on both our Legal Assessor and the professional parties themselves to feel absolutely able to object at any point, just as they do to questions on occasion asked by their opposite number.

That concludes what I would wish to say at this point. Are there any observations, Code A from the GMC team?

Code A: No, we are grateful for that determination and for that insight into your approach.

THE CHAIRMAN: Thank you. Code A?

Code A: I have no observations to make. Thank you.

THE CHAIRMAN: Thank you very much. Then we will proceed, Code A, with your witness.

Code A: Yes. May I just mention in terms of timing that, as you have properly mentioned, we have a video link set up for this afternoon at, I think, two thirty, with Code A We have abandoned the hope of calling Code A today, so he will now be giving evidence tomorrow. We are going to start with Code A. I do not in fact think she will be nearly as long as Code A but it is conceivable that we will get to the point where we would have to apply to interpose Code A. I do not foresee that that will cause anybody any difficulty but that might happen.

Code A: Sir, can I just indicate now, if that were to happen there would be no concerns on this side.

THE CHAIRMAN: That is extremely helpful, Code A Thank you. Yes, Code A we will have the witness, please.

Code A: Thank you. Code A please.

Code A, Affirmed
Examined by Code A

(Following introductions by the Chairman)

Q Is it Code A ?
A Yes.

Q Code A , I want to ask you a little bit, please, about your experience. There came a time when you worked for a period as a consultant on Dryad Ward. Is that right?
A That is correct.

Q In particular, in relation to any patient that we are dealing with you worked there from 1994 to around September of 1996 when you then went off and did various other things.
A That is correct.

Q I just want to deal, please, with your experience prior to taking up that job. You became a consultant when?
A In June, I think, 1994.

Q Your speciality was?
A I am a geriatrician.

Q I think you had been a consultant geriatrician since June 1994?
A That is correct.

Q Prior to that, can I ask you if you had had any particular interest in geriatric work or palliative care?
A I had no particular palliative care experience other than you get working in a busy general district hospital, but I had worked, I think, for three or four years as an SpR, a senior registrar as it was in those days, in geriatrics.

Q I think just going right back, I think you did your ---
A I cannot remember if it was three or four years. I am sorry. I would have to look at my CV.

Q I think you did your house officer training in 1983 to 1984?
A That is correct.

Q When you came to your post at Dryad Ward it was as the consultant, and was Code A already in post?
A She was.

Q I think you worked there - you have made a separate statement about this and I am going to lead you, if I may, because the dates are quite complex, but we can simplify things. I think you started in June of 1994 as a consultant on Dryad Ward?
A As far as I remember, yes.

Q How often would you visit Dryad Ward?
A It was scheduled for once a fortnight but I was, I think, normally around a week in between, so if people wanted me to go along to the ward for any problems I could pop in on a weekly basis, if required.

Q I think there was a period between 11 July 1996 to 12 August 1996 when you were on sick leave, and I am taking this from a statement that you made ...
A Yes.

Q ... and I am going to lead you. I think, actually at the time you made this statement you had your secretary's assistance to tell you.
A Yes, that is from their own records.

Q All right. Then I think from 16 September onwards, effectively, you were, first of all, on sick leave and then you went on maternity leave?
A That is correct.

Q It follows that from around September of 1996 onwards you were not performing any ward rounds at the Gosport War Memorial Hospital?
A Correct.

Q Just coming back to the earlier part of 1996 and your dealings there, you were visiting the ward once a fortnight?
A That is from my secretary's records, yes.

Q If required you could go a lot more often?
A Yes.

Q Dealing with patients there, did you come across patients who were being dealt with in a palliative manner?
A At that time the functions of the ward was really for patients who were then deemed too frail to go to nursing homes, so many of the patients there were very unwell. I do not remember - I am not quite sure what you are asking. These were patients who we would generally expect would not have a very long length of life.

Q So far as the use of analgesic drugs, and particularly opiates, is concerned, you had had general training in their use no doubt.
A Of course.

Q By the time you came to be dealing with patients on Dryad Ward in 1994, when you started, what was your experience up to that point?
A In general, you mean?

Q Yes.
A On any medical ward you will have patients who are dying and patients who are distressed, so these are drugs we would use when required.

Q When you came on to Dryad Ward, was it your impression that Code A had greater or less experience than yourself?
A She had worked in that setting for longer than I had.

Q Did you also come across Code A?
A Yes.

Q What view, if any, did you form of her experience in that setting?
A Again, she had worked in that setting longer than I had. I cannot really comment beyond that.

Q So as the consultant, what was your role and relationship in relation to Code A? How often would you actually see Code A?

A A From memory, she attended most of the fortnightly ward rounds and we would talk about all the patients on the ward round.

Q Was that in general terms the extent of your dealings with her?
A Yes. Obviously I was open to telephone advice if required.

Q So far as the use of opiates in relation to analgesia for the elderly is concerned, did you have any particular knowledge or experience of opiates specifically with the elderly, or would you yourself have had to had reference back to the BNF or similar documents?
A I problem would have been fairly happy prescribing routine doses, because most patients we see in any branch of medicine now are elderly. I have a low threshold for using the BNF to be absolutely sure of dosages for many drugs, but I would generally have felt fairly happy initiating morphine type drugs.

Q I want to turn to a particular patient. It is Code A Do you in fact have any particular recollection of him?
A I do not remember him. All I know is what I have read in the medical notes.

Q I think it is right to say that you have made two statements and, as a result of those, you were asked to go through Code A notes and translate various things and also comment on your own role.
A I cannot remember the order in which things happened. I think the police interview was the first time I looked at the notes, as I recall.

Q Could I ask you, please, to take up the file to your left which is marked A? I am not going to ask you a great deal about this patient, but I just want to see if you can assist us, please. If you turn to page 196, this patient, as we can see, had come from Mulberry Ward. Where was your regular hospital?
A At that time, I was largely at QA: Queen Alexandra.

Q Your job at Queen Alexandra was what?
A I think at that point my acute ward was Mary Ward, which was a stroke ward –no, it was not. I think at this point it was Anne Ward, which was a general medical, elderly care ward. I did other things as well.

Q Does that mean that were occasions when you yourself referred patients to Gosport War Memorial Hospital?
A Absolutely.

Q When you were referring pots to the Gosport War Memorial hospital, would you on occasion refer them for rehabilitation?
A The patients I would send down – I was very careful who I sent down – and again, this is from memory, I had I think one or two patients whose care I could write down very clearly what I wanted done and when I wanted to do it and if patients were medically unstable, it would quite inappropriate. These would be patients perhaps I think some who had bad cardiac failure who would take a long time to get better and would require meticulous weighing, keeping an eye on their blood tests and on the acute ward, sometimes patients were fighting for attention from very, very unwell patients and from memory patients I sent down did well. But patients who need a large amount of rehab input would not be suitable for transfer.

Q It follows I think that you would have to be fairly satisfied that the patient was in a relatively stable condition before you could transfer them.
A Absolutely. It is not an acute medical unit, nor a rehab ward. It was not set up to be.

Q You would have known at the time that you were referring patients to the Gosport War Memorial Hospital that they presumably would get limited medical input?
A Yes, absolutely.

Q Can we just look at this particular patient briefly? We can see that he had been admitted on 5 January, transferred from Mulberry Ward and his essential problems were immobility, depression, a broken sacrum, he had a small superficial area on his right buttock, heels were suspect, he had been catheterised, transferred with a hoist and we can see at the bottom, "Long standing depressive on lithium and sertraline."
A Yes.

Q Underneath that, we can see an entry for 9 January. The writing I think is that of Code A Code A Then underneath that, do we see a review by yourself?
A That is correct.

Q Your review I think was on 10 January.
A Correct.

Q If you just keep a finger in there, please, and go to page 208, just to lead you into the 10th, as it were, do you see the entry for the 9th?
A Yes.

Q That reads:

"Small amount of diet taken. Very sweaty this evening but is apyrexial. Has stated [something] that he has generalised pain. To be seen by Code A in the morning."

That is a nursing note. Then we can see the following day there is a reference to:

"Condition remains poor. Seen by Code A and Code A To commence on Oramorph 4 hourly this morning. Code A seen and is aware of poor condition. To stay on long stay bed."

That just I hope helps you a little with the background. Can you take us, please, through your note and the relevance of it to this patient?
A I have summarised the problems. He had depression, I think it was resistant depression, and it was a chronic problem. He had a catheter in situ, he had ulceration. His Barthel at that point was zero, which meant he could swallow, he could eat and drink a little if he was fed, but he could not actually do anything for himself at all. He would have been incontinent. Having reviewed the notes, I have written "for TLC". Clearly he had spent a while in hospital. He had not really improved. He was distressed and he was in pain. I had spoken to his wife; I have written "Discussed with wife", because sometimes when you speak to a family you get a very different picture than you get from reading the medical notes, but from what I have written here, clearly she did not say anything to make me feel that he was not likely to survive; it was doing very badly.

Q When you write, as you do, "for TLC", we have heard quite a lot about that expression. We all know what it means: tender loving care. Is it a euphemism for ---
A It is not an expression we would use today.

Q It is not an expression you would use today?
A It is not in current use today, no. When I wrote it then, that would mean that the focus should not be on prolonging life, but on making sure that he is comfortable. If he had something like a urinary tract infection and that gave him discomfort, then you would treat that. So it does not mean you do not treat, but it means the focus of what are doing is on making sure the patient is comfortable.

Q If you could just read the words underneath, please.
A Yes.

"Discussed with wife. Agrees in view of very poor quality [something scribbled] for TLC."

I should think that is probably meant to say "of life", but I agree it is not well written.

Q If you go to page 202, you will find a drug chart. Do you see towards the bottom that Oramorph has been written up?
A Yes.

Q Would that have been consistent with your understanding of what was going to happen for this patient?
A Yes, and also if somebody is a little bit confused and is uncomfortable, sometimes if you just take the edge off the pain, they actually respond to you much better and are much more settled and able to do more.

Q So far as the Oramorph is concerned, the prescription that is written I think is for 10 mg in 5 mls. Is that right?
A Yes.

Q 2.5 mls to be given four-hourly.
A Yes.

Q Then if you look underneath that, do you see a further prescription for Oramorph, 10 mg in 5 mls, 5 mls to be given *nocte*.
A Yes.

Q That would be to give the patient a restful night.
A Yes. That would be the hope.

Q Could you just help us, when you left this patient, would you have taken a view that Oramorph would be sufficient to settle him?
A I think I would not have known at that point. You do not know. You start. I think he had complained on a couple of occasions and so you treat what you can and then see what happens. It is not a known. It is not something you know at that moment.

Q But at that moment, with the patient in the state that he was then in, what did you think he needed?
A It was written up during the ward round by the looks of it, so I am sure I suggested a small dose of opiates to see how he was if we took the edge of his pain and then review.

Q Could you have a look, please, at page 201? You can see that this is under the heading "As Required Prescription".
A Yes.

Q I think this is Code A writing and it is written up as a variable dose.
A Yes.

Q We have seen other forms of variable doses much wider than this. Were you aware that Code A was writing up variable doses, first of all?
A Yes.

Q Had you come across variable doses before?
A Yes.

Q Can you just give us some sort of context?
A All sorts of drugs, not just palliative care drugs, in terms of care units, you often use variable doses of vaso active drugs and the nurses then review them. I have been asked to write up as a junior doctor large doses, variable doses of opiates for palliative care wards.

Q Can you give us an idea of the sort of acceptable range?
A I cannot absolutely remember, but I do remember being asked I think to write one up to 150, because I remember being quite taken aback as a junior doctor.

Q Can you remember what sort of patient that was;?
A It was on a palliative care ward, but I have absolutely no memory. It was a routine thing that I was asked to do.

Q Did you know at this stage, as a consultant, something about conversion rates between oral morphine and intramuscular?
A I cannot remember exactly what was known then. I clearly know what the advice is, but whether it was the same information then as now, I honestly do not know. I am quite sure I would have started at – diamorphine is more potent than morphine, it was known then, as it is now.

Q Would you have known how much more potent? Would you have known ---
A Yes. You double it.

Q Would you say that again, please?
A Yes.

Q You said something about doubling it and I did not quite catch it.
A You used to halve the amounts of diamorphine from Oramorph, depending on what drugs were around.

Q May I ask you this? If you had yourself been converting from Oramorph to diamorphine, is that something – you said you had a fairly low threshold for the BNF – you would have checked, or would you simply have written it out?
A I suspect I would have known.

Q Without recourse to the BNF?
A It is 13 years ago, but I think so.

Q If that is right, then your understanding would have been to halve it in order to obtain the same degree of analgesia.
A Yes. It is different advice now, but I would probably have halved it, yes, if the current dose was adequate.

Q Would you have known anything of the particular sensitivity of prescribing opiates to the elderly?
A Of course, yes.

Q You say, "Of course, yes." You have been working in geriatric care. It is not obvious to all perhaps, but you had a particular expertise.
A I thought you were asking me rather than ...

Q We can see at page 201 that in fact it looks as if this prescription was written on the day after your ward round.
A Yes.

Q Your next visit would have been scheduled for two weeks later?
A Correct.

Q It is pretty obvious and I am sorry to ask such an apparently stupid question but can we take it you did not see this prescription?
A I cannot see any way I could have done, no.

Q And you can see that this patient was in fact started on I think 15 January on 80 mg of diamorphine – 80 mg being the minimum dose that a nurse could administer within this prescription?
A Yes.

Q Is that a prescription that you think you would have written?
A I might have used the variable dosage range, but I would have used a lower starting dose.

Q Where would you have started, do you think?
A I had not seen the patient at this time, so if his pain as adequately controlled on I think he was on about 30 mg of morphine, then I would have used a lower dose than this, but presumably the pain was not adequately controlled on that lower dose, so a straight-forward conversion probably was not appropriate.

Q If you had simply been converting from 30 mg, which I think we have seen the patient was on, according to your formula, hoping to achieve the same rate, it follows that you would have written a prescription for 15 mg?

A A 10 to 15.

Q 10 to 15?
A Well, that is current day. Yes.

Q In terms of increasing a dose of diamorphine, what was your understanding then, if you are able to recollect it, of the incremental nature of the increase?
B A Well, on the wards generally in an acute hospital we would write a baseline diamorphine dosage and we would have "as you need it" top-ups and then as it was then, you could review the patient a few hours later and easily change the dosage.

Q Can you just take us through that because this may be important? When you talk about "as you need it" top-ups, would this be for somebody on a syringe driver?
A Yes.
C

Q When you talk about "as you need it", are you talking about what we have heard about as break-through pain?
A Exactly.

Q So how would you deal with break-through pain and how would you titrate the dose? What would you do?
D A Normally we have a baseline diamorphine dose and on a drug chart there is an "as you need it" PRN section and you would have additional doses of diamorphine that could be given as required.

Q How would that extra diamorphine be given?
A Sub cut usually. If it depends on a syringe driver. I think they tend to use a second needle actually but I do not know what was done then.
E

Q I am trying to take you back, though to 1996.
A I really cannot remember but we would have used additional dosages as needed.

Q Can you give us any idea about the sort of additional dose you would have used?
A Again, my mind is full of what we know and what we do now and it is now standard practice but clearly if you have a patient on a fairly small dose, then you use a fairly small
F top-up; if you have a patient on a much larger dose, you would use a larger top-up, so it is not a fixed number.

Q In trying to use a comparison, and say you had somebody on 40 mg of diamorphine through a syringe driver, when you talk about a top-up dose what sort of dose are you thinking about in your brain?
A 5 to 10.
G

Q And see how that worked?
A Yes.

Q How long would you give the patient to see if that did work or not?
A It is usually after about four hours; if the patient has had the syringe driver going through at a steady dose, unless they are in a lot of pain and particularly if they do not like
H additional injections, then you would go back and review your baseline dose.

Q In addition to the diamorphine, if we go back to our page 201, we can see that midazolam was written up. Would you have been aware then of the effects of midazolam?
A Did I know about the drug? Yes.

Q Not only would you know about the drug, you would have known the effects that it would have?
A Yes. Did I know it was written up here? No.

Q And you did not know that it was written on this prescription?
A No. Sorry, I was not sure what you were asking me.

Q You would know that it would have a sedative effect?
A Yes.

Q Again, just looking at the sort of dosage when coupled with the diamorphine, is this a prescription that you would have written?
A No.

Q Why not?
A That is a high dose of midazolam.

Q We are calling an expert to deal with what happened with this patient and I am not going to ask you about the other increases, which I think you know that there were.
A Yes, I have been through the statement.

Q At the time, you were not aware that these increases were happening?
A I cannot see how I should have been.

Q If you had been aware of the initial dose, of the prescription, and the increases, would you have done anything about it?
A If I saw the patient at the time and it looked like the dose was too strong and they were very, very drowsy, I would suggest that they were cut back, but if the doses happened to be about right for the patient, then I would not necessarily cut them back. It would depend entirely on how the patient was.

Q How often did you get a request, can you remember, from Code A in this relatively brief period for assistance in terms of prescribing?
A I do not remember very many. I do not remember being called out of hours, so to speak.

Q Do you remember any? You say "I do not remember very many".
A I actually do not, no. That does not mean it did not happen. I just do not remember.

Q I understand. Finally this in relation to your approach to prescribing at the time: your normal practice in relation to the use of opiates would be what? What would your aim be with any particular patient?
A It depends why you are giving the drugs. Sometimes for breathless patients, you are just aiming to help with breathlessness. For a patient in pain, you are aiming to relieve the pain as best as you can, but there is a ceiling dose which varies from patient to patient

A because of the side effects. So you have to compromise sometimes between pain and side effects, if that is what you are asking me.

Q But the side effects that you have been looking out for would be what?
A Respiratory depression, some patients get very sick on it; constipation; some patients get very muddled on it and do not like that feeling. With some patients you can actually discuss what you want to do.

B

Q Did you find some patients, just dealing with Oramorph for a moment, of yours did actually have a bad reaction to Oramorph?
A As in?

Q They did not like it or it gave them ---
A Yes, the same with codeine; some patients are very sensitive to very small doses of
C opiate drugs. That is common.

Q We can put that file away for a moment. I do not think you had any other dealings with this patient?
A No, not from the notes and I have no memory.

Q Just two other patients very briefly to deal with: can you take up file B which is that
D of Code A ? Please turn to page 242. I think we have actually got a second page of this elsewhere in the notes. Stupidly, I have not made a note upon it. It is at the back of the bundle somewhere. We have found it. If you go to later in the bundle, to 935, this patient had been admitted to your hospital having had a fall I think back on 5 February.
A No, I saw her in Haslar. She was under a medical team, I think.

Q Why were you seeing her at the Haslar?
E A Patients who were felt suitable for rehab were always seen by a consultant or senior medical member of the team before they were transferred over.

Q You are absolutely right that she was at the Haslar. The notepaper is from the Queen Alexandra. You see the patient at the Haslar?
A Yes, but we dictate a tape and then it is typed up by our secretaries back at QA.

F Q Just reading through this briefly,

> "Thank you for asking me to see this 83 year old lady, who was admitted under your care some 11 days ago following a fall. .....she's had weakness."

You talk about her being a bit battered and she feels that her mobility is starting to improve in her hands and she stood with physios.

G

> "Examination confirmed atrial fibrillation. I could not hear any murmurs."

Over the page:

> "I think the most likely problem here is a brain stem stroke leading to her fall. I note she has iron-deficient anaemia. Upper GI investigations might be helpful as, in view of the atrial fibrillation, one might want to consider Aspirin here."

H

You are reluctant to consider Warfarin.

"Alas, I don't think her brain stem stroke would show up particularly well on a CT and we're now 11 days post-ictus."

A That is after the event.

Q "I'll get her over to Daedalus Ward, Gosport War Memorial Hospital, for rehab as soon as possible. I'd be grateful if her notes and X-rays could go with her."

First of all, do you have any independent recollection of this patient at all?
A I am sorry, no.

Q Can we take it from your earlier answers that you would have considered this patient was stable enough for transfer to the Gosport War Memorial Hospital?
A I think at this point Daedalus was up and running as a rehab unit. The hospital was being used slightly differently. So the first patient was on Dryad Ward, at which time it was purely a long-term care ward. I did take one or two patients over there who actually did very well.

Q Can you keep your voice up, please?
A I took one or two patients outside the normal parameters who actually did very well there but they were only patients I knew. But at this point as I recall Daedalus was a rehab unit, so its function was different.

Q It still would not have had any acute facilities?
A No, so somebody who went off, medically speaking, you would have to transfer up to QA or back to Haslar.

Q In transferring her over to Daedalus, would you have expected her to receive such rehabilitation as possible?
A Yes. It is supposed to be a rehab unit. I was not working on the ward but I assumed that is what it did.

Q That is dated 16 February. It is dictated on 16 February. Is that when your visit would have taken place?
A Yes. It was dictated at the same time.

Q Can you just go back in the notes, and I should have shown this to you previously, to page 148? I think it may explain your involvement, as it were, with this patient. I think I see you nodding. This is a note of 13 February '96 to Consultant in Elderly Medicine:

"Thank you for seeing this elderly 83 year old woman."

I am not going to read through the whole of this. At the bottom we can see these words:

"She has been slow to mobilize and need help to walk."

Something "herself, feed and wash herself. (Bartel score 5)."

Is this effectively the referral to you?
A That would have been a referral which I may or may not have seen when I saw the patient, but, yes.

Code A I think we can put those notes away

Code A: I am sorry to interrupt but Code A own note is two pages on at page 151.

Code A: I am grateful. Page 151 is the clinical note that you made. Is this reflected in the letter that was ultimately written?
A Yes, absolutely.

Q Just looking at the middle of that, I think you reflect a history and underneath half-way down do you say, and can you read out your own writing for us?
A "Since fall, pain arms and shoulders. Walked a few steps with physio. 2 to transfer. No problem eating or drinking. Complained of being unable to use fingers since admission but improving. Stress incontinence – not new."

Q Over the page, does your note continue?
A "Denies any other problems. No obvious source of blood loss".

I was worried about the anaemia. "Mixed diet" because I was worried about the anaemia. "On examination, sensible, cheerful...."

Do you want me to carry on?

Q I do not think we need to unless it adds to your letter.
A No, I do not think so.

Q Can we just look at the bottom? I just really need help reading your writing?
A "Probable brain stem stroke (she has had her neck X-rayed)"

I could not find the X-rays. I assume it was normal. So that was really back to the team to check she had not done any damage to her neck.

"Iron deficiency, anaemia. Diabetes on insulin, immobility. Sounds as though just managing at home prior but she would like to get back."

Q Meaning she would like to get back home?
A Yes, so she needs a trial of rehab.

Q Then "To Daedalus GWMH".
A "? Had enough amoxil?" I must have looked at her drug chart and perhaps she had already had more than I was expecting. I go on: because I was concerned about the anaemia, I have asked them to repeat her bloods and look at her iron levels.

Q You end,

"I am not sure whether we will mange to get her home but we'll try."

A

A Yes.

Q So that was the plan, as it were?
A Yes, trial and rehab. She was only just coping before.

Q Could you put that file away, please, and take up file J and turn up page 52. This is
B Code A
A Oh yes.

Q There is a glimmer of recognition.
A Yes.

Q It is rather later on, I think, in your career, as it were?
C A Yes.

Q We are now in 1999. Is this a note that you would have made at the Queen Alexandra Hospital?
A Yes, from memory I think he was at one of the acute wards at QA at one point.

Q Do you have any recollection of him, in fact?
D A He has been talked about in the corridors more recently, but I do not remember whether I really remember him or not. These patients are thirteen years ago.

Q There is no criticism of you at all.
A Sometimes we have discussed patients before the trial and so sometimes you are not quite sure what you really remember.

E Q It is important, obviously, that you stick to what you think you can remember.
A I cannot talk outside of what I have written down here.

Q All right. If we go to page 51, first of all, that is 13 August. Is that a note by - is it
Code A ?
A I am sorry. I do not know. I do not know handwriting.

F Q All right. We can see at the bottom there, "Transfer to Dryad Ward on [16 August 1999]".
A The top writing is mine.

Q It is yours?
A Yes. Underneath is somebody else. This is the 16th and there is the 18th.

Q I am sorry. Stop for a moment. Page 51 with a line either side of it.
G A I am sorry. I am on page 52. I do apologise.

Q That is all right.
A Yes, I have it now.

Q That is the first note I am looking at. That I do not think is yours, is it?
A No, that is not my writing.

H

Q We can see right at the bottom of that, this is the only thing I wanted to ask you about this, "Transfer to Dryad Ward on [16 August 1999]", and then, "Not for 3555". That is a notation we have seen.
A Yes.

Q We understand what it means. Is that a notation that you used on occasion?
A Yes.

Q We understand that it means not for resuscitation ...
A Correct.

Q ... in the event of a cardiac arrest. Does it mean, in your view, not for further treatment?
A No. It is completely different.

Q Could you now go over to page 52 to your note and can you just help us through it?
A

"Obese
Cellulitis
Pressure sores - buttocks/sacrum
thighs
exudate"

I assume what I mean is that there is some exudate coming out from the pressure sores.

Q Meaning what?
A Possibly infection. Sometimes wounds just leak, even without being infected. "Swabbed", because I was obviously worried about infection, and I have talked about Intrasite dressing:

"... change daily
faecally [incontinent]
legs - much better

Dryad when bed available"

Q Did you think at that time, or does this reflect that you would have thought at that time, that this patient was stable enough to be transferred?
A Yes.

Q He, plainly, had problems.
A Yes.

Q You were giving advice or, indeed, direction as to how to deal with those problems?
A Yes. At that point I do not think there is anything - from what I remember he was very, very obese. From what people told me anyway. No, I am going to have to stick with what is written there. Nothing there has indicated that I was concerned about him, other than, obviously, he had a lot of problems, yes.

Q Yes. The note underneath, is that yours or not?

A No, that is not my writing.

Q At this time in your career you were no longer working at the Gosport War Memorial Hospital at all.
A No.

Q So once this patient had left your care and gone to the Dryad that would be it, as it were?
A Yes, I would not expect to get involved again.

Code A: That is all that I ask you. Thank you.

THE CHAIRMAN: Thank you very much indeed, Code A, the room is going to be used in a few minutes for the first test for the equipment, but it is in the time that we would normally be breaking for lunch, in any event. Can I ask, without holding you to it, how much time you would anticipate needing for this witness for your cross-examination, or Code A, if it is you, to be cross-examining?

Code A will not be very long. I will be a little longer. I think I will be at least 40 minutes.

THE CHAIRMAN: So everybody knows what the situation is, the window booked, assuming the test works okay, is for two thirty. So it is a matter of whether we take a slightly shorter lunch so that we can start earlier and embark on the witness and then go in at two thirty or thereabouts, or whether we go part-heard, as it were, or do not even attempt. Do you have any views yourself as to how you would wish to approach it?

Code A: No.

THE CHAIRMAN: Very well. Code A

Code A: Unusually, for me, I prefer a shorter lunch, because the next witness could be a little while and I think it would be fairly unattractive for this witness to have to potentially come back tomorrow. She has waited already a whole day and she has been very helpful so far.

Code A: I do not think Code A will be very long.

Code A: We are much more in the hands of the defence. I thought she might be a little while.

Code A: I do not think Code A will be very long at all. I will not be asking her about episodes of patient care.

Code A: I see.

THE CHAIRMAN: We started at nine o'clock today so I am conscious of the fact that it is, potentially, a long day. However, if we accede to Code A request, and I am going to check that everybody is willing and able to do that, and take a shorter lunch, if it turns out that Code A is correct that the video link witness is not going to be so long then it would simply mean that we would finish earlier and I guess that would not be unattractive either after a long day.

What I am going to suggest then is that we break for half an hour, which would have us coming back at twenty-to two, with the caveat, as the Panel Secretary has reminded me, that if there is a problem with the video link test things may change anyway. So what would happen is we would all of us be individually informed of any change, but unless you hear to the contrary we would like to try and get started again at twenty-to two, please. Thank you very much.

(To the witness) You remain on oath. Please do not discuss the case with anybody else, and I hope that is going to give you sufficient time to get some lunch.

THE WITNESS: Thank you.

(The Panel adjourned for lunch)

THE CHAIRMAN: Welcome back, everyone.

Code A, before you start with your questions, I have just been given a message from the Panel Secretary and it is this: the witness has just spoken to her and indicated that she has been thinking over a previous answer that she had given and would wish to say something before we proceed.

Code A: I think it is probably best that I clarify that, if I may. (To the witness) Tell us what you want to say.

A I really am terribly sorry. You asked a very clear question. We were talking about swapping Oramorph to diamorph and you asked me very clearly would I be as certain in my knowledge back thirteen/fourteen years ago as I am now. I was thinking outside, many of the things we consider that are routine practice, and I qualified in 1983, are absolutely outrageous by today's standards and I cannot imagine not knowing all this. Looking back on this, I cannot be absolutely certain I did, which is not very helpful and I am terribly sorry.

Q It is difficult for you to distinguish from the knowledge you had then from the knowledge that you have now gained?

A Yes.

Q We are looking at 1996, of course.

A Yes, thirteen years ago. I am terribly sorry.

Code A That is all right. Thank you for that clarification.

THE CHAIRMAN: Thank you. Code A

Cross-examined by Code A

Q Can I just explore that comment? Many things that happened would be considered absolutely outrageous by today's standards?

A This was in 1983, when I first qualified.

Q You are not talking about 1996?

A No, 1983 when I first qualified.

Q Then I had misunderstood. Can you take us back to your role? What you told us was

you were the consultant for Dryad Ward in 1994 to 1997. Yes?
A Yes.

Q You had many other responsibilities as well, I think?
A Yes.

Q You were based at the Queen Alexandra Hospital. Were you responsible for several wards there?
A I am sorry. I have not looked through that. I did not expect to be asked.

Q Do not worry. I was not going to go through the detail of it.
A Yes.

Q But you had responsibilities in a number of other ...
A Areas, yes.

Q ... areas on the Queen Alexandra Hospital. Were you dealing with patients anywhere else as well?
A I think at some point I had a day hospital, which is a type of outpatients, at St Mary's, if my memory serves me correct. I am not absolutely sure.

Q I have a document which talks of Anne Ward.
A Yes, that was the acute ward.

Q That was the acute ward at the Queen Alexandra Hospital?
A Correct.

Q Elizabeth, is that another ward?
A That was a stroke rehab ward. That was at QA.

Q You were seeing patients in outpatients at the Queen Alexandra Hospital as well?
A Probably at St Mary's.

Q OPD is what your diary suggests.
A That is outpatients, yes.

Q Then Guernsey Ward?
A That was also straight rehabilitation.

Q Where was that?
A That was definitely down at St Mary's Hospital.

Q Dryad Ward, clearly, you did ward rounds once every two weeks?
A Yes.

Q Then there is mention on a document I have seen of your job plan of F3 Ward?
A Oh yes. I had responsibility for six acute stroke patients up there. They were patients over the age of 65.

Q Then, in addition, I have "ADH/DDH", which may be the Dolphin Day Hospital?
A Yes, that is correct. I am sorry.

Q That was part of the War Memorial Complex of buildings?
A Yes.

Q What is the ADH?
A Amulree Day Hospital, which was a similar set up but based at St Mary's.

Q So you were dealing with three different buildings?
A Yes.

Q You must have had scores of patients for whom you were responsible at any one time?
A Yes.

Q What you told was that you had periods of sick leave during 1996 and, as a result of that, together with maternity leave, I think you were not doing ward rounds at the Dryad Ward from September 1996 onwards?
A That is correct.

Q I think there was no full-time consultant for Dryad Ward until Code A started in February 1999.
A I do not know.

Q It is in your statement that he started in February 1999.
A Okay.

Q That is where I have been taking it from and if it is in your statement ...
A It will be true.

Q ... that will be right. Were there some locum doctors employed during the time of your sick leave and maternity leave from July 1996 until August 1997?
A Correct.

Q There is a statement that I have seen from you which sets out various locum doctors and I think there were four locum doctors whose names were given, where some locums were for five days, others for several weeks, and I think the longest locum was a period of four months from the end of April 1997 until the end of August 1997. Those locums, would they have covered the full job plan that you and I have just gone through, the three different ---
A I honestly do not know because it is not something that I had any input into. I was off sick and on maternity leave, and we are not responsible for organising our own cover.

Q I understand. It follows from the dates you have agreed with me that certainly from the summer of 1996 there was no full-time consultant to support patients on Dryad Ward until Code A started in February 1999.
A Correct.

Q During the time that you were working until you stopped work in the summer of 1996, can you tell us how much communication you had with Code A on a regular basis?
A I think, as I already mentioned, I did a fortnightly ward round and Code A as often as she could, came. From memory, I think mostly Code A did attend. Particularly when I was doing Dolphin Day Hospital, I would be there if somebody wanted me to pop in in

between weekly sessions. I think occasionally I was asked to go to the ward, but there was no other direct communication.

Q During the time that she was the clinical assistant at Dryad Ward and you were the consultant and working, in other words, up to the summer of 1996, what would you want to have been told by Code A about the day-to-day care and decisions in relation to patients on the ward?

A We would have gone around with the notes and looked at every patient together with the notes and talked about what had happened since I last saw them.

Q You would deal with patients with Code A as and when you were both together?

A Otherwise, if she was not with me, one of the nurses would come with me and I would look through the notes on my own.

Q What about communication with Code A when you were not present for a ward round? What you have told us is that there may have been phone calls, but you do not recall any.

A No, I do not.

Q If you were not there and a decision was reached to start a patient on a syringe driver, would you have expected a phone call from Code A to tell you that?

A No. Only if it was something unexpected or there was some concern over whether that was the right thing to do. I would not routinely have expected to be informed.

Q What about if a decision was made to increase the dosage of any form of medication that a patient was receiving? Would the same answer apply?

A Yes.

Q Essentially, is this the position? You were familiar with Code A practices and her experience and her ability to make decisions?

A Yes.

Q I think you also will have come across Code A during the time that you were working as a consultant and dealing with some of her GP patients. Would that be right?

A Not large numbers. Only those that – we are a huge district, so I am sure some of Code A Code A will have got referred to the hospital, but I do not think I saw large numbers.

Q I understand. I am simply asking, would you have had the opportunity, both through working as a consultant at Dryad and through seeing other patients of Code A, to form a judgment about Code A skills and abilities as a GP?

A Yes. Not as a GP, no. That would not be appropriate for me to make that decision, I do not think.

Q But you had the chance to see her abilities as a clinical assistant?

A Yes.

Q How did you find her?

A I was very happy with her care. As I think I have mentioned, I did bring one or two patients over who were going to need a protracted period of time in hospital and for whom I

A could flowchart very carefully what I wanted to be done and it was and these patients did well.

Q Coming back to Code A how did you find her as a doctor when you dealt with her on the ward rounds?
A My memories are good. I do not remember any particular concerns at the time.

B Q What would you say about her level of conscientiousness?
A She knew the patients, which is – because of the way we work at the moment, with junior doctors coming and going, that in itself counts for quite a lot and I always thought she cared about the patients and put their interests first. I thought the decisions she made were generally sensible from memory.

Q Would you have been aware of any time pressure on her?
C A Yes. I did know she was time pressured.

Q What did that mean in practical terms, Code A being time pressured?
A I think the thing I remember most was that I did not feel the note keeping was of a high standard, but I felt it was probably more – well, it was more important – she saw the patients than wrote a large amount in the notes. From patients referred in from other community hospitals, the standard of note keeping did not seem to be out of the ordinary.
D

Q Can I just explore that? You said you thought it was more important that she should see the patients than write large amounts of notes.
A Yes.

Q Was it apparent to you that the constraints on Code A time were such that that was a choice that needed to be made? She could either write notes or spend time with the
E patients.
A I think that is what I must have thought, yes.

Q What you have just told me is that the notes that Code A wrote were equivalent to that which you might have seen in other cottage hospitals.
A More than some, yes.
F
Q More than some?
A I remember seeing one patient in outpatients who came from another district hospital and the only reason I knew they were an inpatient was because they had a wrist band on; there was nothing written in the notes at all. And that was not unheard of at that time, which does not mean it is good, but it is what was happening.

Q I am grateful. So it follows that the level of note keeping by Code A was
G equivalent and better than ---
A From my impression of other ---

Q Better than other equivalent units.
A Yes.

Q Would it be fair to say that you were aware of the way in which Code A prescribed
H to patients?

A A Generally we would look at the drug charts on the way round. We would discuss things as we went round.

Q How were the drug charts kept, if you can recall, for ward rounds when you were at Dryad?
A I do not remember having any particular concerns.

B Q Would you have seen prescriptions such as the type that you were asked to look at for Patient A, Code A, prescriptions for a range of medication in a syringe driver?
A Yes. I was aware that she gave a range.

Q You have told us that you had seen that before in other units.
A Yes.

C Q Was it appropriate to do that in the circumstances in which Code A was treating patients on Dryad Ward?
A I felt it was appropriate to use a range of doses, yes, because she was only there once a day.

Q So far as the nursing staff were concerned, was it clear that the range of prescription was something that the nurses could deal with competently and effectively?
D A I do not remember being concerned.

Q You did not raise any issues with Code A about her prescribing?
A I do not think so.

Q You knew about the anticipatory prescribing.
A I am really sorry. I just do not remember.

E Q I am going to suggest you did not raise any issues with Code A about her note keeping.
A No.

Q You have told us that on an occasion in the past when you were a junior doctor, you remember being asked to write up a variable dose for a patient up to 150 mg.
F A I am not absolutely sure. Again, this is more than 13 years ago. 15 years ago.

Q Was that diamorphine?
A I am pretty certain it was a syringe driver dose and I am pretty certain the top end was 150, because we were slightly taken aback, but we were told it was routine.

G Q You were told it was routine. It would not have been a nurse that gave you the instruction to write up diamorphine; it would have been a senior doctor?
A No. It would probably come from a nurse, the protocol. This is what you were supposed to do. My memory is – this has to be more than 15 years ago, so I cannot be held to it – I do have a memory of being on a palliative care unit and being told this was standard procedure, the nurses would alter the doses as necessary and this is what we had to prescribe for every patient who came on the ward.

H Q Can you tell us whereabouts in the country that was?

A I am honestly not sure. I really am not.

Q Whereabouts was the unit you are talking of?
A It might even be Portsmouth. I honestly cannot remember. I did try and look back to see if we had any old protocols on the ward before the trial, but I could not find any.

Q Is this your recollection? Writing up variable doses of drugs such as diamorphine to be delivered by a syringe driver was pretty standard practice many years ago?
A I thought so, from my own experience.

Q You have told us when you were asked about conversion rates that if you were moving from oral morphine to diamorphine to be given by injection, the calculation that people would make then is that you would halve the dose.
A This is what – I did bring up again – I cannot imagine not knowing it, but then this is such a long time ago. Things that we take for granted now were not necessarily standard practice then. So I am sorry, I cannot be absolutely clear on that.

Q But doing the best you can, that is the calculation that used to be made?
A I think so, yes.

Q You have told us that you used to halve the dose to diamorphine, depending on what other drugs were around. That is my note of what you said to Code A If that chimes a bell with you, can you tell us what you meant?
A Yes. I think mostly you look at the patient really before you decided on what dose to give. If they were on Oramorph and their pain was satisfactorily controlled, then you would convert them directly. These days, you would use a third. If their pain was not controlled, then you might go a little higher than that and also write up as you need it, prn, rescue breakthrough pain medication.

Q Would you agree that it is vital to see the patient or know what their present condition is?
A Absolutely.

Q Before determining what an appropriate dose may be?
A Mostly, yes. I would not do it without having seen the patient recently at least.

Q We have heard that on occasion a doctor might be asked to make a prescription over the telephone, give a verbal order, but absent that happening, you would want to see the patient or know the patient's history and present condition.
A If I had seen the patient the day before and I had a very clear picture of them in my mind and I trusted the nurse on the other end and I was in the middle of doing something else, then I – as a junior doctor, I gave a lot of verbal orders. It was fairly standard practice, which you would not do now.

Q I understand.
A But if I had never seen the patient before or I was not happy about the person, the nurse, I did not trust the nurse on the phone, then obviously not.

Q Can I come to the nursing staff on Dryad Ward? How did you find the level of nursing that was provided for your patients on Dryad?

A A In terms of if I wanted things like daily weights done, daily blood pressure measurements done, fantastic actually. Things got done much more efficiently than perhaps was done on the acute ward because of all the pressures of looking after a lot of very ill patients. They were very good at things like bed sores. Patients came in with dreadful bed sores and they healed. Quite often, we sent them down from the acute ward and I was not expecting them to get better and some of these patients did very well.

B Q Would it be fair to say that it was a well-run ward?
A I thought so, yes.

Q That requires good leadership and it requires willing nursing staff.
A Yes.

Q Was it clear that that was how things were done on Dryad Ward?
C A I was not aware of any problems.

Q As to the patient mix on Dryad, what you have been very clear about is that it was not an acute ward.
A No.

Q It was not an acute medical unit, nor a rehabilitation ward. It was not set up to be.
D A No.

Q I wonder if you can just help us with what that means in practical terms for patients who might be transferred to Dryad?
A If they are patients for whom acute medical treatment would be deemed appropriate if their condition deteriorated, then you might have to think about transferring them back to the acute ward, depending on the patient or what the problem was. If it could not be handled
E simply – because as far as I remember, we did not use even subcutaneous fluids then. If we had to re-hydrate patients, I do not think we did subcutaneous fluids or anything, as far as I remember.

Q If there was a medical problem, you would have to think about whether to transfer the patient over.
A Yes, if it was appropriate to do that. If it was not something that could be sorted out
F simply with antibiotics and just careful – getting them to drink on the ward, if it was something more serious than that.

Q Tell us why you would have to think about whether it was appropriate to transfer a patient out if there was a medical problem? Why would it not be done automatically?
A It might not be in the patient's best interests to send them on a long ambulance journey. It is quite distressing to be bumped along on a long ambulance journey if you are a
G patient who is a bit muddled and a bit confused and also if you think the chances of them doing well if given full medical treatment are poor, then you would think hard about sending them up the road.

Q What would you say to someone who said, "Well, it is always in the patient's best interests for them to be referred for assessment and investigation"?

H

A A No, it is not always, I do not think. For patients who are unlikely to benefit from further aggressive management. It is a decision we make every day in the hospitals. We decide where to draw the line on what treatment you are prepared to give patients.

Q Patients who are unlikely to benefit?
A Yes.

B Q What do you mean by that?
A That they are very unwell and unlikely to be made better by further medical treatment.

Q It was not a rehabilitation ward either.
A No.

C Q Again, in practical terms, what did that mean for the patients who were transferred to Dryad?
A That we were not taking rehabilitation patients I do not think at that point. I think one or two came through for whom – I mean, some patients are so frail they actually cannot cope with daily physiotherapy, so we were not offering – patients who needed daily physiotherapy, it would not have been appropriate to transfer at the time. Is that your question?

D Q It is essentially, yes. Together with, what were the facilities anyway for physiotherapy on Dryad when you were there?
A I think sometimes we sent one or two, because some patients came down who were expected not to survive and they got better. Patients sometimes do when you just leave them alone for a little bit actually and just make sure they have good nursing care, food and water. I think we sent a couple down – I am not absolutely sure – to the day hospital for physio I E think and I think sometimes we had people come on to the ward for us if they could, but my memories are hazy. I am sorry. I cannot be sure of details.

Q It is many years ago. One thing you say in your statement made for the General Medical Council – it is paragraph 14 for those who have it – you say:

> "Families had sometimes been under the impression that their relative had been F transferred to Dryad for rehabilitiation when this was clearly not the case, nor appropriate."

A Yes. That was not uncommon at the time.

Q Can I just explore what you mean?
A Yes. Patients would have been seen by one of my colleagues. At this time the G criteria were such, as I have already said, we were looking at patients who were thought to be too frail for nursing homes. They were not fit for rehabilitation. These are the patients that would be sent on, but quite often nurses on the ward they had come from would say, "Oh, no, they'll be great when they get there. They'll get some rehab." So there were some communication problems and I do remember speaking to some of these families and the patient may have been in the hospital system for several months, they had been across several wards. Before they came into hospital, they were walking the dog and the relatives very H reasonably wanted to know how on earth they got where they are now and I do remember it

A could take me quite a long time just to read through the notes and find out what actually happened to this person. So communication was not always appropriately done for the families when the patients were transferred down.

Q Is this patients or families who may have been misinformed as to what Dryad Ward could provide for them?
A Yes. I think it was a lack of knowledge at the acute end, because these patients were
B coming from all over the hospital.

Q One of the problems that that of itself might create is disappointment, resentment, complaints, about the care that the patients or relatives might have expected to be afforded at Dryad, but which could not actually be given?
A Yes.

C Q How was that dealt with?
A I do not remember any complains at this time, but I do remember talking to some families and I just remember going through the notes myself and thinking, "Yes, I understand where the family are coming from", because their loved one was living independently six months ago, came in with a fractured neck of femur, they had a gastrointestinal bleed, they had a heart attack, they had one thing after another and quite often, what I really had to do was just spend quite a lot of time going through the notes myself working it out and then just
D taking the families through what had happened and explaining things as best I could.

Q I understand. So it is clearly the case that some families were, for whatever reason, under a false impression about what Dryad could do?
A Yes.

Q Again, you have made it plain that patients being referred to Dryad would not be fit
E enough to go to a nursing home?
A No, these days that is different, but that was the criteria thought to be appropriate at the time.

Q If they are not fit enough to go to a nursing home, they are not fit enough for rehabilitation?
A Absolutely not, no.
F

Q Can we turn to Code A please, Patient A? It is file A. I am afraid I am going to take you through slightly more of the records than you were taken through before because I think Code A had, was it 30 years of depression?
A I do not remember, I am sorry.

Q I am not going to go through that length of time or anywhere near it, but perhaps I can
G take you to page 48 in the records. This is a clerking note from 14 September 1995 when Code A was admitted to the War Memorial Hospital under the care of Code A The Panel have heard from her. We know that Code A is shown as chronically depressed. A number of medical problems are referred to on that page. There is reference to his previous medical history, "PMH", two-thirds of the way down the page. It is query Parkinsonism. Can you read the next line for us?
A "Varicocele repair".
H

Q One member of the Panel is medical. The others may already know the answer to this but what is a varicocele?
A It is a minor procedure.

Q And "hypothyroidism" is an under-active thyroid.
A Yes.

Q No heart attack.
A High blood pressure.

Q "Diabetes." The next is?
A Chronis bronchitis or a stroke.

Q Thank you. There is reference to chronic depression for clearly some period of time; the suggestion is the 1950s. If we go on to page 51, I think the note continues. In the middle of the page we see the letters "O/E" "In wheelchair, thin" and is it "fine tremor"?
A Yes.

Q "CNS" is the central nervous system I think.
A Yes.

Q "Very immobile + Parkinsonian with cogwheeling shuffling gait". Cogwheeling is a way of walking?
A Yes, cogwheeling is more to do with ---- Certain neural conditions can give you a higher tone, make you a bit stiff and particularly in Parkinson's you get a tremor superimposed on that, so the stiffness comes and goes a bit.

Q The word "gate" should refer to walk and be spelt slightly differently?
A I think so.

Q Over the page on 52, the plan is to continue his then medication. I am sorry, we should look at the impression at the top of that page. "82 year old man with long history of depression and multiple medication". Is it "antibiotics"?
A I actually do not know what that says, I am sorry.

Q "Required ECT in the past. Mood and self image deteriorating along with physical capabilities over months, possibly since moving into a rest home away from his wife. Also very anxious at times. Deteriorating appetite and weight loss, in part due to shame at eating in public."

That is what it says. We see the plan and the question of whether he should receive more electroconvulsive therapy was raised but he did not get it. Can I take you on to page 181, which I think is Code A entry. I beg your pardon, it is a nursing entry. The nursing entry for that day, 14 September;

"Code A has been admitted from Hazeldene Rest Home at the request of Code A has recently become more depressed and less able to care for self – requiring assistance with washing, dressing etc."

I think what we see, if we go back to page 55, is that by 18 October, so going on a month or so after his admission, Code A has recorded that Code A is "eating well, seems better and brighter – wife has noticed the improvement". The plan is formed; "no ECT. Discharge next week" is what is suggested and we will see, if we go on a page ---

Code A: I am sorry to interrupt but the witness is looking slightly bemused and I am wondering if there is a question at the end of this.

Code A: I am setting the scene. If there is an objection, I will give ground and the objection can be heard.

Code A: We know the scene. The witness knows the background to the patient and I just wonder if there ought to be a question quite soon at least that the witness can actually answer.

Code A: There will be a question. At an earlier stage in the proceedings, the Panel wanted half an hour to familiarise themselves with every patient. The Panel at this stage are juggling 12 case histories in their minds and I think it would be unfair on the Panel if I simply go straight to "This is what happened on this day", without reminding us all of the history. I do not think we have been taken through the history in this detail with this patient before. I do not apologise for doing so.

THE CHAIRMAN: Speaking for the Panel, it is of assistance to get some insight rather than just being led straight to points and their being put. That clearly we have complained about in the past. To that extent, I think we are absolutely with you, Code A However, we need to be conscious of whether the witness is following and I think Code A initial point was that the witness was appearing somewhat bemused as to where we were.

Code A: I apologise if that is the impression I was giving you.

A I just wondered if I was supposed to know something that I did not.

Q But you will have looked at these records before?

A I do not think I have. When I did the police interview, I did not look at any of this actually.

Q When you saw Code A, would you have had access to his medical records?

A Whether I would have access to his Mulberry Ward records, I honestly do not know because quite often departments keep their own records, for obvious reasons, in hospitals.

Q Are you saying that there may well have been occasions when you saw patients and you did not have their medical records with you?

A Oh, quite frequently and also the psycho-geriatricians' records were not with the normal medical records.

Q What about at Dryad? When patients were referred into Dryad, did you always have the medical records?

A Not always because records get lost, but if they come from a psycho-geriatric ward, I honestly have no idea whether their records came with them or not, I am sorry.

Q I am going to keep going with this exercise, if I may.

A That is fine. I just wondered if there was something awful I just did not know I had been involved with.

Q We see a discharge letter on page 57. I think the calculation as to his age is wrong; he is not 71. We have seen he was 82 a few pages ago. There is reference to the past medical history and we have looked at the clerking notes that deal with that. This covers, on the second page, 58, the physical examination that we have looked at. We see from page 58 that when he was discharged he was on a variety of medications including Sertraline and lithium carbonate, which I think are drugs for depression?

A Sorry, Sertraline is and lithium is a mood stabiliser, yes.

Q Can I take you on to page 63: we must recall that Code A was discharged to the Hazeldene Rest Home on 24 October. Here he is six weeks later being admitted again to the War Memorial Hospital and the note on admission back to the War Memorial under Code A Code A is a quotation. Putting it in a quotation suggests that that was what the patient himself had said: "Everything is horrible".

A I would assume so. I do not know better than you really.

Q There is a description of information which may be received from the rest home from Code A, "Verbally aggressive to wife and self. Staying in bed all day. Not mobilising. Constipation. Not eating well." Then, "Hopeless and suicidal". "PPH", that is his previous history, "Chronic depression" and reference again to previous medical history. If we were to look at page 126, we can see in the right hand column, about two inches down from the top, the date that we have just looked at on the clerking note, it is the same date, 13 December 1995, and it is also at the bottom of the page. This is the nursing note on Code A re-admission to the War Memorial. The reason for the admission is written there as:

> "The rest home cannot cope with him. He has put himself to bed and refuses to get up. He has become both physically and verbally aggressive towards staff at the rest home. Lack of energy and self-motivation."

I think we have another note at page 145 at the top of the page apparently in the same handwriting and to the same effect. If we go on a little bit in the history and go back to page 65, there are entries in the medical notes for 20 December 1995. The second entry refers to a ward round in which someone has written "Mobility" and then two downward arrows. Then two days later there is an entry,

> "Generally weak today. Left-basal crepitations. Chest infection."

Over on page 66, taking it on another few days, another ward round by Code A. We see he is described as "chesty, poorly, abusive, not himself at all". There is reference to him being catheterised at the end of last week and a request for a geriatric review. If we go on, you will see that there is a request made to Code A on page 67, 2 January 1996:

> "Thank you for seeing Code A who has been treated for many years for resistant depression. On this admission his mobility initially deteriorated drastically and then he developed a chest infection. His chest is now clearing but he remains bed bound, expressing the wish to just die. This may well be secondary to his depression but we would be grateful for any suggestions as to who to improve his physical health."

A We see another ward round below that of Code A. "Poor food intake, fluid OK. Deteriorating. Some breaks in skin now. Query whether fit for ECT" and a reference to Fortisips, a high protein diet, and "needs more time to convalesce". There is a downward arrow on page 68 at the top with reference to diazepam, meaning reduce the diazepam.
A Yes.

Q "Watch for benzodiazepine withdrawal". Can you tell us about that?
B A If you stop or decrease doses abruptly patients get a withdrawal reaction. If you decrease the dose or stop benzodiazepines abruptly, patients get a withdrawal reaction and become very agitated.

Q I am grateful. "Probably will need nursing home" is the entry just below that. Then we have an assessment by Code A on 4 January '96 in which she sets out a number of problems I think.

C Sir, I am looking at the clock at the same time as I am doing this exercise. I have already indicated that if it were felt appropriate to interpose, I would not have any objection.

Code A: I have just been given a note, which I suspect comes from the Panel Secretary, that the video link is not going to be fixed. I gather they were missing a cable or had a kinked cable at the other end which they were trying to replace. That they have not been able
D to do. I am told that the only way Code A could give evidence this afternoon would be over a telephone. We would be content with that on this side of the room but I am very much in the hands of my learned friends and the Panel.

Code A: My experience of technology is that the lowest level of technology is usually the most likely to be successful and telephones are fine.

E THE CHAIRMAN: I think a number of members of the Panel have also had experience of the telephone link-ups and they do seem to lend themselves very well. So if everybody is content with that course, we can take that.

Code A: I certainly think with a non-contentious witness there is no difficult with that at all. In that case, could I just speak to my instructing solicitors to see what the timing is. We are going to make some inquiries to see what time it would be best to set that up.
F

THE CHAIRMAN: Very well. Meantime, we will continue, Code A

Code A: (To the witness) We will come back to 4 January 1996, please. Again, just looking at Code A note that we have on that page, page 68, an 82 year old, "frail", she describes him:

G "Chronic Resistant Depressed -
Very withdrawn
Completely dependent - Bartel [score of zero]
Catheter - by - passing
Ulceration (superficial) of [left] buttock and hip
Hypoproteinaemic"

H She says:

A

> "I'd be happy to take him over to a [long] stay bed at [the War Memorial Hospital]. I feel his [rest home] place can be given up as he's unlikely to return there"

Would this be typical of some of the patients that were admitted to Dryad?
A I would think so.

B

Q If we go on, you have been asked to look at Code A clinical note at page 196. There is a transfer document on the previous page, 195, which talks about his poor physical condition and reference to the broken pressure areas and also problems with his scrotum that were then apparent. We know there is an entry on 9 January, page 208, if I can take you on through the history. You have been taken to the entry at 9 January in the middle of that page, where Code A is saying he had generalised pain:

C

> "Small amount of diet taken. Very sweaty ... but is apyrexial",

- and we know you saw him the next day, on 10 January, and that is the entry that we have at 196.

Oramorph was what was proposed. I think your entry at page 196, the first word is "depression". I think it might have been misinterpreted by some as "dementia", but depression is the first word.
A Yes, I am afraid it is.

D

Q We have seen worse handwriting than yours. Do not worry. You have told us what "TLC" referred to, that the priority at that stage of this patient's life was keeping him comfortable.
A Yes.

E

Q That would be the primary duty of those caring for him?
A Yes.

Q Doctors and nurses?
A Everybody.

F

Q Keeping someone comfortable when they have bed sores or other types of pain means comfortable 24 hours a day?
A Yes.

Q Not just for periods of time, between nursing episodes, it means comfortable whilst he is being nursed as well?
A Yes.

G

Q We know that from page 199 Code A had been receiving Arthrotec, which is a drug you describe in your statement for the GMC as a pain killer.
A Yes.

Q Forgive me. I said your statement for the GMC. It is not. It is a statement you made for the police. For those who have it, it is page 6 of 13. (To the witness) It is a pain killer which is a tablet which is given twice a day and is dealing specifically with his

H

Parkinsonism?
A No, it is a pain killer. Parkinson's is not painful, it is a disorder which affects how you move. This was for pain.

Q We know his Arthrotec was stopped. If we look at this drug chart on page 199, we see it was last given on 10 January, which was the day of your ward round.
A Yes.

Q If you remove one form of pain killer, might you think it appropriate to replace it with some other?
A We had started him on Oramorph, did we not?

Q That is what happened. I agree. We can see at the top of page 199 that Code A was receiving sertraline and lithium that he had had for many months before and also receiving diazepam but we know had been reduced at an early stage in hospital.

There is another drug chart that we have at page 202 which also shows sertraline and lithium and follows on from the other drug chart that we just looked at, at page 199, and we will see that sertraline and lithium had been stopped on 11 January 1996. These are drugs dealing with mood and, in the case of sertraline, depression. Can you confirm for us that, generally, it was thought appropriate if patients are on a lot of different medications and they have reached the final stage of their lives that it reduces the risk of complication if you reduce the number of drugs they are on?
A Yes. You look at the ones that are most likely to be of benefit to them and maintain those. It can also be difficult to persuade patients to swallow tablets so you focus your attention on the ones you really want them to have.

Q Yes. Would you approve the decision to discontinue the sertraline and the lithium in the case of a patient such as Code A ?
A I find that one hard to say actually. If he was very, very depressed regardless, it may have been a reasonable thing to do. I cannot give an opinion really.

Q We know they were discontinued on the 11th. That was the day they were written up and stopped, clearly the same day because no more sertraline was given. The 11th was the same day that Code A wrote up the prescription for diamorphine. If you turn to page 201, we see the diamorphine, 80-120 mg, midazolam and hyoscine to be given by syringe driver. That was when prescriptions were written up, although, of course, no medication was given for another four days.

Again, what would you say about the decision to write up an anticipatory prescription for those drugs at that stage, given that other drugs were being stopped and Code A may still have been in pain and discomfort?
A I think it was a reasonable thing to do in a functioning unit where you trust the nursing staff.

Q It is clear from your earlier answers that you trusted the nursing staff as well.
A Yes, I do not remember any concerns.

Q I wonder if we can just take it on? Code A was now receiving Oramorph on 11 January. We have seen that from page 202. We see that Oramorph continued to be given for the next few days. It was discontinued on 15 January. Clearly, shortly before the diamorphine was started on the syringe driver, on page 201, on the morning of the 15th.

Can we just look at what Code A condition was between those dates? If I can take you to page 225, please. There is an entry for 13 January, reference to the catheter bypassing twice and the patient appearing depressed. Would it be your experience that nursing staff and medical staff are very well able to form a view of the patient's level of comfort, or the lack of it, even in a patient who may not be speaking to them?
A Not all but most.

Q If you are nursing a patient, perhaps changing dressings on bed sores or moving them on a regular basis to try and prevent bed sores developing or giving them a chance to resolve, you will get an impression in a typical patient of how comfortable or uncomfortable they are at that stage?
A Most nurses will pick it up.

Q Would it be your experience of Dryad Ward that, as a doctor dealing with patients, you depended absolutely on the feedback from nursing staff as to how the patients were progressing?
A Not absolutely, but ---

Q You undertake your own assessment when you are there.
A Yes.

Q But as to how the patients are doing when you are not there ---
A I have to listen to what they say, yes.

Q There has to be a relationship of trust between doctors and nursing staff.
A Yes.

Q That they will report to you what is relevant?
A Yes.

Q And contact you if need be out-of-hours?
A Yes.

Q Or when you are not there. I think there is an entry on page 218 as well. We have mentioned problems with his scrotum. That is referred to on 9 January on this document. The particular entry I wanted to refer you to was 16 January. It appears that another problem has arisen. Code A right ear is very blistered and swollen. Would that be a fairly common picture, that a patient who is not eating very well has become rather withdrawn, who is bed bound with a Barthel score of nil, that the skin may break down?
A I do not know if it explains the right ear but, yes, the skin will often break down.

Q I do not know if you recall, Code A was really very wasted. Cachetic, I think, is a word that is used.
A I do not remember that word being used, but he was hypoproteinaemic and it said his intake was not great somewhere.

Q If you were to turn, please, to page 231, this is a Waterlow Pressure Sore chart used to assist nursing and medical staff to formulate plans for the patient, but in the middle of the page, under the heading "Special Risks", I think you get eight points for terminal cachexia and that, clearly, was what was thought to be an appropriate description of Code A It means that the muscles of the body are very wasted.

A It means somebody has not eaten enough for a long time and they are wasting.

Q Yes. It is not a condition that one can suffer from as a result of not eating for a couple of days.
A No, no.

Q This is long term.
A Yes.

Q Is it appropriate, from what you have seen of the medical records, to say that Code A was clearly very unwell at this stage?
A Yes.

Q He was dying.
A Yes.

Q You can see that clearly through the records, can you not?
A Yes.

Q In those circumstances where the patient is dying, again, would it be appropriate to give a level of pain relief that those nursing him and doctors caring for him considered to be appropriate?
A Yes.

Q Again, do you really need to see the patient in front of you to make a decision as to what level of pain relief is appropriate?
A As a doctor?

Q Yes. If you were asked to say, "is 60 mg appropriate for this patient or that patient", you would need to see the patient.
A I would, yes. I am not quite sure I understood your question actually.

Q The Panel will hear from someone later on who did not see the patient and I am just asking your view as a practising doctor of ---
A There are some doses that will never be appropriate.

Q I understand that.
A You build up to them. You would not just start at them. I am sorry. I was not quite clear what you were asking from me.

Code A: Thank you very much, Code A

Re-examined by Code A

Q Just dealing with those last questions. You were asked if a patient is dying is it right to give a level of pain relief which those caring for him consider to be appropriate and you agreed that was right.
A Yes, and if the patient can have an input into that decision that is often helpful too. I do not think that would have been possible here but, yes, it is not a blanket rule.

Q The aim of any such medication, can we take it, must be to provide pain relief?
A This chap was also very agitated and distressed. It was not just pain, I think, looking at

A the notes.

Q Clearly, the prime purpose has to be either to deal with pain relief or, on your view, agitation. Can we just think about this particular patient? You were aware when you saw him with Code A that Code A was going to prescribe Oramorph.
A Yes.

B Q That was in your mind on 10 January and you believed it was in Code A mind on 10 January.
A Yes.

Q We can see from page 200 of the notes that on 10 January that is what she prescribed.
A Yes.

C Q Did she say anything to you about prescribing what would have been, in effect, eight or so times that dose of diamorphine? Did she say anything to you that she intended to prescribe 40-80 mg of diamorphine at the same time?
A I do not remember her saying anything along those lines.

Q If she had said anything of that nature - I am sorry, I should not just leave it there. Together with diazepam?
D A I do not remember that being discussed.

Q If she had said anything of that nature would you have raised any concern with her?
A I would not have been concerned that the drugs were being thought about, even though it would not be appropriate to give them, but I would have used the starting dose.

Q You would have raised that particular prescription?
A Yes.
E

Q All of the history that you have heard, with this patient we know that by the time he was started on 80 mg of diamorphine he had, the day previous, been receiving - I think we worked it out, was it 25 mg orally?
A 25 or 30 at some point, yes.

Q Whatever those caring for him were seeing, can you imagine any circumstances in
F which it would be appropriate to give that patient what would be, in effect, a fivefold increase in opiates?
A Not as a starting dose. You might go up to it quite quickly but you would not start.

Code A: That is all that I ask. Thank you.

G THE CHAIRMAN: Doctor, I indicated at an earlier stage there would come a time when members of the Panel would have an opportunity to ask questions of you and I said I would introduce any of them to you at the time if they did have questions. Code A is a lay member of the Panel.

Questioned by THE PANEL

H Code A: Good afternoon, doctor. This is just for clarification for me. You were asked I think by Code A what the side effects for diamorphine would be and you made a list of

what they could be. I tried to frantically write it down, but did not get them all. Would you repeat them for me, please?

A Yes, of course. Some people are very sensitive to even small doses and will feel sick and nauseous on it. The other major gut complication is constipation, which is very common. You can get respiratory depression, which means you lose your drive to breathe. So sometimes somebody given a big dose of morphine will not breathe very well. In somebody who has chronic bronchitis, that could be quite a small dose to have that effect. Your level of consciousness may depress. Even on really quite small doses, some people can get quite confused, even tiny doses. Codeine can have the same effect. It can make them agitated and hallucinate. Those are the biggest effects.

Q You just mentioned that these side effects can be done with small doses?

A Oh, yes.

Q Would it therefore follow that there is a greater chance of having these side effects if the doses are quite large? Does that matter?

A Yes. All things are more likely to happen as you increase the dose, but some patients will, on a very small dose – sometimes we give them even a little dose of codeine, which is a similar sort of drug, and they will tell you the next morning, "I had a horrible night, doctor, because I hallucinated all night." So yes, it can happen in small doses, but it is more likely on bigger ones. Is that what you are asking me?

Q Yes. So it would be prudent to start on a smaller dose, just for the side effects possibilities?

A Yes. In this case, he had quite a small dose of Oramorph to start with.

Q But what about when we get up to the prescriptions for the diamorphine?

A You would tend to start on the lower dose, partly because of side effects, and you actually do not know how much you are going to need to relieve the patient's pain. So you tend to start low and build up very quickly, which is easier to do in a hospital because there are lots more people around in a big hospital like QA.

Q Would the effects of morphine/diamorphine have more – or would they react differently to somebody who is severely depressed? Would there be more likely to be side effects for someone who is severely depressed?

A I honestly do not know. I cannot think so particularly, actually.

Q The confusion would not be greater perhaps, or the agitation would not be greater?

A Well, you get some odd effects. I cannot remember all the pharmacology, but when you use very, very high doses, bigger than these, of morphine, you can get – patients can get very agitated. That tends to be much higher doses than we are talking about here. I have seen it on our palliative care ward at QA when we are using doses of 500 mg over 24 hours; much, much bigger doses. But I do not know, I honestly do not know whether very depressed patients would react differently. Anybody who is a little bit confused normally, then it would make them a little bit more confused and the effects may be more pronounced than in somebody who is not normally confused.

Q The likelihood of those things happening would be more as you increased the dosage?

A Yes.

Q My other question to you is, you also told us I think prior to the incident we are looking at, you had seen one that, you were taken quite aback that had a range to 150.
A This was as a junior doctor, yes.

Q Seriously, how many years prior to that are we talking?
A I honesty cannot remember. I would have thought probably within the last 20 years. Code A is 13 years ago, so several years before that, because I became a consultant in 1994.

Q I think you said that this rare to see a dose like that, one that went up to 150.
A I was surprised when I was asked to do it, but I was told it was standard procedure for the unit. I do not know more than that. I am sorry.

Q In your history before you got to the ward, had you seen prescriptions of this width before?
A Not on acute wards, no, we did not routinely do that. But in a way, we were in a much easier position, because there was a doctor available 24/7, so it was very easy for the nurses to get somebody to come back and review the patient's medication. There was not quite the same need to prescribe a big range of doses.

Q If someone was going to be there within 24 hours, the next day, you would not anticipate going from a range of say 80 to 120, would you?
A It is quite difficult to know how much pain relief somebody is going to need. You just do not always know. At the end of the day, you might give 5 and it does absolutely nothing and then you give another 5, it has done absolutely nothing a couple of hours later and then you start giving 10. So you may end up escalating the dose fairly quickly, because what you do not want to do is have a patient in pain.

Q That is the reason you would start low-ish?
A Start low and be prepared to build up rapidly if needed.

Code A I think that answers my questions. Thank you very much indeed.

THE CHAIRMAN: Code A is a medical member of the Panel.

Code A you said at one point – it was when you came back in and you wanted to say to Code A about what used to happen was outrageous.
A This was back in 1983.

Q Can you amplify on that? What was outrageous?
A I remember in those days, if you were over 70, quite often it was thought perfectly reasonable to give you some oral antibiotics, drink water if you are up to it and that was thought okay. I remember being told you could not treat pulmonary emboli in patients over the age of 70 because it was too risky, giving them heparin, which would be an outrageous statement to make today. We are thrombolising people up to the age of 80 for stroke. But it was of its time.

Q Is your judgment of outrageous a judgment of what you saw when you were working, or is it a judgment of the practice of medicine in general?
A I am not quite sure what you are asking me.

Q Are you drawing simply on your experience of what you saw where you worked, or are you making observations on the way in which people were treated?
A As a houseman, yes. At the time, I was of the system, but looking back a few years later, I remembered some of the patients and I thought, "Goodness, we would not do it that way now."

Q You are not making an observation about the practice throughout the UK in that time?
A No, I cannot. I was just walking around outside and I was just thinking about what I had said and I thought, "Oh, actually, I need to qualify that."

Q You said just very recently – and again, I am not clear what you were saying – that you would want to see the patient – I think this is right and this is where I need you to put me right – if – can I put it this way; I may be wrong and that is why I want you to answer the question. If a decision had been made to change the track of treatment to end of life – was I right in picking that up?
A Yes. I am very unhappy making those decisions without knowing a patient, without having seen the patient.

Q The patient in your care.
A Yes. It is a decision I am asked often on the phone on the acute wards and I do not like making that decision unless I have actually been to see the patient. I would rather see them more than once, if possible.

Q You saw the patient I think the day before on the ward round.
A Yes.

Q Of course, you did not see her again because she died two weeks later and you did not go more than fortnightly.
A No, I did not see him again.

Q So would you have expected to be contacted to be asked whether you wanted your patient to be treated in that way?
A I think we had already established that [Code A] outlook was very poor. My hope – a slim one, I think – was that perhaps if we just relieved a bit of his pain and his discomfort, he might feel happier in himself, he might be able to mobilise more, he might be able to eat and drink more.

Q Was that your understanding on that 9 April or whatever?
A But if that did not work, then I discussed with his wife, I thought the outlook was poor and I have written "TLC". At that point, I thought the treatment of symptoms was paramount.

Q But we have established the very next day he started on subcutaneous ---
A No, no. That was a few days later, was it not?

Q A few days later. Before you saw him again.
A Yes. I think in this case, just looking at what I have written in the notes, I was quite clear, I have been very clear, more so than I normally am, that his outlook was very poor and

A I have written, although I have written "TLC", I think that palliative care would be appropriate.

Q This is a problem that we have had with a number of witnesses – it is not a criticism – as to what is the difference between palliative care and end of life care? Is that an apposite thing to talk about with Code A, for instance?
A I am not really sure what you are asking me.

B

Q He is for TLC.
A Yes. At this point, symptom control is paramount. My hope was that he might actually have picked up a little bit. If we just alleviated his pain, in a nice calm ward for a couple of days, he might have picked up, in which case clearly you would change tack.

Q In your words, it was to make him not uncomfortable.
C A Yes.

Q But a diamorphine pump was started on him.
A Yes.

Q At I think what you have said you thought was quite a high dose.
A Yes.

D

Q Would you agree that that might have implications as to where the treatment was going?
A I think I would have no question – what we were looking for was to alleviate symptoms and those are completely individual decisions made on an individual patient basis. So what he needed really – I would have started this at a lower dose, but I do not have a problem with him being started on subcutaneous diamorphine if that was what he required at
E that time.

Q He was started at 80 mg.
A Yes.

Q You have said you think that that is a high dose.
A Yes, to start.

F

Q If you think that is a high dose, would you have expected somebody to ask you if that was an appropriate stage to enter for your patient?
A I think the feeling at the War Memorial was that it was not an inappropriately high dose, therefore there was no need to contact me. I think it was done to alleviate distress and pain.

G Q Could you just explain what you said then? It was a feeling at the War Memorial – ?
A I do not think anybody at the War Memorial was concerned that this was – I do not know, but I assume – that nobody at the War Memorial felt that it was an inappropriately high dose. That is all. Otherwise, I think somebody would have contacted me if they were concerned.

Q It was your patient.
H A Yes.

Q Your responsibility.
A Yes, I know.

Q So nobody did contact you.
A No.

Q Does that reflect in effect that you had such a high degree of trust in them that you left it to them to make the decision?
A I think it depends what you feel the whole issue behind putting up a diamorphine pump is. It is another stage in end of life care that you move to under certain conditions, but it is not in a way particularly different than writing up a big dose of Oramorph. It should not be. As you know, you move to a driver when patients cannot swallow, when it becomes difficult or burdensome for them take medication.

Q Can I crystallise it into the same question this way? Back in 1996, did you have such a high degree of trust in the nursing staff and Code A that you were content to have the situation as it was?
A Clearly, because I was not – they probably would have told me the next week that he had died and he had died on the syringe driver and I clearly was not concerned and presumably trusted them as far as I can remember.

Q Did you know he died?
A I really – this is 13 years ago. I am sorry.

Q You do not remember two weeks later saying, "Where's Code A ?"
A No.

Q So there was no opportunity to discuss ---
A I do remember one person dying unexpectedly and I still remember that now, because it was an unexpected death, but this I do not remember.

Q Just one very quick point. Can I take you to that Waterlow score at page 231, because there is something I do not understand on it. If you take the second column, which is dated 22/1/96, Code A drew your attention under "Special Risks", terminal cachexia, 8, a high score. A high score is a bad score.
A Yes.

Q But at the top it says "Build/Weight for Height – average".
A I cannot comment. The two do not tally.

Q It is incongruous.
A Absolutely.

Code A : Thank you.

THE CHAIRMAN: You will be pleased to hear there are no further questions from the Panel. What we now have to do is to turn to the barristers to see if they have any questions which arise out of the questions asked by the Panel. Code A ?

Further cross-examined by Code A

Q The idea of starting a patient on a certain dose and being able to adjust that dose you say is much easier to do in a large hospital?
A It is, because there is always a junior doctor on the end of a bleep, so you can get somebody along usually within half an hour.

Q What about in community hospitals?
A Well, you have a GP who is in the middle of their surgery, so it is not as easy.

Q There are weekends as well?
A There is nobody. There is a GP on call.

Q There is and we have heard from a couple of those and we have heard from nursing staff that in this particular hospital some of the GPs may be difficult to get out over the weekend or they may be difficult to persuade to adjust the dose of analgesia?
A Yes.

Q Is it clear then that in a community hospital where there will not be a doctor 24 hours out of every day, you cannot just tinker with the dose by going a small top-up on a regular basis?
A If you best guess that what the patient is going to need is way too low, it is going to be much more difficult to get the dose up to an appropriate level, particularly over a weekend.

Re-examined by Code A

Q Just on a very similar topic, you were answering questions from Code A and you were reminded of your evidence that earlier on in your career I think it was that the range up to 150 ---
A I think I said several times that I cannot be absolutely sure because it is a long time ago.

Q You cannot be absolutely sure that that was the level?
A No, I absolutely cannot. I remember being a bit surprised at being asked to write the dose up but what that dose was, I cannot be absolutely sure, I am sorry.

Q You also said that was a dose that you were being asked by a nurse to write up?
A Yes, as far as I remember. We do write drugs in advance of patients going to the palliative care ward just so that they are available for the nurses to give.

Q I understand that but that is anticipatory prescribing which you describe as a reasonable thing if you trust the nursing staff but do you have to put limits on your anticipatory prescribing if you are going to give a variable dose. Do you write out variable doses now?
A Me, no.

Q You do not?
A No, I do not have to because I only work in the acute unit.

THE CHAIRMAN: Doctor, I know that you were here yesterday hoping to get on to give your evidence and we kept you waiting this morning. I apologise for that but I would like to say that it is only through the attendance of witnesses such as yourself that a panel like this is able to make proper inquiry into what happened months and often many years before. We are most grateful for your assistance in helping to build up for the Panel a clearer picture of that situation in those times. You have our considerable gratitude, not least for your patience and forbearance whilst we have been going through the process. You are now free to leave.

A Thank you very much. Can I ask one very quick question, and I am terribly sorry. Am I allowed to discuss the case with other people who have already been interviewed or must I just say nothing until the ----

Code A: We should really ask the Legal Assessor, I suppose. There is no objection to witnesses discussing their evidence post-event. It is preferable that it does not happen just in case a witness needs to be re-called. What must not happen in any circumstances is to discuss evidence with a witness who is about to give evidence or may give evidence in the future.

Code A: I agree with what Code A says, particularly about the one thing which must not happen, but one does have sympathy with doctors who have given their evidence being free to talk about matters with a colleague who has already given evidence. I appreciate technically there is some risk that we might all suddenly decide we need to re-call Code A and other witnesses. I think the danger is probably minimal but I take my friend's point.

THE CHAIRMAN: I hope that is clear to you, Doctor. It is certainly a lot clearer than if I had attempted to explain that to you.

A Yes. I am sorry to delay you further. Thank you.

(The witness withdrew)

Code A: We would be grateful for some time to set up the telephone link.

THE CHAIRMAN: It is time for the break in any event.

(The Panel adjourned for a short time)

TELEPHONE LINK CONFIRMED WITH Code A

THE CHAIRMAN: Is Code A not going to be joining us?

Code A: No, sir. The next witness is Code A who is on the line now.

THE CHAIRMAN: Code A, can you hear me?

Code A: Yes, it is not brilliant but I can hear you.

THE CHAIRMAN: I will try to speak slowly and to speak up. I am sure everybody else here will do the same. If at any stage you are not able to make out what has been said, please

indicate and whoever is speaking will, I am sure, try to repeat what they had just said. First of all, may I ask you if you have a form of affirmation in front of you or near to you?

Code A I do.

THE CHAIRMAN: Would you like to read that to the Panel, please?

Code A Affirmed
Examined by Code A

THE CHAIRMAN: I was not in here when there were others speaking to you earlier but may I take it that you understand who is able to hear you at this time?
A I am not entirely sure but I understand it to be the Fitness to Practise Panel, the defence and the prosecution.

Q Yes, the GMC Legal Team also and I should tell you two further things. This is a public hearing, so members of the public are entitled to attend and there are members who are in attendance today. I hope they can hear you, although the speaker through which we are hearing your voice is rather a distance from the public gallery. Finally of course there is a shorthand writer here who is going to help create a transcript of everything that is said.
A OK.

Q Other than that, we have the Panel's Legal Assessor, who is an independent lawyer who provides us with legal advice, and we also have the Panel Secretary and Panel Assistant who are responsible for matters of administration. That pretty well covers the room. I am going to pass you now to Code A from the GMC Legal Team.
A Thank you.

Code A can you hear me?
A I can hear you, thank you.

Q My name is Code A and I am representing the GMC today. I am going to ask you some questions very briefly to start with and then there will be some more questions by the barrister who is acting for Code A Do you understand?
A Yes, I understand.

Q First of all, just a little bit about you. Is it right that you have been employed as a consultant in old-age psychiatry since 1989?
A That is correct.

Q You are also employed by the Wessex Deanery as a Director of Specialty Education?
A I am still employed but the title has changed. I am now an Associate Dean for Educational Development.

Q You are a Member of the Royal College of Psychiatrists?
A Yes.

Q You qualified originally as a doctor in 1980?
A Yes.

A Q You then qualified as a specialist in psychiatry in 1987?
A Yes.

Q And, as you have already clarified, you have been a consultant psychiatrist since 1989.
A That is right.

B Q I am only going to ask you some questions very briefly to clarify an entry that you made in medical records relating to a patient called Code A That is a patient that we are dealing with under the reference Patient H.
A OK.

Q I hope that you have been provided with a fax of just a few pages from those medical records?
C A Yes, I have received eight pages, including a letter and the entry in the notes.

Q I am very glad to hear it. I am going to ask you just very briefly to look at those and to confirm the contents?
A OK.

Q As I say, it will be very brief. If you look firstly at page 173, I hope you have a page
D of 173 with a dash either side of it at the bottom?
A Yes, I do.

Q I am just giving everybody here a moment to get that page for themselves. Do we see at the bottom of page 173 that there is a referral which starts, "Dear Psycho-Geriatrician"?
A Yes.

E Q It is a request for the psycho-geriatrician to review this patient?
A That is right.

Q Signed I think by Code A ?
A I cannot read the signature.

Q Very well. It may be that there is going to be no dispute about it but in any case that
F was a referral that eventually led you to review the patient: is that right?
A That is right.

Q If we turn to page 176 of the records, on the bottom half of the page and just over into the following page do we see the entry that you made?
A Yes. I have that.

G Q Because it is in handwriting, what I am going to do is simply read to you from your statement how you transcribed the notes and just ask you to confirm that that is what is there.
A OK

Q This is what you wrote.

"8.10.98 Psychiatric Review.
H

A Thank you for asking me to see Code A who presents with a history of heavy alcohol intake over the past few years. His current admission was precipitated by a fall resulting in a fractured left humerus.

On examination today he also presents with low mood, a wish to die and disturbed sleep."

B There is a question mark meaning possibly "secondary to pain".
A Yes.

Q "His ST memory", so is that short-term memory?
A Yes.

Q "...is slightly impaired". There is a mini mental state examination score of 24/30?
C A That is right.

Q "My impression is that Code A suffers with 1) early dementia 2) depression.

I suggest 1) sedative antidepressant to improve mood and sleep. I have taken the liberty of prescribing Trazodone 50 mg nocte."

D You put in brackets:

"(I am aware of impaired liver function but this would be a concern with all antidepressants.)"

A Yes.

E Q "I shall arrange F/U", meaning follow-up?
A Yes.

Q "...by our team once we know to where Code A is going to be discharged."

A That is right.
F

Q You have signed it?
A OK.

Q That is your note?
A Yes.

G Q And, just to clarify one or two things about it, please, we have already heard a little from another witness about a mini mental state examination but I think you clarify in your statement that it is a standard test of memory and general brain function?
A Yes.

Q That someone with 30 out of 30 has a good memory?
A Yes.
H

A Q Someone with, say, 5 out of 30 has a very poor memory?
A That is right.

Q Code A scored 24 out of 30 and does that show that he had a slightly impaired memory and brain function?
A That is correct.

B Q When you have written "early dementia", what does that mean, please?
A Early dementia means a degenerating process affecting the brain which is likely to be followed and probably will deteriorate further.

Q Does the use of the word "early" suggest anything about how serious it was at that moment in time?
A Yes, "early" would indicate that it is a mild form of dementia.

C Q As reflected in the mini mental state examination?
A Yes.

Q Trazodone is an antidepressant?
A Yes.

D Q Does that also have some sedative effect?
A It does.

Q What sort of dose is 50 mg?
A 50 mg is the lowest starting dose. It is possible to start even lower but not by giving tablets; that would require giving a liquid of the medication.

E Q You wrote in relation to that prescription or suggestion that you were aware of impaired liver function?
A Yes.

Q Why did you write that? What is the significance when it comes to medication?
A The significance is that impaired liver function is a factor which has to be considered with most medications because break-down of medication in the liver is obviously an F important part of the pathway. When you give medication, it needs to be broken down and got rid of somehow and the liver is an important part of that pathway. If there is impaired liver function, it might mean that the medication is not excreted or broken down as quickly as it would be in a person with a healthy liver and so that means it needs to be taken into account and it needs to be monitored subsequently.

G Q Would that need for caution or concern apply only to antidepressants or would it apply to other medications?
A It applies to a wide range of medication, but antidepressants are know to be broken down in the liver, particular Trazodone, and therefore I felt it was important to highlight this further.

Q It may be an obvious question but how would you have been aware of the fact that this gentleman had impaired liver function?
H

A I was only aware of that through looking through his medical records and obviously having access to test results, especially results of liver function.

Q In this case, in terms of your prescription for Trazodone, I think you made clear in your statement that you were balancing the risks which come with Trazodone and someone with impaired liver function against the need to promote sleep and general well-being.
A Absolutely.

Q And your conclusion was?
A That it was an appropriate drug to use in this particular patient, and this is obviously, at the end of the day, down to clinical judgment. I think I said in my statement that in an ideal world no medication would have been the safest option ---

Q Sorry; can you just explain what you mean by that?
A I mean that in terms of liver function not introducing medication might have been the safest option, but not to treat his disturbed sleep and obviously low mood would also carry a risk with it.

Q Moving on to the last part of your entry, when you dealt with arranging follow-up, what was it that you envisaged happening?
A My plan at that point, and I knew again from the medical records that there was a provisional plan for residential placement and it would be common practice for us to follow up somebody after discharge from hospital if we have initiated psychiatric treatment.

Q That would be done by?
A Either myself or by a member of the community team.

Q Thank you. The last point is simply to identify for the Panel that at page 117, which you also have ...
A Yes, my letter.

Q ... you have, in essence, set out your findings and recommendations in a formal letter.
A That is right.

Code A I am not going to ask you more about it because we have dealt with the essence of it. Those are all the questions I am going to ask you. Thank you.

THE CHAIRMAN: Thank you very much, Code A

Cross-examined by Code A

Q The same letter that you have just been asked about, on the second page towards the end, I think you make the same point about the Trazodone.
A Yes.

Q You say:

"I do of course hope he tolerates it in view of his liver and renal failure."

A Yes.

Q What you told us, as I understand it, is it is important for a doctor who is prescribing to bear in mind that a patient may have - liver failure was the one you dealt with?
A Yes.

Q But it is not an indication not to prescribe if it is an appropriate drug.
A Absolutely. It is always a fine balance between treating, potentially, at risk of causing adverse effects and not treating and the risks of not treating.

Q You, clearly, were trying to help Code A sleep better.
A Absolutely.

Q Prescribing in the hope that his mood would be elevated somewhat?
A Absolutely. My main aim at that point would have been to improve quality of life because my treatment would not have had an impact on his general physical state. I was not treating him medically in that sense.

Q I understand. Can I turn to a different topic, and that is Code A?
A Okay.

Q I think you knew Code A?
A I did know Code A but not well. I have never worked directly with Code A

Q Have you treated patients along with Code A?
A No, I have not.

Q Have you treated any patients where she was the general practitioner?
A No, I have not.

Q It may be that you cannot answer any questions I have about whether you formed a view of Code A and the sort of care she provided for her patients.
A I feel unable to comment directly because, as I said, I have not had direct working relationships with her. What I did know of her at the time was that she was one of the general practitioners in Gosport and, as far as I knew, she was a well respected GP.

Code A: I am grateful, but I will not ask any more than that. Thank you very much, Code A

THE CHAIRMAN: Thank you, Code A

Code A: I do not have any further questions. Thank you.

THE CHAIRMAN: Very well. Doctor, we have completed the questions from the barristers. This is a time when if any of the Panel members have questions for you they are able to ask them. I am just going to check to see whether any of them do have questions. (No verbal response) There are no questions from the members of the Panel so it follows that your testimony is complete. Thank you very much indeed for agreeing to make yourself available to assist us today. I understand that you have been put through a great deal of inconvenience before you had the opportunity to answer the questions and I would just like to say how very grateful the Panel are to you for sticking with the process. It is only by hearing evidence from witnesses such as yourself that we are able to build up a clear picture of what happened, often at a very considerable time in the past. So we are most grateful to you and you are free to hang up. Thank you.

A

TELEPHONE LINK TERMINATED

THE CHAIRMAN: Code A

Code A Sir, I think that is all the evidence we have for today.

B

THE CHAIRMAN: Very well. We will break now and resume at 9.30 tomorrow morning, please. Thank you very much indeed.

(The Panel adjourned until 9.30 a.m.
on Friday 3 July 2009)

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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 3 July 2009

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

Chairman: Code A LLB JP

Panel Members: Code A

Legal Assessor: Code A

CASE OF:

Code A

(DAY NINETEEN)

Code A of counsel and Code A of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

Code A QC and Code A of counsel, instructed by the Medical Defence Union, appeared on behalf of Code A, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Good morning, everybody. Code A

Code A: Can I just indicate the schedule for today, please. The first witness that we have is Code A and I will be calling him in a moment. We have then got a statement to read to you, or parts of a statement to read to you, from Code A Although Code A was here yesterday, I have released him today. I have taken that decision because before he is called there is quite a lot still to do. We have chronologies, which I am afraid are still not finalised, although we are getting very close to finalisation. I know that the defence would like you to have read through, certainly at some stage, Code A statements, certainly prior to the time that Code A is cross-examined. I also want to resurrect the issue of whether you should have Code A reports at this stage. Knowing that we were rising, I think the suggestion is 3.30 today, I did not frankly want Code A hanging around with the possibility that we might be able to get an hour's worth of evidence, but frankly with the likelihood that he would not. So I hope that was the right decision. He will be available to give evidence on Monday. I think he is making a request through me that the Panel might sit at 10.00 to allow him to catch the 6 o'clock train from Newcastle rather than come up the night before, and I wonder if consideration could be given to that at some stage.

THE CHAIRMAN: We can do that right. The Panel do not have any objections. The only observation is that we know that it is going to be a tight week in terms of other things happening. On Wednesday, for example, we will not have use of the room. If you are content---

Code A: We might be inviting you to sit until the end of the days, 5 o'clock, when Code A is giving evidence, but that might be affected by whether you receive the reports or not, but I will raise that argument later.

THE CHAIRMAN: Very well.

Code A: Can I start then, please, by calling Code A The Panel might just want to turn up their chronology for Patient H.

Code A Sworn

Examined by Code A

(Following introductions by the chairman)

Q Code A, I should start by thanking you for being so accommodating because you have been waiting for a long time to give evidence, and so thank you very much for your attendance here today. Code A, I want to ask you, please, about the time when you were employed as a registrar and then a specialist registrar at the Queen Alexandra Hospital back in the late 90s, but can I ask you first of all what your current occupation is?

A I am a consultant geriatrician at Queen Alexandra Hospital.

Q How long have you held that post as consultant geriatrician?

A I am a consultant since 2 January 2001.

Q Could you pull the microphone slightly closer to you. You have a soft voice and I do not want to have to ask you to repeat everything you say. Just tell us a little bit, please, about the training up to the time that you were employed as a registrar at Queen Alexandra Hospital. First of all, where did you qualify?
A I qualified in India in 1981. I trained in general medicine in India till 1987. Then I worked as a hospital practitioner in India till 1989. I came to UK for further postgraduate training in September 1989. I passed the PLAB test of the GMC in September 1989. After that I started training in the UK initially as a senior house officer in general medicine between November 1989 till ---

Q The exact dates perhaps do not matter.
A ---July 1992.

Q From 1989 you effectively went through the normal route, as it were?
A Process of training. Then I became a general medical registrar in 1992. I worked one year at Stockport as general medical registrar, then one year at Wrexham in North Wales, again as a general medical registrar, then three months at Cardiff as general medical registrar.

Q Can I just cut this a little bit short. At what stage did you begin focusing on geriatric medicine?
A That is 1994 I started my career in geriatric medicine as a staff physician at Worthing Hospital in West Sussex.

Q When did you take up your first post at the Queen Alexandra Hospital?
A I came back to training in December 1997, but I became a specialist registrar in geriatric and general medicine at Queen Alexandra Hospital in December 1997.

Q Have you been there ever since effectively?
A I was specialist registrar till February 2000 at QA in Portsmouth, then I went to Southampton General Hospital to complete my training in geriatric medicine, which I completed in December 2000, and then I became a consultant from January 2001.

Q Going back to the Queen Alexandra Hospital?
A I went back to the Queen Alexandra, yes.

Q We have got a good picture of your training and your career up to that time. Now, I want to take you back, please, to the time that I think you were a specialist registrar and you came to deal with a patient called [Code A]. Now, I know that you have made a number of statements about that. If there comes a time when you need to refer to the statements you can, but I do not think you will need to because I am going to take you through the notes that were made in relation to that patient. If you look to your left you should see a file with a large "H" on, a patient bundle for Patient H, and if you could start, please, by turning to page 166. You will find the page numbers that I am going to refer to have a little line either side of them. I am afraid you will see on occasions there is a multiplicity of page numbers, but it is page 166 that I want you to turn to first.
A I have got it.

Q We can see that it appears that on 23 September 98 (the date is not terribly clear) the patient had been admitted to Accident and Emergency, and was this at the time when you were working at the Queen Alexandra Hospital?
A I was, as a specialist registrar at Queen Alexandra Hospital.

Q As a specialist registrar what sort of patients were you then dealing with?
A As a specialist registrar I was trained both in general medicine and geriatric medicine. We were part of the general medicine on-call duty, so I would be looking after all the acutely ill medical patients coming into the hospital, either through casualty or direct admission to the wards.

Q Can everybody hear the evidence? (To the witness) You are quite softly spoken, so if you can imagine you are shouting across a busy ward. I do not suppose you ever do, but---
A Okay. Sorry.

Q Now, this is not your note, I think, that we are looking at here, is it?
A This is not mine.

Q Okay, but we can see that the patient had had a fall, he had fractured his left humerus, is that right?
A Yes.

Q That was the cause of his admission. Then I want to turn, please, to the first document that you would have written upon. If you could go to page 171. So this is a few days after his admission. Do we see your writing on this page?
A I can see my writing on this page, yes.

Q Is it both the top and the bottom?
A Both the top and the bottom.

Q So the first entry, I think, is 25 September. Does this note follow an examination of the patient?
A It does.

Q The patient would then have been on one of your wards.
A He was.

Q Would this examination have taken place in the presence of anyone else?
A It would have, yes.

Q Who else is likely to have been there?
A I do not remember exactly now who was with me. Most probably when I do the ward round as a registrar there would have been a nurse present at the time, and also another junior doctor.

Q Possibly a senior house officer?
A Senior house officer.

Q Can you just take us through your note, please.

A A I have written on 25 September 1998 "high [gamma GT]", it is an abbreviation.

Q The relevance of which is what?
A Gamma GT is an enzyme produced by the liver. I do not know the exact reason, but it is usually high in people who have a high alcohol intake.

Q Is it linked potentially to liver disease?
B A It could lead to liver disease.

Q The next entry?
A I think I have written "[high] MCV" and "[high] INR", probably that is what I meant when I wrote that, indicating that he has mean corpuscular volume of the red blood cells. "MCV" stands for mean corpuscular volume, which refers to red blood cells---

C Q We have had so much intricate information in this case that I am going to try and cut to the chase; are all these indicators of a high alcohol intake?
A In my opinion, yes.

Q Right. Can we move to the next entry.
A "still in pain", possibly from the fracture he sustained. His left arm was bruised. Sensation was normal. Normally after a fracture of a bone in the upper limb we have to
D be careful about complications from the fracture, so normally we would be testing for sensation because of any neurological nerve damage.

Q Right.
A So his sensation was normal. Also, vascular complication; it can press on the brachial artery, resulting in loss of blood supply, so I checked his wrist pulsation, which was normal.

E

Q That was all right.
A I suggested regular pain relief, and I think it is magnesium hydroxide, probably for---

Q That is certainly what it was when you wrote your statement.
A Yes.

F

Q You would have given him that for what?
A For possibly constipation.

Q "T4", is that a reference to his thyroid function?
A Total T4 and TSH both refer to thyroid function test. TSH is the thyrotropic hormone produced by the pituitary. It is slightly elevated, indicating his thyroid was
G probably under-acting.

Q That can affect the metabolism rate of the body?
A Not at this level.

Q It is not low enough for that?
A Not low enough for that.

H

Q Could I ask you to keep a finger there, please, and we are going to have a look at some prescriptions that you have written. If we could go, please, to page 113 and 114. 113, I do not think that is your prescription, is it?
A No.

Q Can you help us with what it is?
A I think it is chlordiazepoxide.

Q Which would be for what?
A Normally when patients are admitted to hospital and if they happen to have excess alcohol intake, since they are not consuming any alcohol in the hospital, there is a chance, there is a risk, I would say, of alcohol withdrawal symptoms, and the sedation are usually given to prevent or treat alcohol withdrawal symptoms.

Q All right. Could you look to a prescription on the following page, page 114.
A Yes.

Q I think the top half at least is dealing with pain relief.
A Yes.

Q Would this be pain relief in relation to the pain that he had in his arm as a result of the fracture?
A I think so.

Q Have you yourself actually written these prescriptions?
A The signature, it looks like min, those top two.

Q Let us just have a quick look at those, please. The first prescription is?
A Is codydramol, which is a combination of paracetamol and codeine.

Q Is that regarded as a medium level analgesic?
A It is a medium level analgesic.

Q And you wrote this prescription on 25th, we can just make out, I think, so that was on the same day as the note we have just been looking at?
A Yes.

Q And the level of co-dydramol that you are prescribing is what, please?
A It is two tablets.

Q What is the dosage rate of co-dydramol, do you know? Is it 5 mg?
A One tablet contains 500 mg of paracetamol and 30 mg of codeine.

Q We can see that that was given to him until, is it, 30 September?
A He had a dose I the morning of 30 September.

Q And then it looks as if he was switched to paracetamol?
A Yes.

Q Is that your prescription for paracetamol?

A A As well; in fact I stopped the co-dydramol. I can see my signature there and crossed it off and then I wrote up the paracetamol on 30 September.

Q If co-dydramol is a mid-level analgesic, how would you describe paracetamol?
A It is a mild analgesic.

Q Is it the lowest level or is there something below paracetamol?
B A I cannot think of anything below paracetamol

Q You will need to use another marker, I am afraid. Could you also turn to page 106 just to see what other drugs this patient had been on. Turn to 106 and 107. These are not your prescriptions, I do not think, are they?
A They are not my prescriptions.

C Q But we can see I think on the day of his admission he was given morphine, and is that at a dose of 2.5 mg?
A Sorry; it is not my prescription.

Q And you cannot read it?
A I cannot read it.

D Q It may be 225 mg PRN I suppose. That was started it seems on 23 September and it was given to him also on 24 September twice --- no, 24th and it is rather difficult to read the next date, but in any event by the time you came to him on 25th I think your prescription would have taken over, as it were?
A Yes.

Q Then if we look underneath that there is a nurse prescription, as it is called, for
E paracetamol. It may be 23 September as well, and then underneath that codeine phosphate was also given on 23 September and it looks as if that was stopped on 25th? Right at the bottom, do you see the last entry on page 196?
A 25th at 11.30, yes.

Q Codeine phosphate, last one given on 25th September at 11.30?
A Yes.

F

Q Then over the page there are two entries for morphine prescribed on 3 October. This is jumping forward in time of course but since we are here we might as well look at these prescriptions. 3 October, morphine, and it looks like that was given on 3rd and possibly 5th or 6th and then underneath that we can see codeine phosphate was given again on 8th, 9th, 12th and 13th. None of those are your prescriptions?
A None of them are my prescriptions.

G

Q If we could go back now please to the clinical notes at page 171, I think you next saw the patient three days later on 28th?
A Yes.

Q Can you just take us through your note, please?
A I noted his renal function was deteriorating. NA is the abbreviation for sodium;
H the sodium was low in his blood – serum sodium. Again I noted that he had low TT4 and

high TSH and I queried hypothyroidism. He was dehydrated in my clinical opinion at that time. No JVP: I could not see elevation of jugular venous pressure, which indicates a fluid overload.

Q Is that a good thing or a bad thing?
A It is bad thing. Jugular venous pressure is elevated in heart failure. Jugular venous pressure is very low in dehydration, so we need a normal level of jugular venous pressure.

Q He was dehydrated?
A He was dehydrated.

Q What action did you take. If we can see to the right hand side of the page, is it stop ---
A I stopped his diuretics, which will make his dehydration worse because he will pass more urine. I started him on intravenous fluids, and I wrote IV fluids, and I suggested to the doctors to repeat his Us and As, that is urea, electrolytes and creatinene.

Q Was that so that you could see how well his kidneys were then working?
A I could assess his kidney function and also I could assess how severely he was dehydrated.

Q Can we go over the page to the following entry. The next entry is not made by you, is that right, but the bottom one is?
A The bottom one on 30 September was mine.

Q We can see the day before that he was seen and there is a note at 2 that he had impaired renal function and there is a suggestion is it I think of alcoholic hepatitis?
A I could say it but that is not my entry.

Q I entirely understand. It is still identified that he is hypothyroid?
A And also I did find that he was hypothyroid.

Q I may have missed it but were you taking any action on the hypothyroidism? Were you giving him any drugs for that?
A Unless I see it through the prescriptions, I cannot say that we have done anything to treat his hypothyroidism. There is no indication from the clinical notes that I could say he was given thyroxin, which would be a replacement for hypothyroidism.

Q Can you go to your entry on 30th, please. We can all read it: "Renal function slightly better". Is it "still drowsy"? Do you see it?
A Yes, I see it.

Q And underneath "still drowsy" you have written what?
A "No flap". Flap is a clinical sign; normally when patients were asked to stretch out their hand like *this* if they have liver disease and so many medical conditions which can cause flap, they cannot maintain in a sustained fashion, so they will have flap if they have liver problems or liver failure.

Q So no flap is a good indication?
A It was a good indication, yes.

Q "Apyrexial, no fever": is that the next entry?
A Yes.

Q It is difficult to read this but I am going to take this from your statement. Is it "100 systolic"?
A When I gave the statement, that is what I thought it was: 100 systolic blood pressure. I cannot be sure now.

Q Would that be a good thing or a bad thing?
A I do not remember the patient now. It depends upon what his previous blood pressure was. If his blood pressure had been high and suddenly dropped to 100, it was a bad thing, but if it had remained at 100 for a long time, there is no change in his condition.

Q 100 systolic of itself is not a high blood pressure?
A It is definitely not a high blood pressure. It could be low blood pressure.

Q We can see at the bottom of the page "Stop all sedations". What is underneath that? Is it "fluids ---"
A I think I wrote "continue fluids".

Q Why were you stopping sedation?
A Because he was drowsy and because if there was a suggestion he could have liver disease, sedation will make it worse.

Q Why? I am not asking for a chemical explanation but why would you not want to give sedatives to somebody who had liver disease?
A Normally we would try to avoid sedation in people with liver disease because liver disease itself will lead to sedation and so it will aggravate or increase the drowsiness.

Q And so if you do give somebody with liver disease sedation, do you have to take extra care?
A We normally take extra precautions, care.

Q Is it as a result of the previous alcoholism that you have to be particularly careful of sedation or is it because the alcoholism may have led to liver disease?
A I was careful here because he was drowsy already. That was the reason I think – I do not remember now – I stopped this sedation.

Q But if you see in the notes that somebody has got liver disease, that is a signal to you, is it, to be cautious about sedation?
A Yes.

Q Can we go to the next page, 173? There is a ward round I think by a registrar, which is not yourself. Is that right?
A The entry was not mine.

Q Can you just help us, and I appreciate it is not your writing, but if we look at the bottom of that entry "stop fluids mane", meaning the next morning?
A Yes.

Q "Dietician" and then "consider---"
A "NG tube tomorrow".

Q Is that naso gastric tube?
A Naso gastric tube.

Q Why would that be being considered?
A Probably he was not eating enough to maintain nutrition.

Q Can we then have a look at your entry, which I think is next, dated 2 October '98 and just take us through that, please.
A He was "still very sleepy, sleeps in the morning, awake at night. Oedematous" – that is he was having fluid retention; I thought it was ---- to increase all the (steroidism) that is possibly secondary due to his liver condition and also intravenous normal saline. He had a massive bruise, low albumen.

Q I am sorry to ask you to pause; the massive bruise was where? It may be obvious from the injury?
A I presume it was from his left arm, from the fracture of the humerus.

Q The fact that he is oedematous, can you tell us where he was oedematous?
A I do not remember the patient now but usually they are oedematous if they are bed ridden, in the legs and the back, what we call the back sacrum.

Q "Stop IV fluid". Why?
A Because I thought he was getting oedematous secondary to intravenous saline.

Q Meaning that it was the saline itself which was causing his swelling?
A Probably I assumed he was not able to excrete sodium because of his kidney and liver involvement.

Q Then underneath "Stop IV fluid" what do we see?
A "Encourage protein drink".

Q Again it may be obvious: why were you doing that?
A To build up his nutrition, to improve the albumen in his blood so that his fluid retention will come down.

Q The note that follows after "protein drink", is that a reference to a psychiatrist geriatrician?
A In those days we used to call them psycho-geriatricians. Now they are called consultants in mental health for older people.

Q A different label but the same creature?
A Yes.

A

Q Why were you considering that referral?
A I honestly do not remember why I asked for it.

Q Might that be referable to his alcoholism and depression?
A Possibly.

B Q "For LTC"?
A LTC means long-term care.

Q What did you mean by that phrase with this patient?
A The long-term care is NHS continuing care in a National Health Service facility where they will have both nursing, medical and other specialist input.

C Q If we look below that we can see your referral I think to the psycho-geriatrician which reveals your thinking: "We will value your opinion regarding this gentleman with..." Can you read the next bit?
A "with alcohol abuse/liver disease. He is very withdrawn and depressed."

Q Again, if we can just follow on through this note and go to the following page, 174, I think we can see a note on 2 October '98 "seen by dietician"?
D A Yes.

Q I am not going to read all the way through it but we can see that he will be ordered a high protein diet "and will continue top be encouraged with the supplement drinks over the weekend" and there needs to be an accurate record of what he takes. There is a suggestion that naso-gastric feeding might be the only method of meeting his nutritional requirements. That is not your note but I think your note does appear below
E that, 4 October?
A Yes.

Q Just tell us, please, what you have written?
A "Still sleepy. Encouraged diet. Eating well now. Credit Kingsclear list. ? LCT." That is long-term care.

F Q Kingsclear? Is that a rehabilitation ward?
A It used to be a rehabilitation ward at St Mary's Hospital.

Q Why were you considering a rehabilitation ward at St Mary's?
A Once his acute condition was treated we would be looking at ways to discharge patients. It could be either rehabilitation in the process of physiotherapy and occupational therapy for a few weeks. Then a discharge to a safer destination after that.
G So probably that was the reason I thought he should be considered for rehabilitation.

Q The clinical notes continue, of course, if we look over the page. I am not going to go through those. He is seen by an SHO and by a dietician on 6 October. He is seen by another SHO on 7 October, where there is still said to be severe swelling. We can see at the bottom he is not keen on a residential home. If we go over the page, please, to 176, I do not think any of your writing appears, but we do see at the top on 8 October that he is
H now eating and drinking. Below that, we can see on 8 October, that day, he is seen by

A a psychogeriatrician. His note starts: "Thank you for asking me to see Code A who presents with..."

Code A: It is Code A

Code A: We have heard from Code A so I will not take you through that. Over the page, please. We will come to another note, I hope, of yours.

B A Yes. On 9 October you can see my entry there.

Q Can you take us through that?

A "Gross oedema. Eating well. Barthel only 5. On Trazadone and add diuretics. Repeat Us&Es, LFT. High social services." Probably I wanted them to refer him to Social Services for nursing home placement.

C Q If we go to your final entry, I think if we go to the following page, 178, there is a ward round by an SHO on 12 October. Then do you see him on 13 October?

A Yes.

Q Again, can you take us through your note, please?

A It is my ward round. "Still needs both nursing and medical care. He is also in danger of falling and the risk may remain for a while till he is fully mobilised. He also

D needs special needs to be attended to regarding the left arm which is ..." I cannot read.

Q When you wrote your statement you thought that was "which was swollen".

A Probably, yes. "So I feel a short spell in long-term NHS bed." Can I turn the page now?

Code A: Yes.

E A "Will be appropriate. Still very oedematous. Weight keeps going up."

Q Weight keeps going up? Yes?

A "Albumen is still low at 23. Add Frusemide. Review with Us&As."

Q What is that all about?

F A It was my assessment of his medical condition to see where he would be appropriate; whether to send him home, or to send him to a rehab ward or to a NHS continuing care facility. I think I summarised my thoughts at that time that he needed long-term NHS care, because of his multiple needs; of both medical nursing and ----

Q So he is not at that stage in a fit state to go home.

A No.

G Q But not necessarily requiring an acute ward on a hospital bed there.

A No.

Q I am sorry. The last entry you made was "review with..."?

A With Us&As. Review with results of urea electrolytes.

Q Is that looking at his kidney function again?

H A Yes.

Q Half-way down the page underneath the dietician notes we see the results of 13 October. Do any of those help us as to his kidney functions?
A His urea electrolytes and creatinine were within normal limits on that date, but his albumen was still low at 24 and his bilirubin was elevated at 48. His alkaline liver enzyme was also elevated at 181.

Q Can you give us a picture of this man's state of health on 13 October?
A I assessed him on 12 October.

Q Yes.
A In which I summarised that he was still oedematous and he is requiring both medical and nursing care. That was the reason I wanted him to go to an NHS facility.

Q We can see from the note on the following page, which is not yours, that he was transferred the following day after 14 October to Dryad Ward for continuing care.
A Yes.

Q Just to remind you, I think you made this comment in your statement about this man; that he may have stabilised, in your view, and maintained some level of health. Equally, you say, he could have died suddenly or quite quickly due to his condition. His liver function was abnormal. Does that still reflect your opinion of this patient at that time?
A I think so.

Q What reservation, if any, do you have?
A I honestly do not remember the patient now.

Q With this gentleman, at this stage of his transfer, having looked at what appear to be your continuing concerns about his kidney function, would care still have to be taken using sedatives with him, or had that moment passed?
A Sorry. Could you please repeat the question?

Q Bearing in mind this patient's kidney function at this point when you last saw him on 12 October, would care still have to be taken in relation to sedation, or had that moment passed and he could be sedated normally?
A In anyone we prescribe sedation we have to be careful. Particularly if they have liver disease, we have to be very careful.

Q That is all I ask you about that patient. I am going to turn to Code A, if you take up File J. If you turn, please, to page 55. This gentleman the Panel I think will probably remember was a very large gentleman who was admitted to accident emergency at the QAH on 6 August 1999. We are looking now at an entry by you on page 55. I am not going to ask you to go all the way through them, but if you look at the few pages before, you will see clinical notes relating to this patient's care at the Queen Alexandra Hospital. The point at which I think you come into the picture is on the day of his transfer to Gosport War Memorial.
A Yes.

Q Can you help the Panel? This note that we see on 23 August 1999 on page 55, this

A is your writing?
A It is my writing.

Q Can you tell us, please, where this assessment of the patient took place?
A Shall I ...?

Q We know he was transferred on this day, 23 August, to Dryad Ward.
B A It happened in Dryad Ward at Gosport War Memorial Hospital.

Q What were you doing on Dryad Ward that day?
A As part of my training in geriatric medicine, I used to attend Gosport War Memorial Hospital under Code A for getting training in rehabilitation and experience in continuing care.

C Q So how often during your daily routine, as it were, would you be going over to the GWMH?
A I do not know how long I attended that. Normally we have this type of training in spells, six weeks or eight weeks. So I would have gone to Gosport once a week for probably between six to eight weeks.

Q Right.
D A But I do not know exactly how long I attended.

Q If you go to Gosport once a week, does that mean you spend a whole day there, or you do a session, which would be half a day? How long would you be spending?
A It depends whether I attended the day hospital in the morning and the ward round in the afternoon with Code A It could be the one day, or just the half a day ward round.

E Q Can you recall meeting Code A at the GWMH?
A Yes.

Q Can you give us any idea of how often you would have had interaction with her?
A Probably once a week, Tuesday afternoon in the ward round, very briefly.

Q Very briefly on Tuesday afternoon?
F A Yes.

Q Would you be doing a ward round with her, or would you just come across her on the ward?
A I would be doing the ward round with Code A who was my consultant at the time. If I remember correctly, Code A used to attend at the same time another ward round with Code A So I do not remember Code A joining the ward round. I do not
G remember.

Q But you remember seeing her.
A Yes.

Q This entry on 23 August 1999, can you remember whether you were on your own, or whether or not you were with anybody?
H A I would have been with the ward sister in the Dryad Ward.

Q Do you remember Code A ?
A I do remember Code A

Q Do you think that is who you would have been with on this occasion?
A Not necessarily. It could have been any of the ward nurses who could have accompanied me.

Q Can you take us through your note about Code A on 23 August?
A "Problems. Obesity. Arthritis bilateral knees (that is both knees); immobility; pressure sores; on high protein diet. Melena stool on 13/8/99. Haemoglobin stable. Albumen 29. Number 5(?) constipation. On Doxazosin. Mental test score very good. No pain. Better in himself. No AJVP."

Q Sorry. What does that mean?
A It means he is fluid overloaded. Or he may be dehydrated. It is abnormal (?) finding; that is we do not see jugular venous pressure normally.

Q "CVS cardiovascular system." I ticked it, indicating it was normal. RS (respiratory system), I ticked it. It means normal. PA (per abdomen) I wrote "obese," indicating he had a large abdomen.

Q Can I ask you to pause? In order to make this entry, what was the process that you actually went through with the patient? Does this require an examination or not?
A Absolutely.

Q Just take us through a standard examination that you would have performed with a new admission patient.
A I would have gone through his medical notes which were sent from Queen Alexandra Hospital. Then I would have introduced myself to the patient. After asking his permission, I would have gone through some of the questions I would have wanted to ask him. Then again with his permission I would have examined him, taken his pulse, noted his blood pressure, which the nurses would have done it. Then position him in a comfortable posture, then examined him; his heart lungs and examined his abdomen by making him to lie flat.

Q At some stage obviously you have made a note about all of that?
A After finishing the examination we normally write in the notes.

Q Let us just go on through the rest of the note and then we will come back to the issue of note taking. "Legs"?
A "slightly oedematous.
Chronic skin changes.
Ulcers dressed yesterday.
Need reviewing later this week".

Normally nurses take the dressing and see whether the ulcers were healing.

Q So that would mean having a look to see what is happening underneath?
A Underneath the bandages.

Q Can we just go back a little bit, I am sorry to do this, "Legs slightly oedematous". You told us a little bit about that. That is likely to be the result of what?
A Swelling of the legs in elderly patients, there are so many reasons for them to have swelling of legs. It can be dependent oedema, what we call dependent swelling, because the hands, the feet, the fluid collects there, or it could be due to low protein or due to heart failure, or it could be due to fluid overload.

Q Can we look at what you have recorded underneath that: "Need reviewing later this week", and then what are those comments that we see?
A I wrote "[Repeat] Hb U/E LFT Friday".

Q Why did you make that note?
A Because he had "? melaena", that is passing black stool, on 13 August, I wanted to monitor his haemoglobin to make sure that the haemoglobin remained stable, indicating he was not bleeding.

Q We will have a look at his haemoglobin in a moment. I just want to come back to the issue of this examination. Can you help us, so far as you are concerned is this a standard examination that you performed, is it a very high level examination that you performed? Where would you put it?
A It is a standard examination that I would have performed.

Q The notes that you have made, we can all do things better in life, but looking back on it now how do you regard this note?
A It could have been a bit more in detail, I am sorry to say.

Q Well, I am not criticising it, but I just want to know where you would put it. You think it could be a bit more detailed?
A It could be a little bit more detailed.

Q All right. How long would this sort of examination have taken you, do you think?
A Gosport War Memorial Hospital, it is a continuing care and rehab hospital, so we do not normally get very sick acutely ill patients, so we would be looking at nearly twenty patients in a one half-day session, so normally it would be a quick examination, but someone transferred newly on the same day, as you suggested, I would have spent a little bit more time with Code A

Q The reason for that would be what?
A To make sure that we assess him thoroughly in a more detailed way.

Q So you know what you are starting with, as it were?
A Exactly.

Q How long do you think this examination would have taken you approximately?
A I do not remember how much time I spent with Code A

Q You cannot give us an idea of whether this is a five minute examination, a half hour, an hour?
A I would say about fifteen to twenty minutes, but I may be wrong. I do not know.

Q As you have become more experienced, are you able to do your examinations rather quicker now than you did when you were a specialist registrar, or is there a sort of standard you have to perform?
A As we get more experience we get quicker.

Q Your fifteen to twenty minutes, is that with the benefit of your knowledge now or is that what you think you would have been doing then?
A What I would have done then.

Q Could we have a look, please, at the drug chart at page 173. Do you see a drug chart beginning on 23 September, the day of this examination?
A Yes.

Q Are these drugs that you prescribed?
A Yes.

Q Can you just take us through them briefly. Doxazosin?
A Doxazosin is anti-hypertensive; that is given for blood pressure, high blood pressure.

Q Frusemide?
A Frusemide is a diuretic, a water tablet.

Q I am just making a note as you speak. Clexane?
A Clexane is a type of heparin called low molecular weight heparin, which is an anticoagulant.

Q Why were you prescribing Clexane at this time?
A To prevent venous thromboembolism.

Q Because the patient was in bed?
A In bed.

Q Underneath that, paracetamol?
A Paracetamol is an analgesic, and 50/50 cream is a topical cream for the skin, and magnesium hydroxide, which is a laxative.

Q Over the page, page 174, we have moved on, I think, to 25 August, and I do not think those are yours, are they?
A No.

Q Could we go, please, to have a look at some haemoglobin levels and just ask your assistance as to what we can glean from them. I think if we go to 214 – I am sorry, if you look at the page following that, we can see that his blood had been checked on 12 August, I think, so that would have been when he was at the QAH?
A Yes, Anne Ward, QA.

Q Anne Ward. In fact, if we look on the following page, 6 August 99, I am afraid these are not in a terribly helpful order, so we have got at page 218 6 August 99, then we have got 216 12 August, then I am afraid we have got 215 which is 19 August---
A I do not have a 215.

Q Have we not put the 215 in? Do the Panel have 215, which is on its side? Ah, some do. Can I ask for some copies to be made. I do not know if Code A has got it, and if he has I am the only one in the room without it, because I have just sent mine off for copying.

THE CHAIRMAN: Obscured beneath the print is the usual marking with two horizontal lines, but it is in at page 220.

Code A Oh, I see. Well, I am going to go back to 218, having sorted that out, because that is the earliest for the haemoglobin and I have not got the later document anymore; I will have it back I hope soon. Can you just help us, please, the haemoglobin, is that the entry in the bottom left hand corner?
A Yes.

Q On this document that we are looking at, page 218, which is referring to 6 August, we can see haemoglobin, is it 15.2, or it might be 15.7?
A Sorry, it could be 15.2 or 15.7.

Q Can you just tell us what that means, what we should be looking for?
A Haemoglobin is a protein in the red blood corpuscles. The normal range is between 12 and 16. It is slightly different for men and women. Men have got a slightly higher level than women. The average 12 to 16 is normal.

Q What are you looking for when you are looking at haemoglobin?
A It is the level of haemoglobin in the blood.

Q So far as this patient is concerned, why were you asking for haemoglobin to be checked?
A When I saw him at Gosport War Memorial Hospital there was a suggestion that he had been passing black stool in QA.

Q Is that an indication potentially of bleeding?
A Bleeding.

Q Would that be gastrointestinal bleeding in this case?
A If he had been passing black stool it would have been a gastrointestinal bleeding.

Q Right.
A I wanted to check his haemoglobin to make sure that it is remaining stable, that there is no further bleeding, or no bleeding.

Q If there is a bleed from the GI, what are we going to see happening to the haemoglobin?
A It would be dropping. The level would be dropping.

Q So if we look on 6 August first of all, page 218, we can see it is probably, I think, 15.7, so within the normal range?
A Yes.

Q 12 August, which is the page before, it looks like 11.5.
A Yes.

Q 19 August, which is the page we have now found again – yes, it is 220 with a line either side or 215 in large writing – haemoglobin 12.9. Are you with me?
A No, sorry.

Q Can we just pass this to the witness just to make sure he is looking at the same page. (Same handed) Sorry, Code A that is our fault. Can you see 19 August 99 now?
A Yes.

Q Haemoglobin 12.9.
A Yes.

Q Then page 214, with a line either side of it---
A Yes.

Q ---haemoglobin is 12.9, yes?
A Yes.

Q So at that stage, we have heard that this patient had been on Clexane.
A Yes.

Q His haemoglobin apparently was being watched.
A Yes.

Q He had had one occasion, I think, of a black stool.
A I was told that he had.

Q At this stage, when you assessed him on 23 August, and you prescribed Clexane, was there at that stage any reason not to do so in your mind? Page 55, if you want to go back to your clinical note.
A I do not think I prescribed Clexane. I just continued Clexane, which he came in on---

Q You continued it?
A Continued with Clexane when he came in from Queen Alexandra Hospital.

Q Okay. If this patient had a GI bleed would you have continued Clexane?
A No.

Q Why not?
A It would have aggravated this bleeding.

A Q Having come back to 23 August, let us just remain with him at the Gosport War Memorial, and I am going to ask you to look at two other areas of his care. Could you go to page 75, please, with a line either side of it.
A Yes.

Q This is a "Lifting/Handling Risk Calculator".
A Yes.

B

Q We can see that he was above eight stone. We know this gentleman was very well above eight stone.
A Yes.

Q Under "Mobility" we can see "Can stand but unable to walk, unable to assist, dead weight" and he scored 10, meaning he is really unable to move himself.
C A Yes.

Q Under "Special Risks" we can see 5 is put into the box again "Pain", so he had pain?
A Yes.

Q He has scored a total on the lifting/handling risk calculator of 20.
D A Yes,

Q The risk calculator, is that designed to assess risk to him or to those looking after him?
A I honestly do not know. I did not make this assessment.

Q In these days of health and safety I expect it would be those looking after him.
E Can we move on, please, to the "Waterlow Pressure Sore Prevention/Treatment Policy", page 76. It is the following page after the risk calculator. This is now a note made on the day following yours, and I am not going to spend very long on this. He is shown to be obese. In relation to his skin there is an entry that he has broken skin, is that right?
A Yes.

Q There is an entry that he has peripheral vascular disease, he is in fact bed bound
F and he has got poor appetite, yes?
A Yes.

Q These forms would be filled in by whom?
A By nurses.

Q Okay. Finally, on this area of the annotations, can we look at page 78, with a line
G either side---
A Yes.

Q ---to look at his Barthel score. 23 August 99 he scored 6, and he is, we can see, continent, he is independent feeding, he is dependent in relation to his toilet, he needs major help in relation to his transfer, which means getting out of bed, effectively, does it not?
H A Yes.

Q Mobility is marked as "unable"; dressing he needs help but he can do half unaided. Stairs obviously he cannot do and bathing he is dependent on others to help him and he scored 6. It is not the worst score that we have seen in this particular case, but it is not a very good score, is it?
A I would say 6 is a very low score.

Q And that is on the day that you saw him. A nurse would fill this in?
A A nurse would have filled it in.

Q Can we go back to your notes at page 55? There is a note "? Malaena"?
A Yes.

Q Can you tell us what that is please? You have made a passing reference to it already.
A Probably I would have been told that he has passed black stool and that is why I queried it.

Q For that reason you would have been watching what was happening in relation to his haemoglobin, as we have seen?
A Yes.

Q Could we go to page 84 of these notes?
A Yes.

Q Does your writing appear on this page at all?
A Not on 84. This is a nursing care plan normally.

Q If we look at the entry for 25 August, it is rather difficult to read I am afraid, but can we see a reference I think it is to fresh blood?
A I can see the entry, yes.

Q Fresh blood in the bowel action would indicate what?
A Some fresh blood present, indicating there could be bleeding.

Q If we go to page 63, and I am sorry to jump about in the notes, we can see a further reference to that; first of all on 25 August "passing fresh blood per rectum".
A Yes, I see it.

Q "? Clexane verbal message from Code A to withhold 18.00 dose and review with Code A mane". Then I think it is "Code A", which was a name a lot of people used for him, "also vomiting". Now, that is not your note, is it? That is a nursing note again?
A Yes, not my notes.

Q Then on 26 August we can see: "Fairly good morning, no further vomiting – Code A contacted re Clexane. Advised to discontinue and repeat haemoglobin today and tomorrow" and then "not for resuscitation"? Yes.
A Yes, I see it.

Q Let us just deal with that in stages. First of all, do you recall this contact, and it looks as if it was from Code A ?
A I do not remember the conversation but probably I would have spoken to her on the phone.

Q It appears that you advised discontinuing Clexane, and that would accord with the evidence you have given earlier?
A Yes.

Q If you thought there was a bleed, you would stop it?
A Yes.

Q Would you also have asked for a repeat of his haemoglobin?
A Probably, yes.

Q "Not for resuscitation": first of all, can you recall, did that come from you?
A I do not recall that coming from me.

Q Might you, at this stage of a patient's care, have taken a view that he was not for resuscitation?
A Probably that decision would already have been made somewhere down the line when he was being looked after, either at QA or at Gosport.

Q I understand that, but this note appears to be a reflection of a conversation with you. You have got no recollection of it.
A No.

Q Would you ever take the decision that a patient as not for resuscitation over the telephone?
A No.

Q Not for resuscitation in your mind means what?
A Just that, not offering cardiopulmonary resuscitation.

Q If there is a cardiac arrest?
A In the event of a cardiac arrest.

Q Is it an indication that the patient is not for continuing care or for any other medical care?
A Not at all. What I meant was that other treatment should continue.

Q With this patient, if you had found on your initial examination good evidence that he had a GI bleed ---
A Sorry, could you please repeat the question?

Q If on your examination you had found good evidence that he then had a gastro-intestinal bleed, what action, if any, would you have taken?
A It depends upon the patient's condition at the time. Could you please repeat the question?

Q Yes. If you had found that this patient had a GI bleed, a gastro-intestinal bleed, what action, if any, would you have taken?
A I would have assessed his pulse, blood pressure, and assessed his circulation, assessed all other vital parameters and if he has been bleeding excessively, then I would ask for further treatment.

Q What would that further treatment be?
A Again, depending upon the patient's condition, if the patient was willing to have other treatment, probably I would have started an intravenous drip, kept him probably nil by mouth, as we call it, not to eat or drink, and considered giving him --- I am not sure what was the protocol back in '99 because it is all changed now; now currently we would give intravenous omeprazol to suppress the acid but I do not remember what the protocol was at that time, and probably I would have spoken to my senior consultant and decided what else I would have done at that stage.

Q You would have taken advice?
A I would have taken advice.

Q Just in relation to the entry "not for resuscitation", can I take you back to one further document at page 48, because you were indicating that that is not a decision that you would have made, as it were, over the phone, but it may have been made earlier. If you go to page 48 of the notes, we can see this is an entry for 7 August '99.
A Yes.

Q You will be pleased to know that I am not going to go through the whole of this note which I do to think is yours?
A It is not mine, no.

Q I think we can see at the bottom of that there is the following comment: "Agree not for" and it looks like 535 --
A It is 555.

Q And that is an indication that his patient is not for resuscitation?
A Yes.

Code A: I have a little more to ask the doctor, but this might be a convenient place to break.

THE CHAIRMAN: Doctor, we are going to take a break now. I remind you that you remain on oath, so you should not speak about the case to anybody, nor should anybody speak to you about the case. You will be taken to a place where you can at least get some refreshment.

(The Panel adjourned for a short time)

Code A: Doctor, you will be pleased to know that I have very few questions about the next and final patient, but I think you wrote a letter in relation to her and I want you to look at it. It is Code A Patient K. There are two documents I am going to ask you to look at. The first is a clinical note at page 145.
A Yes.

Q Just to remind the Panel, this lady, as we will see, was being reviewed in April of '99 by Code A but she is not admitted to the QAH until 9 October '99 and then she is transferred to Dryad wad on 21 October '99, and so we are looking at a period six months prior to her admission. I am not going to spend very long on this, Doctor, but just seeking your help, please. If you have a finger in 145, could you also go to 81? Is 145 a note made by you?

A Yes.

Q And is page 81 a letter, I expect typed by somebody else but dictated by you in relation to that same clinic?

A Yes.

Q What I am going to do is concentrate on the letter first of all and then we will have a brief look at your clinical notes to see if there is any addition that we need to make to your letter? Were you reviewing this lady on 1 April '99? Do you have any recollection of her at all?

A Not at all.

Q You say:

"Thank you for referring this lady to Code A clinic."

Code A speciality was?

A Code A is a geriatrician.

Q "I have seen her on behalf of Code A. She has been complaining of increasing swelling of her feet. Her routine blood test suggested a high ESR" –

meaning?

A High erythrocyte sedimentation rate.

Q "...mild anaemia, renal impairment and low protein with serum albumin 20. Today she is not complaining of anything apart from swelling of her legs. Her urine test today showed +++ protein with no blood. Her past medical history includes hypothyroidism and mild congestive cardiac failure. She is on Frumil 1 per day and Thyroxin 100 mcgms. She lives with her grand-daughter who looks after her.

...blood pressure was 150/90"

JVP is what?

A 1 centimetre.

Q Yes, but is it jugular venous pressure?

A Yes.

Q Just pause there for a moment. What is that an indication of ?

A It is a slight elevation of jugular venous pressure. We normally see a jugular venous pulse just about the clavicle and probably hers was slightly elevated.

Q And that would be an indicator for what?
A Of congestive cardiac failure.

Q "....she has got massive pitting leg oedema. There is no lymphadenopathy." That means?
A No enlargement of lymph glands.

Q "Breasts normal. Cardiovascular system revealed a short systolic murmur, chest was clear, para-abdominally it was soft, and central nervous system examination was normal."

This is a full examination of the patient?
A It was a full examination of the patient.

Q "In summary, this lady who is hypoproteinaemic ---"
A Yes. Hypoproteinaemia means low protein in the blood.

Q "... is probably suffering form nephritic syndrome with renal impairment."

Can you put that into plain language for us?
A She has leakage of protein in her urine. She had 3+ protein in her urine when the urine was tested in the clinic, indicating that she was leaking protein in her urine. That is usually a condition in the kidney called nephritic syndrome which allows the protein to escape into the urine. Because she was losing protein in the urine, I assumed her low protein in the blood was because of the leakage in the urine.

Q All of this, in your view, might be arising from what?
A I thought it is all probably coming from a condition called multiple myeloma, which is a condition in the blood. There is increased secretion of immunoglobulin by a cell called the plasma cell, which is a haematological or a blood condition which is not akin to leukaemia but something similar – increased plasma cell production and an increased immunoglobulin in the blood.

Q We know that this lady was also under the care I think of somebody called Code A, I think it was, who was also looking at the possibility of this lady having this condition?
A When I saw this lady, I was not aware of her being under Code A otherwise I would have mentioned that in the letter.

Q I think you take the view that she is probably suffering from nephritic syndrome with renal impairment, which is all probably secondary to myeloma. Over the page, you have arranged a few tests, including, is it, urine and electrolytes?
A Urea and electrolytes. CRP is C-reactive protein, which is a protein which will go up in any inflammatory condition. A very high CRP indicates inflammation in the body.

Q And LFT is
A It is a liver function test, thyroid function test.

Q Myeloma screen?
A Myeloma screen includes measuring the immunoglobulins in the blood and also doing a protein electrophoresis whereby they can see which protein is elevated, which immunoglobulins are elevated. I also asked for a urine Bence Jones, which is immunoglobulin which is normally leaked into the urine because the kidneys cannot retain them – urine Bench Jones protein. I also arranged for a full blood count, ESR, which is erythrocyte sedimentation rate.

Q I think in your statement about this lady you sum this lady's condition up as the following, and I am going to lead you, if I may: Her blood pressure was normal for a lady of her age, which was 88. She was not in pain or breathless. Jugular vein pressure was 1 centimetre. This indicates how well your heart is working. 1 centimetre is just above normal, showing that her heart as not working to its full capacity. This was nothing to worry about. Is that still your view?
A Yes.

Q Her legs were swollen with fluid which when pressed by your finger, the indentation stayed. So that is when you talk about massive pitting?
A Pitting oedema.

Q Her glands, lymph and breast were normal. Her heart examination with a stethoscope revealed a murmur. This is turbulence across the heart valve when the heart is pumping. This is quite common in the elderly. Her chest was clear. An abdominal examination was normal along with the central nervous. She was suffering from low protein in the blood, losing protein in the urine, with a kidney malfunction which could be secondary to myeloma, which you then decided to investigate.
A Yes.

Q I do not think that you dealt with this patient again?
A No.

Cross-examined by Code A

Code A: I am going to ask you questions on behalf of Code A Can I just stay with that last patient, please? I am going to ask that some documents be circulated so that they can be inserted into that bundle. I know Code A already has a copy of these. He was given them at least a week ago.

THE CHAIRMAN: Code A, are you content for the Panel to receive that?

Code A: I am sure I was given them. I have no objection at all.

(Documents circulated)

THE CHAIRMAN: These are for insertion into the bundle on the pages indicated.

Code A: They are marked with two page numbers. That is how they are marked in the originals. The Panel may choose to put a ring around the first of the numbers in each case. (Document handed to witness) I wonder if you could take us through these

documents, because you will be in a position to explain what we are looking at. These are blood results of Code A ?
A Yes.

Q If we are start at the last of them. That gives the earliest specimen in time. It shows a specimen taken on 22 October 1999. It shows, along the bottom line, the tests that were ordered by the doctor. Yes?
A Page number 351?

Q That is right.
A Yes.

Code A Towards the bottom of the page, underneath the details of the patient (name, date of birth, hospital number) there is an indication of the requesting clinician, which would be the consultant's name typically?
A Yes.

Q Then the report destination. We have heard that the letters there relate to the Gosport War Memorial Hospital, Dryad Ward.
A Yes.

Q Underneath that there is a line clinical details. What is inserted is "CCF" which is congestive cardiac failure.
A Yes.

Q Then we have some details of a lab number. We then have details of the results of the biochemistry report.
A Yes.

Q Then there are various forms of analysis. The first we turn to is NA, which is the metal sodium?
A Sodium.

Q Then potassium, then various others?
A Yes.

Q The fourth is urea?
A Yes.

Q The fifth, creatinine.
A Yes.

Q Then various others along the top line, including cholesterol. Then on the bottom line, some form of protein, albumen and other tests that are done.
A Yes.

Q In many of those cases, just underneath the indication of the type of test -- for example sodium (NA) -- there is an indication of a range: 135 to 146?
A Yes.

Q Is that the normal range?
A Normal range.

Q I think these reports are designed so that if a figure outside the normal range appears, you get a little star or asterisk.
A Yes.

Q So that, for example, looking under K (potassium), we have a figure of 5.2 for a test from 18 October. We have an asterisk next to that, because it is outside the normal range for potassium.
A Outside the normal range.

Q If we look at the various figures, we see quite a lot of asterisks or stars for the blood results that are shown on these tests.
A Yes.

Q Creatinine, which is the fifth one across, on the top row of boxes, shows a range for men and a range for women.
A Yes.

Q F. relates obviously to females. It is a rather lower range; a slightly smaller range.
A Smaller range.

Q But it starts at a lower level as well.
A Yes.

Q I think we can see, if we look over time, that during October -- and there are entries for 10 October, the bottom one, and 21 and 22 October -- there is some fluctuation in the creatinine level on the first sheet, page 351.
A On 351 there are only three dates, 18, 21 and 22.

Q That is right. It appears to go down, then up again, following the dates.
A Yes.

Q They start at 201, the earliest in time; then it goes down to 161 then back up somewhat to 187.
A Yes.

Q If you go on to the next sheet in time, which is page 345 -- so the first of the four sheets we have inserted -- the urea and creatinine levels are both outside the normal range.
A Yes.

Q And the creatinine figure has changed again from the one we have most recently seen on the 22nd.
A Yes.

Q If we go on, please, to page 347, we can see a creatinine figure, this time for 9 November 1999 at 200.
A Yes.

Q And on the last page of the four, page 349, there is an entry for 16 November 1999. We can see the creatinine level has shot up to 360.
A Yes.

Q Very markedly elevated?
A It looks like that, yes.

Q I am not going to ask more questions about those documents or that patient. But it is an indication of decreased renal function.
A Worsening renal function.

Q Thank you. Can I take you back to Patient H, Code A please? I am not going to take you through the records in any detail at all with regard to this patient, but I want to refer to some of them. These are the problems that Code A presented with in the few weeks after his fall, towards the end of September 1998. He presented plainly with a broken left humorous, a fracture.
A Do you mind if I refer to these?

Q Not at all. (Pause) I will need to remind you of the pages you were looking at. You were looking originally at page 166 of Code A records.
A Yes, I have got it.

Q The information we have is that Code A fractured humorous was not repaired in the three weeks or so before he left the Queen Alexandra Hospital.
A I was not aware of that.

Q I want to look at the medical problems with which he presented. He was suffering from depression over the period of time that he was dealt with and early dementia, if you check page 118. You want to start on page 117.
A 117, I have got, yes.

Q I do not need to take a great deal of time about this. If you turn over to 118, there is a reference to "Examination, mental state." Eight lines down: "Code A admitting there was no point in living." Clearly he was low in mood at the time.
A I could say, yes.

Q Code A gives a summary, in the third paragraph from the end: "It seems as though Code A may have developed an early dementia. Alternatively could be an early Alzheimer's disease or vascular-type dementia. In addition, he seems to have developed depression."
A Yes.

Q She is prescribing trazodone.
A Yes.

Q In the paragraph below, noting that she hopes he tolerates it, in view of his liver and renal failure. Those were two other problems that he had: liver disease and renal impairment.
A Yes.

Q We have seen the records which indicate that he was diagnosed as being hypothyroid. Again, the first reference was page 172. It was queried at an earlier stage, we think, and we have heard from you that you had not identified any treatment that was being provided for his low thyroid function.
A Yes.

Q In addition, there was gross oedema. We have seen that in a note of yours towards the end of the picture, just before he is transferred. That is the note at page 177.
A Yes.

Q I think there is note that is: "Weight keeps going up." Again, that is a note of yours at page 179.
A Yes.

Q Third line down.
A I saw it. I could see it.

Q That is not because of his diet, as I understand it. That was to do with him retaining fluid.
A I assume so, yes.

Q I think he had grossly swollen limbs and had put on a great deal of weight whilst at the Queen Alexandra. Again, because this was increasing heart failure.
A I am not sure he had heart failure.

Q All right. Let me take you to some nursing records to show the information that the nurses may have received from the doctors. Page 16, if you would. As you see, there is a reference to 7.00 p.m. This is 1 October, people could see from the dates on the previous page, and lower down on this page. There is a reference to: "Code A states that he is desperate for sleep. Tends to be awake at night and asleep during the day; typical of alcohol withdrawal." I do not know if you are able to help with that observation.
A Sorry. I did not make entry.

Q I understand that, but are you able to help us with whether it would be typical of alcohol withdrawal for someone to have an unusual sleep pattern?
A I am not sure.

Q What you have told us is that you noted he was drowsy during the day, and you considered it might be due to his liver function. Are you able to comment on this note, and the suggestion that it may be because he had not been sleeping at night time?
A Sorry? Could you repeat the question?

Q What you told us was that he was drowsy and you were concerned that it might be to do with his liver function, and the effect of any medication that had been provided?
A Yes.

Q This was an observation from nursing staff that his sleep pattern (being awake at night and drowsy during the day) would be typical for someone withdrawing from

alcohol.
A I am not sure.

Q I am asking you to comment.
A People do not sleep at night, but we do come across patients at hospital, they do not sleep very well at night -- mainly because of the noise; particularly in an acute hospital -- and they do tend to sleep during the daytime, if that is what -- probably that is what the entry meant.

Q All right. You said it is not your entry, so I will not press you on it. I want you to let me take you to page 22, if I may. There is a nursing entry in the middle of the page for 13 October: "Reviewed by medical team. Continues to require special medical/nursing care oedematous limbs at high risk of breakdown. Right foot already about to beak down. This is due to oedema." It may be there is a letter or a notation before the word 'oedema". "... secondary to cardiac failure and low protein. Also at risk of self-neglect and injury if starts to take alcohol again. Needs to have 24-hour hospital care until healed arm." This is relatively shortly, a day or so, before Code A was discharged from this hospital. Are you able to comment on the proposition that his oedematous limbs were due to cardiac failure?
A I would say due to combination of so many factors. I do not remember the patient, so I cannot specifically say whether his oedema was due to heart failure.

Q What you said in your statement -- and let me get the words precisely right -- in relation to Code A was. At the time of transfer you do not recall Code A But having read his notes, you can say he was unwell. He may have stabilised and maintained some level of health. Equally, he could have died suddenly or quite quickly due to his condition."
A I gave that statement, yes.

Q Was that because, when you made that statement, you had noted all the things I have mentioned: the liver disease, the renal impairment, the gross swelling of limbs?
A I took into account the whole thing.

Q I am grateful. Is it your experience that patients with multiple medical conditions can take a sudden turn for the worst?
A Usually hospitalised patients can take a sudden turn to the worst.

Q I am going to turn to the next patient, Patient J. I will go through a little of the history you have been taken through already.
Can we start with the history of haemoglobin and any bleeds that he may have had, and if we start, please, at page 218. (To the chairman) Sir, I have drawn a chart with dates, times and figures on, and I am sure the Panel may find it useful if they do something similar, and, sir, I am dealing with this obviously chronologically. (To the witness) 218 is the first page, which shows a result from 6 August 1999.
A Yes.

Q Again, I am just looking at haemoglobin for these purposes and the result is 15.7.
A Yes.

Q The next document we have in the sequence is page 216. This is a sample taken on 12 August.
A Yes.

Q It is not entirely clear what the haemoglobin figure is, it could be 13.5 or maybe 11.5, but we are able to confirm, if we look at page 50 of the clinical notes, because a doctor has helpfully written in.
A Sorry, could you please repeat that page number?

Q Sorry, page 51, I beg your pardon. We see, and it is Code A note, I think, on the third line down of that entry on page 51, he has written in 13.5, which I think clarifies the figure that is not easy to read on page 216.
A Yes.

Q Unfortunately, these notes are not in time sequence. If we turn over from page 51 to page 52 we move to 16 August and 18 August, I think; page 53 takes us back to 13 August. It may be useful for people to note at the bottom of page 51 that the next page is page 53. If we are looking at 53, we have an entry in a different handwriting from that of Code A, and this person too has noted a haemoglobin of 13.5 at the top of their entry. So we have seen a drop in haemoglobin levels from 6 August from 15.7 down to 13.5 on 12 August. It looks like this gentleman has had a significant bleed.
A He had a drop in haemoglobin, yes.

Q I think if we look at the nursing records, there is a nursing entry on page 136, and towards the bottom of the page we can see the date of 11 August---
A Sorry, could you please repeat the page number?

Q Yes, 136. Do you have a date in the left hand margin of 11 August and then a time below that of 13.45 "Loose black stools"?
A Yes.

Q There is then an entry below, again dated 11 August, "Care as per plan. Black stools noted. Code A aware" is what the note appears to say.
A I can see.

Q Black stools means there is blood?
A Not necessarily. Black stool can be due to discolouration from medication.

Q All right, but that, combined with the drop in haemoglobin that we have seen between 6 August and the sample taken on 12 August, is likely to relate to an intestinal bleed?
A Possibly.

Q Yes. I think following on, if we are doing a chart, the next result that we have is on page 220. This is the document Code A calls 215, but we know he is wrong, sir, but I refrain from any other comment! This is a sample tested on 19 August and the haemoglobin is 12.9. Next one, if we go to 214, sample on 20 August, and am I right to say 12.9? Probably. The next one is after the transfer to the War Memorial Hospital, it is page 212, and we will note on this document to the extent that we can read it that the

A consultant is given as Code A we see it is the War Memorial Hospital, the clinical details are given as obese and CCF, which stands for congestive cardiac failure you have told us.
A Yes, "CCF" stands for "congestive cardiac failure.

Q The sample is taken on 24 August 1999 and the haemoglobin figure is given as 12.0.
A I can see it, yes.

B

Q People will note that there appear to be a doctor's initials which may be "JAB", I suggest Code A. If we go on, I think the last in the sequence, if we turn one page forward to 210, Code A again signed by Code A, it is specimen dated 26 August 1999, clinical details are "bleeding PR", rectal bleeding, and the haemoglobin has gone down dramatically to 7.7.
A Yes, I can see.

C

Q So that is the end of the charting, I think. There are drops in the haemoglobin level between 15.7 on 6 August and 13.5 on 12 August. We have looked at the nursing records, which show that on the 11th Code A was passing black stools. Your note at page 55 refers to "? melaena" on 13 August.
A Yes.

D

Q I think if we look at pages 50 and 51 do we see any entry – 50 deals with 11 August, 51 deals with 13 August – do we see any entry from Code A indicating that he is aware of melaena? I do not know that we do on page 51.
A On page 50 and 51 Code A has not mentioned anything that he was having malaena.

Q Right. I have already commented that we have to go to page 53 to see other
E clinical entries for 13 August. We have seen the top entry and reference is made to the haemoglobin level. On the bottom entry, again different handwriting, there is reference to "black stools overnight". That would be the night of the 12th?
A Yes.

Q There is an entry lower down, is it "chase Hb"?
A I assume so, yes.

F

Q Again, if we go back to our chart, we will know that there is a drop from the haemoglobin level recorded on the 12th of 13.5 down to the haemoglobin level recorded on the 19th down to 12.9. If there was a further rectal bleed would you expect that to be reflected by a drop in haemoglobin?
A Fluctuation of about one gram is quite common day to day.

G

Q So the picture, if we go back to Code A note on page 51, is that there had been some black stool noted on the 11th, and a significant drop in haemoglobin noted on the 12th. Code A, according to this note on page 51, is not apparently aware of any further black stools that you have referred to on the 13th, although clearly one of the doctors is. We have just seen the note on page 53, on the 13th, "Black stools overnight. Chase haemoglobin".
A Yes.

H

Q Does it appear that this patient is stable or is he clearly not stable as at 13 August?
A I could not possibly comment. I did not see him at the date.

Q All right, but he has had what would appear to be two rectal bleeds over the course of the last couple of days?
A He had black stools reported by nurses. That is all I can ...

Q All right, but what clearly is anticipated on the entry we have at page 51, it is the last full line of Code A entry, "Transfer to Dryad ward on 16/8/99".
A Sorry, could you please repeat that?

Q Yes. On page 51, Code A note "Transfer to Dryad ward on 16/8/99".
A Yes.

Q That apparently was what was planned---
A Yes.

Q ---although for reasons that do not appear in the notes it did not happen.
A I do not know what date he came to Gosport.

Q Well, you saw him on the day he was admitted, page 55, on 23 August.
A Usually, it all depends upon the availability of the bed situation in Gosport.

Q We know that, thank you for helping us, but the proposition I am putting to you is that he clearly was not stable as at the 13th, albeit that discharge to the Dryad Ward was planned for three days later, and you have said you cannot tell us because you had not seen the patient.
A I had not seen him.

Q I understand. Anyway, the transfer to Dryad was on 23 August. We have seen your note several times at page 55, and we know that you prescribed Clexane. Again, I do not think I need to point to where you have prescribed it. If people want to make a note, it is page 173. We have looked at it. I think in fairness this patient had been on Clexane for some period of time. Can I invite your attention to page 182.
A Yes.

Q This shows that for the period in August before his admission to the War Memorial Hospital, again which was on the 23rd, we see along the top line that Code A was receiving Clexane twice a day for a couple of weeks.
A Yes.

Q Clexane again is an anticoagulant.
A It is.

Q There were bleeds or black stools on the 11th and 12th during that period of time and doctors were following his haemoglobin level.
A Yes.

Q Are you able to tell us whether there may have been bleeds that Code A suffered shortly before his transfer, or about the time of his transfer, to the War Memorial Hospital?
A Sorry, could you please repeat the question?

Q Yes. Are you able to tell us whether Code A may have suffered further bleeds either shortly before his transfer to the War Memorial Hospital or at about the time of transfer? The reason I ask is we have noted that there is a drop in his haemoglobin level between the 20th of 12.9, again page 214, and 24 August, which is the day after his transfer, page 212, of 12.0; 12.9 down to 12.0 over a four day period in what we have seen is a continually dropping haemoglobin level.
A I cannot possibly say when he bled.

Q What happened after that was that there was fresh blood noted, and we know from the nursing records --- We have been asked to look at page 63. Do you have page 63?
A Yes.

Q At the top of that we will note it is 23 August, which confirms what I have suggested to you, that Code A was transferred in on 23 August?
A Yes.

Q We have seen your clerking note on 25th, two days after transfer, "passing fresh blood rectally".
A Yes.

Q And the nurses, as you would expect, check what Code A is being prescribed, note that he is on Clexane, the anticoagulant, and seek medical advice in relation to that?
A Yes.

Q They speak to a Code A who advises them to withhold the dose and again that is clearly what happens. If people want to cross-refer to page 172, it is a nursing document "Exceptions to prescribed orders" and in the top line the Clexane is withheld. There is a time put in and noted by one of the nurses. The reason is shown; it is because he is passing fresh blood per rectum. If we were to turn over the page, we would see the Clexane that you had prescribed, doctor, just continuing the prescription that Code A Code A had been receiving at the QA. We see Clexane, the third drug down on the chart, is withheld on 25th and he does not get it again. Back, if we may, to page 63, the plan is that Code A would be reviewed the following day. Clearly the doctor is anticipating Code A attendance.
A I can see the entry.

Q What happened was that you were contacted, as we see, on 26th, this entry, about the Clexane, and the nursing staff very sensibly asking your advice?
A Yes.

Q Your advice was that it should be discontinued, and again we have seen that it was. Your advice was that there should be a repeat haemoglobin done, and we have seen that at page 210. When that was reported, it showed a dramatic fall down to 7.7. Again, I have suggested Code A at some stage saw that and has initialled it as having noted its

comments, noted the readings. Now, you cannot recall this discussion with Code A Code A ?
A No, I cannot.

Q This was in relation to a patient that you had clerked in and assessed a couple of days before on 23rd. Yes?
A Yes.

Q We know that the nursing staff will have had the medical records. Clearly they did for you to know that there had been the question of malaena on 13 August. You will have learned that from the records?
A Yes, definitely.

Q What we have seen in relation to this patient is that, if you turn to page 47, right at the bottom of the page, we have heard from a Code A who made this entry with a review with the registrar: "In view of premorbid state and multiple medical problems, not for CPR in event of arrest." That is a not for 555 entry effectively, is it not?
A Yes.

Q We know that it is said again by a different doctor on page 48, by Code A We know that it is said by Code A again on page 50?
A Yes.

Q He says it again on page 51. If we turn to page 106, this is a QA document, and we see in the top left corner the patient is being admitted to Anne Ward on 6 August. This is the front sheet of a folder of some kind, is it not?
A This is the clerking sheet, yes.

Q We see the contact details of the next of kin. We see personal details of the patient. Right at the bottom of the page, on the right hand side, we see entries agreed for resuscitation status and the views of various doctors were recorded. That I think is something that happened back in the Nineties?
A I am sorry; I did not understand the question.

Q This kind of document would exist back in the 1990s, that entries would be made about the resuscitation status and what it was to be of the patient?
A Yes. We still make the decision in different ways.

Q Can I take you back to page 63? Code A note appears to deal firstly with the morning and her contact with you and then deal with what happened at lunch time. Do you follow?
A Sorry, I do not understand you.

Q I am suggesting that there is a natural break in the middle of the fourth line where Code A is dealing with separate episodes throughout the day. She makes an entry about a fairly good morning, Code A contacted, and deals with what was dealt with with you and then goes on to say that he was unwell at lunch time "seen by Code A this afternoon". Do you follow?
A Yes.

Q I am suggesting that the "not for resuscitation" is an entry she made, having discussed this patient's case with you over the telephone?
A I do not agree with that. It looks like it could have been a summary of events that happened.

Q Well, a nurse would not make that decision, would they?
A The decision of not for resuscitation had already been made for the patient by two consultants, so it was just a continuation of the decision the other consultants made.

Q I understand. You have told us you would not make such a decision over the telephone?
A If the patient had not been for resus, I would not have made that decision on the phone the first time.

Q I understand that exactly. You would want to have the patient in front of you if you were making such a decision?
A If I am making a first time decision for someone's resus, I would assess the patient carefully myself.

Q I understand but what you and I have seen is that on four occasions in the past couple of weeks doctors had entered the notation that this patient was not for resuscitation?
A Yes.

Q If Code A had raised with you the question of whether Code A should be for resuscitation when she spoke to you ---
A She would have already been aware that the patient was not for resus.

Q All right. If she had raised it with you over the telephone, what would you have said?
A If you are asking me whether I would have reversed the decision for 555, probably I would not have reversed the decision.

Q If she told you over the telephone, if she said, "Look, he has been assessed as not for resuscitation" on the documents that she had ---
A There is no reason to reverse it.

Q I understand. What you say in your statement in relation to Code A --- Forgive me. Can I deal with the transfer? Are you able to tell us why Code A was transferred from the Queen Alexandra Hospital to the War Memorial Hospital?
A I did not make the decision to transfer him.

Q No, but are you able to tell us whether it means his conditions was improving as he left the Queen Alexandra or was it likely that this was just to move him to anther hospital?
A I cannot comment on that. They would not have transferred him if he is not stable.

Q Let us agree they should not have done, but it is clear that there was a further bleed very shortly after his transfer?

A A Yes.

Code A I am so sorry, but just so that there is no confusion about that answer, the question started, "Let us agree they should not have done ..." meaning, as I have understood it, they should not have transferred him if he was not stable rather than they should not have transferred him.

B Code A If a doctor is dealing with Code A after he has had a massive bleed, which may well be the position Code A was dealing with him in on the afternoon of 26 August, any doctor would have to make an assessment of the patient at that point?
A Yes.

Q And has to assess how best his needs can be met?
A Absolutely, yes.

C

Q Although we know that the pervious decisions of other doctors that Code A should not be for resuscitation do not mean that he should not be treated fro his problems?
A That could be my understanding, yes.

Q There will be a reason why the doctors are making that assessment at all?
D A Sorry. I do not understand your question.

Q If you ever made an assessment of a patient not for 555, why would you be doing it at all?
A That would be specifically for offering the treatment of cardiopulmonary resuscitation whether the CPR would be beneficial to the patient. If we think there would be a likelihood of a patient having a cardiac arrest, that would be for most patients
E coming into hospital, so we do assess everyone from the CPR point of view and we would be taking into account the patient's wishes. If the patient is not able to make a decision about themselves, friends and relatives then decide what is best for the patient depending upon the current guidelines, guidelines from the GMC and from the BMA.

Q Sure, and tell me if I am wrong but I am assuming that most patients admitted to hospital do not have "not for resuscitation" written into their notes?
F A I do not recall what was the protocol, what was the policy, on resuscitation back in 1999. Now we do tend to encourage patients to discuss with us what their idea is on CPR and so we would be making a decision for almost every patient coming into the hospital, taking into account their wishes.

Q Sure, but I think the law has changed. There is now the Mental Capacity Act 2005 which requires doctors to look actively at what the patient's wishes might be in
G certain circumstances. I want to look back at the 1990s, if I can. There were patients where a doctor may say "not for resuscitation". I just want to explore with you the circumstances in which the doctors might say that of a patient and what you have told us is that the doctors would say that if in their view a patient was not appropriate, was not suitable, for resuscitation, that they would be unlikely to benefit from it?
A The treatment would be unlikely to be successful.

H

Q I want to know if you can help me in what circumstances the doctors would even think that? If a patient goes in with a broken arm, a young fit patient, can you conceive of circumstances in which a doctor would be writing "not for resuscitation"?
A Unless the patient comes in with a living will or advance directive saying not for CPR.

Q We do not need to worry about advance directives or living wills, but would you agree with me that if a young fit person went into hospital with a broken arm, nobody would have dreamt of putting "not for resuscitation"? It was wholly inappropriate.
A I cannot answer the question.

Re-examined by Code A

Q I only have one matter to ask you and I want to get the right page first. Could you go back to Patient K, page 349, which was one of the new documents that Code A put in?
A Yes.

Q It is just to seek your assistance, please, as a doctor because we have one doctor on the Panel but most of the people in the room are lay.
A Could you please repeat the question?

Q Page 349, the creatinine level is obviously very much above normal?
A 360 was very much above normal.

Q Normal being between 45 to 90?
A Yes.

Q And the creatinine level in this case being at 360?
A Yes.

Q You described that, or this was put to you and you agreed with it, it was very markedly elevated?
A Yes.

Q No misunderstanding about that but I just want to have an idea of what creatinine levels can go up to. If you have somebody who is so ill for instance that they are on dialysis, what sort of levels are we talking about with creatinine?
A It all depends upon what was the level before. Someone who has what we call chronic renal impairment, that is longstanding renal impairment, some of them would have an elevated creatinine ---

Q Throughout their illness?
A Yes, but a sudden rise indicates that there is an acute process going on with a chronic condition.

Q So there is a sudden change?
A A sudden change.

Q I understand. Again, I just want to come back to my point: can you give us an idea of what levels you have dealt with in the past and in what circumstances? Have you dealt with levels higher than this or not?
A Absolutely, many higher levels than this, yes.

Q Can you just tell us in what circumstances?
A Recently I saw a man --- Am I allowed to describe this?

Q Do not give the name of the person but you can certainly give a description of his illness.
A An elderly gentleman came in with an acute obstruction of his kidneys and his creatinine was more than 1000.

Q Obviously you have to look at the patient?
A It all depends upon the patient's individual situation, yes.

Q With this lady, are you able to say with your assessment of her whether this was potentially treatable?
A I cannot comment on that. I did not examine her.

Q It depends what the underlying issue is?
A Exactly.

THE CHAIRMAN: Doctor, I mentioned earlier that there would come a time when members of the Panel would have an opportunity to ask questions of you. I am going to look now to see if any of them do have questions. Our medical member, Code A

Questioned by THE PANEL

Code A Good afternoon, just a couple of points for clarification. You were asked about Code A who is H, and about his hypothyroidism, which I think was the term that was used when you were being questioned?
A Yes.

Q You were asked about his hypothyroidism. You may or may not want to look again at the results which are on page 171 of H. I bring this up, because it is a fairly technical area. Would you agree?
A You mean the thyroid?

Q Thyroid functions tests. They are a fairly technical area. My lay colleagues would not understand.
A Renal function test is commonly tested in hospital; almost everyone coming into hospital. The clinical condition of hypothyroidism goes with the levels we see here, but also the clinical condition of the patients. We do come across slightly abnormal thyroid functions test. But what we normally do is to repeat them after an interval, to see whether -- because even an acute condition -- acute illness, sorry -- can make the thyroid test a bit abnormal.

Q That is what I wanted to ask you about in slightly more detail, so my colleagues understand what you say. On page 171 on 25 September, the total T4 level, the

A Thyroxin level, is 67, which is below the lower limit of normal of 70.
A Yes.

Q And the thyroid stimulating hormone is 4.6, which is slightly higher than the upper limit of normal.
A Yes.

B Q Together, that would broadly indicate what?
A Hypothyroidism, low acting thyroid.

Q Is there another way of expressing that than hypothyroidism?
A It is a decreased secretion of thyroid hormone from the thyroid gland.

Q You said it, but let me ask you so it is clear what you mean. Did you say that (a) C there can be a fluctuation of these tests in an acutely ill patient?
A Yes. That is my understanding, yes.

Q Are you saying, by saying that, that this is not an indication of a primary thyroid gland abnormality?
A Yes. That may be the reason why we did not start him on treatment.

D Q And further, what degree of thyroid gland abnormality do these results indicate?
A If he has true hypothyroidism it would be a mild hypothyroidism, if that is what you meant. If you could repeat the question.

Q Mild hypothyroidism.
A Yes.

E Q And in the normal turn of things, either in in-patients or outpatients, is this a level, if you thought it was hypothyroidism (an underactive thyroid gland), would you treat it with thyroxin?
A I have become a consultant now, so my experience is definitely more than it was in 1999. If I see such patients now, probably I would repeat it after three months, and if it is remains hypothyroid (that means remains low), or gets worse, then I will treat it with thyroxin.

F Q What I am getting round to saying is: is it not unreasonable that this gentleman was not put on treatment for what is being called hypothyroidism at this stage of his management?
A I would agree with that, yes. I would have not started him on treatment for this level.

G Q That is helpful. Secondly, with Code A as well, I think Code A had invited you to agree that Code A who was grossly oedematous had an element of heart failure. That is a statement rather than a question. I think Code A invited you to agree that there was heart failure. I think you said that you really were not sure that he had. So can I take you to the same folder, H, and to page 167?
A Yes.

H Q That is a clinical examination done on the 23rd, I think we agreed, of September.

A At the bottom of both the drawings of the lungs, there is cardiovascular system (CVS)?
A Yes.

Q Can you just tell us what the third line down in "Cardiovascular system" means; what it says and what it means?
A It says "JVP (horizontal arrow)". Probably the person who assessed this patient felt that the JVP is not elevated.

B

Q In terms of the question as to whether Code A was at that stage suffering from heart failure, can you tell anything from that?
A When he came into hospital on the 23rd, looking at the entry -- I did not assess the patient on 23rd, but looking at the entry by the doctor who assessed him, I cannot see any features of heart failure.

C Q Yes, but can you explain to my colleagues what the evidence for that statement would be?
A Because his blood pressure was normal. The JVP (jugular venous pressure) was not elevated. His lung examination showed when we view what we call crackles in the left base only.

Q From that would you conclude that there is evidence of heart failure?
D A I would not say he was in heart failure at the time, no.

Q That is the second point. The third point is about patient J, which is Code A Just to put you back in the frame, it is quite difficult swapping between patients. This is the very obese gentleman who had the melaena stool. You said, again talking to Code A -- I did not get your exact words -- you were taken to the difference between a haemoglobin of 13.5 and a few days later it had gone down to 12.9.
E A Yes.

Q And you said something like "a fluctuation of one gram is quite..." Usual? Was that the word?
A Quite expected.

Q Can you explain what that means to those who are not doctors?
F A Estimation of haemoglobin is not correct. It can fluctuate, even within the normally range.

THE CHAIRMAN: Whilst we always welcome persons in the public gallery, if they could try not to make movements or other gestures that might be distracting to those at this end of the room, while we are trying to concentrate on what the witness is saying.

G Code A I broke you in mid-flight.
A Okay. My understanding -- and I am not a haematologist.

Q Your opinion as a physician.
A When we measure haemoglobin in patients, sometimes we do see this fluctuation between either side of 0.5 to either plus or minus. Unless there are other indications that the patient is -- there is evidence of bleeding, we would not give too much importance to
H a slight fluctuation in the haemoglobin, because we do come across slight fluctuations.

Q In the ordinary course of events?
A Yes.

Q Code A also pointed out that between 20 August in the QA and 24 August, which was now in Dryad, the haemoglobin had fallen further from 12.9 to 12.
A Yes.

Q That is still within 1 gram. But do you say the same thing about that 1 gram?
A Retrospectively probably no, because he had bleeding on the 25th.

Q Let me go back a step. When the gentleman was admitted to hospital on 6 August after a fall.
A Yes.

Q This large morbidly obese man who had had a fall and he had broken his shoulder, his haemoglobin was 15.7.
A Yes.

Q Which is considerably higher than 12?
A Yes.

Code A: Is this Code A with the broken shoulder?

Code A Sorry. It is Code A We are talking of Code A No. We are talking of Code A He did break his shoulder, did he not?

Code A: No. He spent 24 hours on the toilet.

Code A: He fell and had a large sore.

Code A I think the confusion is that he is described in the chronology as "following a fall at home". But actually this is the gentleman about whom we heard evidence that effectively he had been in the bathroom and could not get out.

Code A It took two ambulance crews to get him out of the bathroom. He was an extremely big man and he needed two beds. Many things happened to him, but I not think he fell.

Code A: If there are situations where the hemoglobin might be higher than normal when a patient comes in in this kind of scenario which, let us me emphasise again, is a morbidly obese man who did not break his shoulder, but had fallen and was wedged in the bathroom and had a sore.
A Normally we do see in elderly patients when they come in, they have a higher level of haemoglobin, because they are dehydrated; what we call haemoconcentration.

Q So there may be a reason why the haemoglobin is artificially high on admission.
A And when we hydrated him properly, it would have fallen down to 12.9.

Q Nevertheless on the 13th -- and I think Code A also pointed to a nursing note

about the 11th -- there was a black stool.
A Yes.

Q We have a trend of haemoglobin downwards.
A Yes.

Q A definite trend downwards, even from 13.5 to 12.9, and a melaena stool; or 15.7 down to 12.9, with a black stool, rather. It would not be unreasonable to be concerned that there might have been a significant bleed.
A There should have been a -- yes.

Q Can you turn back to page 63 in Code A? Remembering that you were attending with Code A at the Memorial Hospital, undergoing some training with Code A at that time, that is why you were at the Memorial.
A Training with Code A

Q You were here on this page, 26 August 1999, half-way down: "Code A contacted Re Clexane." Above that is the entry about passing fresh blood PR.
A Yes.

Q So we are all on the same level of understanding, "fresh blood PR" signifies what?
A There are two types of bleeding in the gastrointestinal tract. If any bleeding happens in the stomach, the acid discolours the haemoglobin, and when it comes down in the stool it becomes very black and tarry. If the bleeding happens below the stomach, where there is no acid, it can appear as fresh blood, like normal blood.

Q This is fresh red blood PR. Could it mean something serious?
A Yes.

Q It could.
A Yes.

Q A doctor was contacted, this is Code A in the above entry. There is a mention of Clexane. The next note, however, is the next day, the 26th. We deduced it is in the morning, I think, because the Sister has written ----
A I honestly cannot remember when she contacted me?

Q Say it again?
A I cannot remember what time she contacted me.

Q And it is not easy to tell from the note. But you were contacted about the Clexane.
A Yes.

Q Do you remember the conversation?
A Not at all.

Q With what we read on the previous note, and you were phoned about Clexane, do you think that it would be right to conclude that the bleeding was discussed with you?
A Possibly. Definitely she would have discussed the bleeding with me, yes.

Q That seems likely?
A Yes.

Q That seems more than likely?
A Definitely she would have discussed the bleeding. I would have asked her where the bleeding was.

Q So you knew about the bleeding that next morning.
A Probably, yes.

Further cross-examination by Code A

Q Going back to Patient H, Code A, the man with the broken arm. You told us, when answering Code A questions, that this would be mild hypothyroidism. You told us there can be thyroid fluctuations in an acutely ill patient.
A Yes.

Q What was Code A acute illness during the time he was in hospital before transfer to War Memorial? He had a broken arm. (Pause) Do we have to come back to the list of matters I put to you, namely liver disease, renal impairment?
A Sorry? I did not ----

Q Do we have to come back to liver disease, the renal impairment and what I have suggested was a degree of cardiac failure?
A I would assume so, yes.

Q Yes.
A Of course, he had multiple problems.

Q Can I ask you to turn to page 70, again Patient H.
A Yes.

Q Code A asked you to look at an entry where I think a junior doctor made some entries about Code A towards the start of his period in hospital. What we have on page 70 is an indication of Code A ability to engage in the activities of daily living over a three week period---
A Yes.

Q ---starting with his admission on the 23rd. We know that there were a number of concerns to do with his mental health and his outlook on life, and he was certainly expressing a wish to die during some of it, and that may have affected what we are looking at, but are you able to tell us whether there was clearly a significant deterioration in his general condition during the time that he was in hospital?
A The score has come from 13 to 7 – gone down to 3 and then come up to 7, sorry.

Q It hits 3 at one point. Again, perhaps it is inappropriate for me to ask you as a doctor to look at this document, but is this, for the lay members of the Panel, a fairly graphic illustration of how Code A condition deteriorated and then perhaps picked up a bit before he was subsequently discharged?
A His ability to look after himself has deteriorated and picked up.

Q Can you give us the explanation for the gross oedema of his limbs and his weight going up when there were concerns about his nutritional intake, certainly before and whilst he was in hospital?
A I do not remember his condition now, but I was only shown the entry I made in the notes, so based on that I assumed, or based on the entry, that his gross oedema was secondary to hyperaldosteronism, that is increased level of aldosterone due to liver failure, which retains fluid, and also due to the intravenous fluid, he was given quite a lot, and also---

THE CHAIRMAN: I am sorry, the Legal Assessor is not able to hear. Could you speak up a little and perhaps a little more slowly.
A Sorry. I do not remember this patient, but I can only go by what I wrote in the notes.

Code A Yes.
A When I wrote gross oedema I thought it was due to his liver failure, fluid overload and also low albumin. I do not remember whether this gentleman had any features of heart failure at the time, so I do not know.

Code A Well, if you do not remember I will not ask you any more. Thank you.

THE CHAIRMAN: Thank you, Code A

Code A: No questions, sir.

THE CHAIRMAN: Very well. Code A, that completes your testimony. Thank you very much indeed for coming to assist us today. May I add the apologies of the Panel to that already extended by Code A for the considerable amount of time that you have had to expend waiting to get on, as it were. We cannot perform our function properly without the assistance of witnesses such as yourself, who take time to come to acquaint us with matters of detail that are often going back many years, but which help us to build up a clearer picture of the true situation at the time. We are most grateful to you for doing that and you depart with our thanks. Thank you.

(The witness withdrew)

THE CHAIRMAN: Code A would this be a convenient moment to break?

Code A It certainly would, yes.

THE CHAIRMAN: Very well. Thank you very much. Two o'clock, please, ladies and gentlemen.

(Luncheon adjournment)

Code A Sir, may I just indicate to the Panel so it does not occasion any unnecessary delay, Code A will not be here this afternoon. Some attention, in the ordinary course of events, it is not a new problem, but some attention needs to be given to

her leg, and that I think is being done this afternoon. So there is no need to wait for her to appear.

THE CHAIRMAN: Thank you very much for that indication. Yes, Code A

Code A: Sir, the next thing that was going to happen was I was going to read to you the final statement before we call Code A and you will see from the list that that is the statement of Code A Following discussions between my learned friends and myself, there is one inquiry that has arisen that needs to be made, and I think it would be more sensible therefore to read that statement at some point next week. It is a short statement from the person who is now the Director of Corporate Affairs at the Hampshire Trust. So it is not frankly going to matter hugely when that statement gets read to you, and so perhaps you will just allow us time to consider other matters.

Now, can I raise two other matters; first of all, in relation to the chronologies. "We" I was going to say, but really Code A has done a great deal of work and he has provided copies of all of the new improved chronologies to the defence, and Code A has also been doing a good amount of work on those. We have been provided back with copies annotated by Code A and in respect of those we have been able to produce final versions, which I think are now copied up, for Patient A, H, K and I think it is I. I am very grateful indeed to the Panel Secretary, who has also assisted, and the reprographic department here. It means, of course, that we are still shy of many more chronologies. I gather that by the end of this evening a total of ten will be able to be copied up, and so we will be doing two over the weekend. I can only apologise, but, as you will have seen with the one that I think you have been given, they are very detailed indeed, they all have to be checked and it has just taken time to do it. So we can provide you with the chronologies for A, H, K and I now, and we are happy if you want to have a separate bundle for those and peruse those this afternoon. It is a matter entirely for the Panel.

Can I raise the issue again of whether you wish to receive Code A reports.

THE CHAIRMAN: Yes. Before you do, can we just finish with these chronologies. I had understood that both parties wished us to have read the revised chronologies before we started on the expert.

Code A: Well, can I say this: I think in a perfect world that probably would have happened, but the reality is that Code A has some evidence to give of a general nature in any event. We will obviously have breaks in his evidence. I think certainly before he deals with each particular patient, which – the way that I was going to introduce his evidence was obviously to deal with his general comments first about the nature of the drugs that have been used, syringe drivers, hydration and all the rest, and then turn to the individual patients and just run through from A through L. So there will be time, I suspect, during the course of that process for you to have an opportunity at least of looking at the chronologies, if not studying them in great detail. By the time we come to Code A being cross-examined we will have had, I suspect, two days in the middle of next week, on one of which you will have reading time, where you will have an opportunity of spending rather longer on the chronologies. So I would not wish to delay calling Code A on Monday morning if at all possible, because otherwise I think we are going to get into---

THE CHAIRMAN: I think that is understood, and if Code A is happy with that approach---

Code A: Sir, I entirely agree. I do not think it is going to create any difficulties for the Panel because Code A will be taking no doubt the chronological history of the patient he is dealing with at any particular time in order to set the context for his own views. So I do not see any problem with that. I think the other thing that was thought to be a sensible course to take was so that the Panel, before Code A gave his evidence, would have in mind the statements made by Code A about nine patients, I think it is, but I think my learned friend Code A and I agreed there is no difficulty about that not being done prior to Code A giving his evidence in-chief. The important thing is that the Panel would have had an opportunity to read Code A statements before I cross-examine, because obviously I will be raising matters contained in them with Code A of course, will have seen them. He saw them ages ago.

THE CHAIRMAN: Yes. So might that opportunity for the Panel be on the Wednesday, when we are clear that there will not be a---

Code A: There is room for manoeuvre on that, I am sure. I think Code A agrees with that sentiment.

Code A: Certainly. Those are in fact ready now, so those could be handed up this afternoon. They are not particularly lengthy. I re-read them the other evening, and I think it is probably about two hours reading, something like that. It is not an enormous amount of reading. So although they each look quite fulsome, the beginning few pages, once you have read it, is the same pretty much, I think, for the rest of them.

Code A: May I just mention one other thing. Maybe I am misjudging it, but, quite frankly, reading a whole series of statements about different patients makes for a pretty indigestible process. They are not very long, but it may be that the Panel will find it easier to somehow deal with them one by one. We have all had the experience of sometimes forgetting what it was that ever brought the patient into hospital in the first place. That kind of thing---

THE CHAIRMAN: Especially with the speed we have been going at.

Code A: ---arises terribly easily, and I am as burdened by that as anybody. So whatever is appropriate for the Panel, but I simply wonder whether one might be able to break it up in a way. The other thing is, and this is not meant as something to prevent the Panel reading the statements of Code A when they are provided, but my learned friend Code A and I am very grateful to him for doing this, is proposing to provide a single sheet for those statements so that it is very easy to see, when Code A says, "I saw him on 8 December and my note reads", to give you a reference, and all of us a reference, to the page in the files of what it is that Code A was in fact referring to at the time she made her statements. The documents were not in the shape and form that they are now. Again, I repeat, it is entirely a matter for the Panel.

THE CHAIRMAN: I think anything that assists the Panel in navigating its way through what is by any standards a very large amount of paper, particularly in the light of the fact that we have gone through very much faster than normally happens in a case of this length, and, I mean, Code A alluded to it yesterday, it is difficult for the most attentive and assiduous Panel to balance in their heads all of these things without having some sort of a break or structure, so any structure you can give us is going to help enormously. It may be, Code A that the way to do it would be as those structures become available for individual patients, as it were, that is when we are given the statements.

Code A: It is equally difficult for the most attentive of barristers. What we might want to do, once we get to the patients with Code A is to take a break between each patient, possibly not a very long one, but we might do just so that we can re-focus, as it were, on the medical---

THE CHAIRMAN: I am sure that the Panel would find that enormously helpful, so that we are re-focusing each time rather than just running straight through. If that is going to be possible, I think we would welcome it.

Code A: Can I then turn to the next issue, and it is really, rather than making an application, to make an inquiry in a sense. You remember that towards the beginning of this case I made an application to you to receive Code A reports in advance so that you have in mind in advance what he was going to say about each patient, so that when you were listening to the various pieces of evidence you knew what the expert opinion was, and you rejected that application, and I have no qualms with that at all. The point now comes when Code A is about to give evidence, and he is going to be working through his reports, and unless he is stopped, or I am stopped from doing so, I am going to be asking him to have these reports in front of him and I am going to take him through them, because there is no other way of doing it with a case of this complexity and size. Now, it is very much a matter for the Panel whether they feel that they would be assisted, certainly in respect of not necessarily the general report that he has done, but the reports that he has prepared in relation to each individual patient, the Panel would be assisted by having those reports at least at the time of him giving evidence, or we would suggest if you are going to have them at all you ought to have them in advance. It is simply to assist you following his evidence. It gives the GMC no particular advantage because I will be going through the report with him, you will be getting it on the transcript. It may mean, I have to say, that if you were to take that course I could be rather shorter with him, because he will effectively affirm that the reports are his and either he still agrees with the conclusions or he does not agree with the conclusions. I cannot say that it will avoid me having to deal with at least some of the material in each report, partly because there is a public element to these proceedings and it is important that the public know what evidence you are receiving, but it would undoubtedly make the process shorter. So I simply raise that as an inquiry, whether you feel at this stage it would be helpful to have those reports from Code A.

THE CHAIRMAN: I think the key phrase is "at this stage". At the earlier time we did agree that it perhaps would be best if we did not have that information, but when we are at the stage when the evidence of the professor is about to be adduced, particularly because by definition it is going to be long and it refers to a number of different patients, as I said earlier, anything that assists us to navigate is enormously useful. This is a very experienced Panel. Every one of them have been on many long cases in the past, and on

many long cases this would be the time when Panels would be most receptive, shall I say, to receiving those. I might also say that on a number of recent long cases in which I have been involved it has been a time when the defence have themselves said, "Well, we are happy for you to see his in advance, but if it is going to be assisting to know where the issues are, will you see the defence report at the same time?" Now, it may be that you would not wish that or that Code A would not wish that.

Code A: I can give an answer to that straightaway: we would have no objection, obviously on the basis that the defence expert is going to be called. We have now been provided with an expert report, and we would have no objection to you having that in advance at the same time as Code A reports.

THE CHAIRMAN: Would you have a view on that one way or the other, Code A?

Code A: I do most certainly have a view. My learned friend charmingly says this is simply an invitation to the Panel to see if it would assist. He is in fact applying to put this report in to the Panel. The Panel has already heard the application, and I am not going to repeat the nature of the objections I had at that stage. This is something very different to assisting the Panel in the way that we have been trying to do with various documents that have been produced – documents which I stress are non-contentious. This is an utterly different matter. This is a contentious document. This is in effect the GMC's case against Code A

Not only do the objections, which I think the Panel found were made out, stand as they did at the outset, nothing has changed as to whether this should properly be received because we have now reached the stage that we have, but any changes that have taken place since this matter was first raised before the Panel are in fact further indications as to why the Panel should not have the reports of the expert.

There is no problem at all, in my submission, created for the Panel by not having the report of Code A The Panel is going to be deciding the case on the evidence of Code A The report is not the evidence. Indeed, slightly alarmingly my learned friend seemed to be suggesting that in order to shorten proceedings he would give you the report and just ask Code A about certain bits of it, which really, with the greatest of respect, simply is not a sensible way of proceeding from anybody's point of view, and I would certainly have the strongest possible objection if that is what he was proposing to do.

What has changed from the time that this application was first made is that it has been absolutely apparent that the Panel are well able to keep their own relevant notes. There has already been some quite difficult and detailed evidence, for example from Code A There has been no difficulty, so far as the Panel has been concerned, in terms of keeping track of his evidence, making whatever notes are necessary for the Panel to remind themselves of what they need to ask about, or anything of the kind. The Panel, in any event, receives every day a transcript of the previous day's evidence, and I have no doubt that has been of assistance in determining what particular bits of evidence need further explanation or scrutiny by the Panel.

It is going to be absolutely the case with Code A whose evidence in chief is going to take I would have thought certainly two days that the Panel is going to have ample opportunity to consider what it needs in terms of a record of what has taken place.

The important thing, it seems to me, not only as a matter of common sense but also so that justice can be seen to be done, is that the Panel makes it clear it is focusing on the evidence it hears. There is no difficulty about the reception of that evidence. There is no difficulty about my learned friend adducing his evidence. The thing that does assist the Panel in terms of following Code A evidence, and I suspect will also assist Code A is that you have the detailed history of what happened with regard to each patient in the way that has already been set out in advance, as it were, and you know the general nature of it. I must say, I found it of enormous assistance to have something of that kind and of enormous assistance when considering what Code A says in his report, even from our point of view.

The disadvantages for the Panel of having this material in front of it is that it is not his evidence, number one; number two, the way in which Code A report is set out, and this is not a criticism of him for a single second, is that it is not chronological; it is a mix. He will set out the history with regard to the medical notes and then set out a section setting out the history in terms of the nursing notes. One literally does have to turn the pages backwards and forwards to try and get the chronological picture. I presume Code A when my learned friend takes him though his evidence, is going to be dealing with it chronologically. The key thing is the chronologies that are going to be provided to you.

The other disadvantage is that the report contains comments and statements which may well not be borne out in terms of the evidence the Panel has heard, that may well not be borne out in the course of Code A evidence. This is an important further reason in my submission: the report contains some repetitious material – again this is not a criticism of Code A – and indeed it contains a number of repeats of the same opinion. In some cases there are two reports produced by Code A – again, not his fault because he was asked to look at some patients at a certain time back in December of 2001 and then produce a final report.

May I just indicate, just by way of example, just taking Patient H, Code A Code A was asked to produce a report in December of 2001 and he produced a five-page report setting out various matters and giving his opinion about certain aspects of the matter. Code A does not always use the same expressions when he is talking about the same thing. It is not going to be of assistance for the Panel to have a document which describes the same event with different adjectives or appellations made by the same witness, because it is going to distract the Panel from concentrating on what the evidence is from Code A Perhaps creating even more of a problem is that he then produced – again none of this is a criticism of Code A at all – later on, rather more recently, a further report about the same patient, on this occasion five pages, repeating very much the same sort of thing but very often using different expressions – the sort of thing that may trouble a lawyer and a lawyer may have to deal with in the course of his evidence but should not be before the Panel because he may not say that and he may not say it in the same way. Far from shortening proceedings, in my respectful submission, it is going to lengthen them.

These are closely typed reports. Just by way of illustration, he says in respect of simply the second report with regard to Patient H the prescription of diamorphine and midazolam was inappropriate and unjustified. The Panel know that because they know that from what Code A said by way of opening. He says that again in the same paragraph. He says it twice more in later paragraphs. So you are getting it a further five times I think in various paragraphs, saying exactly the same thing. It cannot assist the Panel, or indeed any tribunal, to have a repetition of the same material when the Panel is not going to find it impossible, difficult or in any way a problem following Code A Code A evidence. You now know much more about the case than you knew at the start and it is simply going to add to your work, in my submission, run the risk of giving the reports a prominence they do not deserve because they are not evidence and, far from agreeing with my learned friend's assertion that this is likely to shorten his presentation of the case, I just do not see that happening.

These objections are serious objections and it seems to me everything the Panel has been faced with in terms of the work that it has had to do already and the changes that have taken place indicate that it is simply not necessary, and indeed is a distraction for you to have in front of you.

THE CHAIRMAN: Thank you very much, Code A

Code A I think it is clear from what Code A has said that your charming invitation really is an application.

Code A I think we can certainly see there is objection to it, whatever it is, but I do not entirely accept that it is not a sensible way forward. This is how it is done in all civil proceedings, I believe, that an expert report will be produced and the expert will turn up to confirm that that is his report and then be cross-examined on it.

Code A I am sorry to interrupt. One thing I should have made clear, in case there is any confusion, and I should have said it: I have no objection at all of course to Code A having his reports in front of him. He has got to have them in front of him.

Code A I will only remind you that this is the same afternoon where it is being suggested that you would have the advantages of reading Code A statements in advance so that you know where the issues lie in advance of hearing presumably Code A evidence, and it is not so very different from hearing from Code A and knowing what he has said in advance.

I really do leave it – I am not going to pursue this strenuously – as an invitation, call it an application if you will, to the Panel to consider the pros and cons.

Code A May I just add one thing in relation to what my learned friend has just said, and I am sure your Legal Assessor will advise you in the same way: the statements of Code A are being put in by Code A as part of his case; they are not being put in by the defence as some kind of "would you look at this in advance, please, members of the Panel, so that you know what our case is". He is putting them in as part of his case.

THE CHAIRMAN: Presumably, Code A you have therefore had the opportunity to put them in at the time that you wish. Without prejudging the views of my colleagues, if the Panel were to say that the application, or whatever it is, is not successful, you would have the discretion as to the time at which you put in the documents which you are adducing?

Code A I would but I would still try and behave sensibly and make sure that you got them at a time when it is going to be most helpful to you.

THE CHAIRMAN: Would you therefore agree with Code A that it would be most helpful to the Panel to have that information in advance?

Code A Yes. You will remember, if I may be allowed just to remind you, when I opened this case, I did describe those statements, and I am sure Code A would agree with this, in a technical legal sense: those are known as self-serving statements. They were prepared by Code A one expects with her lawyers and so they are not the same as evidence under cross-examination. Should the event arise that Code A were not to give evidence in support of those statements, then we would have more to say to you about how you should treat that evidence.

Having said all of that, given that that was her response to the police interviews, although she did not allow herself to be questioned in the sense that she did not answer police questions, we do think it is appropriate for you to have those and we have no objection to you reading those in advance of hearing from Code A so that in relation at least to those patients you know where the battle lines are.

THE CHAIRMAN: That is a very helpful indication. Thank you.

Code A, I am going to ask the Legal Assessor now whether he has anything to add to his earlier advice and whether he wishes to repeat any of that earlier advice.

THE LEGAL ASSESSOR: Mr Chairman, I last advised the Panel in relation to the reports of Code A on the second day of this hearing, 9 June, and the issue now raises its head again.

I advise that this should be treated as a renewed application by the General Medical Council. I advise you that you should read the skeleton arguments submitted by counsel on 9 June; it will not take very long. You should then read my advice set out on what I believe is page 20 of Day 2 of the transcripts and you should then read the Panel's own earlier determination on the issue.

Having looked at all that, you should then look at matters afresh today, but asking yourself what, if anything, has changed, particularly with the passage of time, since your determination of 9 June 2009.

You will bear in mind the following points, and I will deal with them briefly. First, as is apparent from the earlier advice, this is not an application that the reports should go in as evidence, and that still means, in my view, that Rule 50 of the Old Rules does not apply and Code A conceded on the last occasion that that may indeed be the case.

Secondly, the new chronologies that have been prepared, and you have one already, are,

as I understand it, fully factual and uncontroversial and will not incorporate the GMC's specific criticisms of Code A as you suggested in the final paragraph of your earlier determination. I understand, I hasten to add, that that was considered carefully but was not felt to be possible. Obviously you will be able to write notes of Code A evidence on the relevant pages of the new chronologies.

The defence view remains that the admission of the reports, even if not by way of evidence, would remain prejudicial. They are based, it is said by the defence, on partial or defective statements or statements which differ from later oral evidence and the defence state that the passing of time does not diminish that prejudice.

Attempts have been made to edit matters into a satisfactory form but that has not been possible.

We are all, I am sure, anxious that the Panel should be properly assisted as much as possible. It might be that the provision of reports shortly prior to Code A giving evidence might assist the Panel in understanding his evidence better when he comes to give it. After all, the Panel has now heard much, if not all, of the nursing evidence in the case and, subject always to the question of memory, it would be able to look at the reference to the nurses' evidence in Code A reports in the light of the evidence that they actually gave.

On the other hand, it does not necessarily assist a panel to be given a very large amount of material which it is forbidden to rely upon as evidence. It is possible that such a course would in fact not assist the Panel and that it would actually be muddling, because the Panel would have to constantly bear in mind that Code A opinion might now be very different from that set out in the earlier reports, and furthermore the Panel would have still to perform the disentangling exercise I referred to in my earlier advice.

You should also consider whether the reception of Code A evidence will be made easier for you, even if you do not have the reports, by it being led chronologically and in relation to each patient in turn.

Mr Chairman, I am sure that the parties will have done all they can to assist the Panel by reaching agreement as to editing by the removal of any material which could conceivably be prejudicial or which is inconsistent. Unfortunately, that has not proved possible.

Whether fortunately or unfortunately, the situation is not that the Panel may take whatever course it would find most helpful. The mere fact that Code A is about to give evidence does not of itself alter the fact that we are all constrained by the state of the law. I refer the Panel to my earlier advice, which remains that I am not able to point the Panel to any clear legal authority which would entitle the Panel to override the objections of the defence and receive the reports at this stage. I therefore cannot advise the Panel that you are able to require the reports to be produced to you, contrary to the wishes of the defence.

I advise that the Panel should go into camera to consider this matter now.

THE CHAIRMAN: Thank you, Legal Assessor.

Code A, do you have any observations on the advice just tendered?

Code A: None, thank you.

THE CHAIRMAN: Code A, do you have any observations?

Code A: No.

THE CHAIRMAN: The Panel will go into camera and we will call you back as soon as we possibly can. Thank you.

PARTIES THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

PARTIES HAVING BEEN READMITTED

DECISION

THE CHAIRMAN: The Panel has received what it regards as a renewed application from Code A for the Panel to receive copies of the expert's report or reports in advance of the expert giving his evidence. The Panel has considered whether the passage of time has raised any fresh considerations which require us to depart from our earlier decision. We have concluded that there are no such fresh considerations which require us to depart from that decision.

We have concluded, as before, that in the absence of consent from Code A on behalf of Code A it would not be appropriate for us to receive the reports at this stage. The Panel therefore rejects the application. We do, of course, note that in one area at least things have changed; that is that, due to the diligence of Code A the Panel will be furnished with the upgraded chronology, if I can put it that way, that we asked for at the time of our previous determination on this matter. We are confident that will assist us greatly.

Code A is now back in the Court of Appeal where he was this morning. He will be continuing with the chronologies this afternoon. As I say, we hope to have them available to you as close as possible to Monday morning. If you are content to receive those which are ready, I think they are sitting on the desk behind you.

THE CHAIRMAN: Absolutely. It will enable the Panel, some of whom have long train journeys, to use the time to good effect, if you are content for us to do so.

Code A An enjoyable use of time before the weekend starts!

THE CHAIRMAN: Those are chronologies for A, H, L and Patient I.

Code A: Yes. That is all that we have for you today.

THE CHAIRMAN: Thank you.

Code A: We will be starting on Monday at 10 o'clock with the Code A

(The Panel adjourned until 10.00 a.m. on Monday 6 July 2009)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 7 July 2009

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

Chairman: Code A LLB JP

Panel Members: Code A

Legal Assessor: Code A

CASE OF:

Code A

(DAY TWENTY-ONE)

Code A of counsel and Code A of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

Code A QC and Code A of counsel, instructed by the Medical Defence Union, appeared on behalf of Code A, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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

Code A: First of all you are quite right.

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

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

THE CHAIRMAN: That does sound familiar.

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

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

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

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

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

Code A

Examined by Code A continued

Q Code A, turning to Patient B, I think you have also have the chronology for Code A, is that right?

A Yes, I do.

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

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

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

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

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

Code A: I do not think she had the report or the x-ray.

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

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

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

That is under her past medical history:

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

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

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

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

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

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

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

Is that dihydrocodeine?
A Yes.

Q
"Seen by Code A – for MST 10 mg BD?",
D

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

"Pain uncontrolled – patient distressed".

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

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

Code A: We can check that.

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

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

Code A: I think it is Code A note, but I may be wrong.

A May I comment. My interpretation when I reviewed the prescribing charts was that I understood that the diamorphine had been commenced on 5 March.

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

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

Code A: The note on 6 March is relating to the historical, the fact that SC has already started, so I think it started on 5 March, although it is difficult to read exactly when it started. It looks like 09.30 in the morning. That is also confirmed by the nursing notes. I think we are there, 5 March it is started. I am turning to your report, which the Panel do not have, at paragraph 7 where you deal with the issue whether in your view there was good evidence of a brain stem stroke. How could this in fact have been ascertained?

A I think, as I mentioned earlier, Code A rightly commented that a CT scan would probably not have been helpful in diagnosing a brain stem stroke, so you would really want to do a magnetic resonance scan of the brain and also the neck because there was a clinical question of whether she had a neck injury or fracture or displacement of the cervical spine. It has to be said that MR access for patients like this was quite hard, difficult, in the early 1990s so I am not critical of them not going ahead with that. I do think that the cervical spine x-ray should have been done, which is what Code A had asked to be checked and it is not clear whether that was done or not. You would have wanted to have excluded a cervical spine fracture in this lady.

Q I want to deal with the issue of Code A plan of treatment. If you turn back to 975, and I think you comment on this in your report at paragraph 9, what if any view do you have of the initial assessment and the plan provided for this patient?

A I think it was reasonable. I would not have expected Code A to question the diagnosis that had been made by Code A I think, as I comment in my report, that the continuing pain two weeks afterwards, in my view, should have raised a question as to what the cause of that was when this was not a lady, as we understand, who complained of pain before she was admitted, so you would expect pain from musculoskeletal injuries to be subsiding by this point. One thing that is not clear to me from reviewing the notes at various points, is the location of the pain from either the medical notes or the nursing notes. There is an entry, for example, referring to the physiotherapist which refers to neck exercises. This is on the bottom of the chronology, page 12, which might suggest she may have had some neck pain and stiffness. Although there is a mention about the sore bottom in the beginning, the

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

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

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

Q Why?

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

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

D A Can I just comment?

Q Yes.

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

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

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

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

A I do.

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

A Correct.

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

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

H

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

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

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

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

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

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

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

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

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

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

Then there is a nursing note:

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

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

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

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

Code A: I am grateful.

Code A: That is in Code A note.

E Code A: Very well.

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

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

THE CHAIRMAN: I agree, Code A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Code A: You should have done, Code A

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

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

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

Code A: Very well.

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

(The Panel adjourned for a short time)

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

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

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

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

A Yes.

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

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

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

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

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

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

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

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

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

B Code A: I have no objection at all to Code A indicating what his additions are. I think it is helpful.

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

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

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

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

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

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

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

G

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C

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

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

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

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

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

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

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

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

A Yes.

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

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

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

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

A Yes, they are.

H

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

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

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

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

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

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

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

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

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

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

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

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

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

"Syringe driver recommenced at 10.50".

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

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

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

H

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

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

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

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

Code A: Perhaps the Panel would just note that there is not an account from Code A with regard to this patient.

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

(The Panel adjourned for a short while)

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

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

THE CHAIRMAN: Code A has seen those, has he?

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

Code A: There is no problem, we can sort it.

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

"Needs plenty of encouragement with food and fluids."

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

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

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

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

"Reviewed by Code A"

This is when she is still at the QAH:

"Usually quiet and withdrawn."

She is catheterised.

"CXR and ECG – NAD."

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

Q

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

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

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

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

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

A Yes.

Q "DNR", do not resuscitate?

A Yes.

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

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

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

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

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

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

And there is another reference underneath that:

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

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

Q We can see that this patient still appears to have had, there is mention there, a urinary tract infection. I do not know if that had resolved by this stage. Would a urinary tract infection of itself cause pain?

A Not usually. It can do if it involves the kidney, but usually you get frequency and some burning but not usually severe pain.

Q We do see that the patient was catheterised?

A Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Marked deterioration over last few days."

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

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

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

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

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

Q Five milligrams?
A For example, of morphine.

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

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

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

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

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

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

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

Q And we can see that the next note that is made on 99B, on 21 August, after Code A note is:

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

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

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

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

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

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

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

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

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

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

Code A: Thank you very much. That is all that I ask you about Code A, and we are going to move on now to Code A

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

Code A: There is, of course, a statement from Code A for this patient.

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

Code A: Thank you.

(The Panel adjourned for short time)

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

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

THE CHAIRMAN: You have a bit more there.

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

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

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

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

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

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

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

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

Code A: I am grateful.

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

A

Management Suggestions

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

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

B

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

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

C Code A

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

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

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

D

Then at the top of page 3:

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

E

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

F

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

Q Are you able to tell us in what form it comes?

G

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

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

H

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

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

B

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

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

C

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

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

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

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

E chronology, on 3 August 1998:

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

We heard something about that.

F

> "To GWMH."

Then:

> "Reviewed by Code A
> Confused, but pleasant and co-operative. Able to move left leg freely. A little discomfort on passive movement of right hip. Sitting out in chair. Should be given

G opportunity to try to re-mobilise. Will arrange transfer to GWMH."

A Yes.

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

> "Quite distressed first thing, but settled after haloperidol. Little breakfast taken, but

H ate well at lunchtime."

A

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

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

Then the following day she is transferred to Daedalus Ward. Can we then look at Code A clinical note?

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

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

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

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

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

H

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

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

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

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

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

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

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

B

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

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

C

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

D

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

E

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

F

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

G

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

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

H

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q That midazolam appears to be being administered on the basis of Code A original
G prescription?
A Yes.

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

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

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

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

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

E

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

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

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

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

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

B

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

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

Q Then the drugs hereafter continue, on 21 August she is described by Code A as being:

D

> "Much more peaceful. Needs hyoscine for rattly chest."

"Much more peaceful" indicating that she does not seem any longer to be in pain, but we do not know whether she is conscious or not?
A We do not have any formal observations of conscious level by the nursing staff at this time.

E Q On the same day we see:

> "Condition very poor."

And in the same line:

> "Pronounced dead at 21.20."

F

This patient's death certificate revealed that she died of bronchopneumonia. We will see this cause of death given again and again. Can you give the Panel a little assistance about that?
A I think the predominant cause of death here was dementia and the hip fracture, I think that is what has led to the deterioration of problems. Bronchopneumonia is a common preterminal/terminal event in any mobile patient and also if you have drugs which suppress respiratory function, that will also often show signs of bronchopneumonia.

G

Q So the diamorphine and midazolam can themselves lead to the inability to ---
A Yes, because they depress respiration and you get less clearance of chest secretions.

Code A : Sir, I think that is all that I want to ask about this patient, and I would welcome the opportunity of just reviewing the notes very briefly. Perhaps we could then treat that as the end of dealing with Code A and we could move on to reading the chronology for
H Patient F. I think you already have them.

THE CHAIRMAN: No.

Code A: We have to hand that one out. We will hand out the notes for Patient F. We will make sure, Code A you get a copy before we break. (Document distributed)

Perhaps we can break there for the moment.

THE CHAIRMAN: Yes. We shall break now for lunch and the Panel will then go straight into the reading of these documents for Patient F. If when we come back you do have anything else on Patient E, we will deal with that first.

I think we shall come back, then, please at 2.50.

(Luncheon adjournment)

THE CHAIRMAN: I see that not absolutely everybody is back in the room. However we shall start but I have to make an immediate confession to you. The Panel have not used all of the time that they intended for the purpose expressed because another matter has come up, which is of general time-tabling. It concerns as much as anything, as I understand it, the administration of the overall GMC operation here.

The Panel have been told of the circumstances and we have given a preliminary view. I understand that the Panel Secretary at the end of the day will discuss what we have just been told further with the parties. This undoubtedly will have some effect on the way in which we all look at where we are going in terms of timescale. At any event we were going to begin with our return this afternoon by asking you if you were able to assist the Panel with a little crystal ball-gazing in terms of how the next few days are going to pan out.

As it had been left, we have all known that, for administration reasons, tomorrow would not be available to us as a sitting day because the room is required although the Panel have been able to make arrangements to do independent reading elsewhere.

There was then the issue of the following day. We had been told that Code A would not be available and we were asked for an update on that and then, of course, as to canvassing his availability for next week. It was an update on that that we first sought from you.

Code A: When I last spoke to Code A – and I have not spoken to him about this for a day or two – so far as Thursday is concerned, that is an inextricable engagement. He is, I believe, speaking at a conference and it is his event, as it were, and he has not been able to extricate himself from it. He will no doubt explain in a moment to you. I have not sought to disturb that because I gather it really is one of those professional commitments that he is unable to escape from.

We therefore have Friday. I certainly hope that I would finish examination in chief on Friday morning. We are going slowly – and that is no fault, I hope, of anybody's – there is material to get through and the Panel have to acquaint themselves with the material before you hear the evidence from Code A. That is actually making his evidence much shorter than it might otherwise be. He is not referring to letters and notes that are in the chronology that he might otherwise have to refer to.

Code A is available on Monday. He was meant to be starting, I believe, his family holiday on the Tuesday but he is understanding as far as anybody in those circumstances can be that he is likely to have to be here Tuesday. Beyond that we have not really got.

THE CHAIRMAN: I think we probably need now to spend a couple of minutes looking at that, starting with observations from Code A and his team, because you seem to be suggesting that if you were to finish your examination in chief during the course of Friday, that would not give a great deal of time for the rest of the process. Do you, Code A, have any sense of the sort of time that you would be wishing to have? It is difficult in advance.

Code A: This is the question one always dreads and I am as bad as anybody at the Bar can possibly be in estimating how long I am going to take to do anything, but I can say this in the presence of Code A: a certain amount of time has been taken by Code A Code A in explaining what I am going to call basics with regard to what is in the books and general matters with regards to analgesia, patient care, opiates and so on. It is not going to be a case of my taking issue with him as to what those precepts are. I will have to ask him some questions about the general approach in the context of this case. I hope that will not take too long. I find it impossible to say now quite how long that part of it will take.

With the individual patients, obviously one speeds up a great deal in terms of the Panel not having to read material. The issues have become narrowed down and the actual issues which have to be explored with Code A on the individual patients are not that wide ranging because a lot of his criticism is directed in certain aspects which, though no patient is identical, repeat themselves in the context of patients. I doubt if it is going to take as much time as it otherwise would. I will have to draw his attention to certain other aspects and so on.

I would have thought, and this can be no more than a guess, I am bound to take the equivalent of a day, and I think it would be wiser to think I might be as long as a day and a half. I hope that is being over-pessimistic, but I cannot really say. It remains a bit of a guess. I shall do my best, of course, to keep matters within the confines of my own duty, and endeavour to keep matters as brief as I can.

THE CHAIRMAN: Taking that on board, and recognising there is then the matter of re-examination from Code A, inevitably a substantial period of time with questions from the Panel and then counsel's own questions arising out of those of the Panel.

It would appear at best to be tough but do-able by the end of Tuesday.

Code A: I was just going to say, that would be my best guess.

THE CHAIRMAN: If it is tough but do-able we need to have in place a Plan B or a longstop in case it remains tough but no do-able.

Code A: The Plan B, I am afraid, has to be to ask Code A to give us another day. That is the reality.

THE CHAIRMAN: Or possible day.

Code A: I already planned to revise my plans, to be available for all of Tuesday. I have changed my holiday plans accordingly. I would be very reluctant to have to come back later in the week because that is the remainder of the time I am spending with my family. I am, however, then on holiday for a further week but at home. If needs must I could come on the Monday or another day that week, although obviously I would prefer not to, but I recognise that may be necessary.

THE CHAIRMAN: The following week we would be, presumably, into the defence case so we would not be able to then revert to the GMC case. We have to finish the GMC case before we can go on.

Code A: I could ask whether I could make myself available on the Wednesday. It is really not something I would like to do.

THE CHAIRMAN: I think if we can at this stage agree on that. I think it is clear that none of us would wish to put you in a position where we would need to be asking you to come back on the Wednesday. There are some things we can all do to try to assist with the days, in terms of the times at which we sit. But within all of that there is an overriding obligation to the doctor to make sure that the Panel remains sharp and receptive. A Panel that is hearing evidence when it is so tired that it is not able to take it on board properly is not doing the doctor any favours at all.

Code A: I fully appreciate that point. Thank you for mentioning it. I think in terms of the cross-examination of individual patients, it is not going to be such tough going from anybody's point of view because we have all been through it, at least in chief, with Code A and it is not as if I need to review each aspect of the patient history, or anything of that kind. I would hope that the concentration problem may not be – who knows – as bad as might otherwise appear.

THE CHAIRMAN: What I am going to say then, Code A, is this. We are going to get on now. The fact that we have not had all the time that we would have wished on this patient is regrettable but it is by no means the end of the world. We can make that up.

We do have the advantage of two days coming up when the Panel can do a certain amount of pre-preparation. One of the things that we can undertake to do is to ensure that for Friday, Monday and the rest of the time in which we may be receiving evidence in chief, that we will not require therefore any further time for pre-reading because we will have done it.

Code A: That would make a very significant difference. I would ask the Panel also to consider whether we might sit earlier on Friday. I suggest that with reluctance, but the reality is that a half hour here and a half hour there does really make a difference.

THE CHAIRMAN: They do indeed. All I have to do is remember that I must also balance the need to keep a Panel sharp and fresh.

Code A: Of course.

THE CHAIRMAN: In principle, I do not see a problem with that. We might as well say now, then, that on Friday, Professor, we will start half an hour earlier and we will see what other savings might be made, if that is convenient to you.

Code A: It is. I am on call for the stroke service in Newcastle on Thursday evening, so I cannot stay here, but if I get the six o'clock train which arrives in at nine o'clock for a 9.30 start – assuming there are no travel delays – that will be fine for me.

Code A: We were looking at a nine o'clock start, but you were here at 9.15. You cannot make it for nine o'clock?

Code A: I cannot release myself. I cannot leave that early in the morning to get here before that. I am sorry.

Code A: Fair enough.

THE CHAIRMAN: We will start at the normal time, but we will be looking to get a half hour here and there in the remainder of the time to make it less likely that we do have to put the thumbscrews on you for the Wednesday. If we possibly can, I think we are all agreed, we are going to be aiming for the end of Tuesday but nobody can commit themselves at this stage.

Code A: I am grateful for all that. Let us move on. (To the witness) We are now going to turn to Code A, Patient F. Do you have the chronology in front of you?

A Yes, I do.

Q This lady, as we can see from page 2 of our chronology, was admitted to the Royal Haslar on 5 August of 1998. She had had a fall which fractured the left neck of her femur. She underwent surgery. Prior to that it is revealed that she was walking 100 yards and then had to stop because of arthritis. She had lived alone, but she was mobile, independent and self-caring. The plan was, as we see at the top of page 3, after the operation:

> "For X-ray and bloods tomorrow morning and then to mobilise when comfortable."

She is reviewed by a physiotherapist on the 6th and further reviewed on the 7th. Then on 8 August, at the bottom of page 5, we see a nursing note:

> "All care given. ... Remains very breathless. ... Sacrum broken in sacral crease. ... Sat out for half an hour. Mobility poor. Unable to tolerate nursing on side. Poor fluid intake. Paracetamol given for pyrexia."

So she had a slight fever of some sort. Does that mean a raised temperature?

A Yes. Yes, pyrexia does mean that.

Q

> "Agitated at time."

Then it says "Cyclizine given". I do not think we have come across Cyclizine?

A It is an anti-emetic.

Code A: I am sorry to interrupt but can we just take note in the history. I am not objecting to the speed at which this is being done. Can we take note of the entry on 6 August, the bottom part of that with regard to "LVF". It is page 3, 6 August, just that little last thing.

Code A: I am sorry.

"Fluid overload – LVF"

Is that left ventricle failure?
A Left ventricular failure, yes.

Q And then –

"Infection."

A Yes.

Q What is the correlation between fluid overload and LVF, if any?
A When you have heart failure, you develop pulmonary oedema, fluid on the lungs. The different diagnosis that the doctors are thinking of there is either the patient has a chest infection or that they have pulmonary oedema due to heart failure.

Q And "Stop ivi". Is that intravenous fluid?
A Yes. They are thinking that the intravenous fluid the patient has been given post-operatively may have precipitated the fluid on the lungs in the context of impaired heart function.

Q Moving on then, bottom of page 5, we have dealt with. On 9 August she walked around the bed but her mobility is described as poor. She walked round the bed with a zimmer frame and assistance. She sat out for an hour. She was unable to tolerate nursing on side, always rolling onto her back. On 10 August, physio revealed:

"*Appears unwell today. ?MI*"

Myocardial infarction?
A Yes, that would be what "MI" stands for.

Q And "?chest infection", so those are the differential diagnoses?
A Yes.

Q "*R/V* [review] *mane.*" Then, underneath that:

"*Patient unwell. Vomiting/diarrhoea, drowsy, denies pain, orientated. Apyrexial.*"

So the temperature has gone?
A Has come down to normal, yes.

Q "*Chest clear.*" Underneath that:

"*14.30: Much improved, alert, bright and orientated.*

CXR ..."

Is that a chest X-ray?
A Yes.

Q
"*... chest infection. On augmentin.*"

A Yes. An antibiotic.

Q Does that necessarily reveal that that was, in fact, the cause of her chest problems, or may there still have been an infarction?
A Their conclusion is that was what they thought at this time the diagnosis was; that there had been a chest infection. It is not absolutely certain that she seems to have got better on the antibiotics, so the temperature has come down. That would be a reasonable

Q At the bottom of that page of the chronology, could I just suggest adding one note which comes from page 511, which you have picked up, I think, in your report, Code A Code A It comes from 10 August 1998, so the day that we are looking at, and there is a Code A ?
A Yes.

Q He states:

"For all necessary treatments and resuscitation..."

A Yes.

Q And then there is a word that, I am afraid, I cannot read. Or "... and resuscitate...", and then there is a word. This is in the middle of page 68 of the notes.
A Yes. I could not read that word either.

Q Whereas with some patients, as we have seen, there is the notation "Not for 555" or "Not for resuscitation" certainly at that stage of the patient's treatment on 10 August she seems to be noted "For resuscitation"?
A Yes.

THE CHAIRMAN: Could you repeat that?

Code A : It is quite difficult to read. It is "511" right in the middle of a page. It has a large "68" – it is right in the middle of the page, 10 August 1998, and I think you can see:

"For all necessary treatment and resuscitate [something]."

Can we go on to the top of the chronology, the top of page 7. This lady is obviously having problems with diarrhoea and her skin appears to be having problems.

"Ate small amount of ice cream. Ulcers need redressing – both legs."

A She had an unsettled night and she was incontinent of faeces, and her sacral area remained red. That would be uncomfortable for her, no doubt?
A Yes, it would.

Q Or painful. On 11 August she is seen by a physiotherapist. She remarks that she remains unwell.

B "L base remains quiet."

A That would most likely be referring to the left base of the lung. The physiotherapist probably listened with a stethoscope herself and would be possibly indicating there was still residual infection.

Q Then over the page of the chronology, I am just trying to stick with the chronology for C the moment, she feels nauseous and she has abdominal pain.

"Later: Much improved, apyrexial, good urine output.
Chest: Good expansion R = L."

Would that be the lungs as well?
A Yes, that would be the lungs.

D Q

"Plan: Switch to oral augmentin...".

Augmentin is used for what?
A It is an antibiotic commonly used to treat chest infections.

E Q

"... encourage fluids" and then "Ensure."

Ensure is ---?
A Is a dietary supplement to help maintain nutrition.

Q Then urine output is down and the plan is to stop IV fluids. Later, we see she is given F a full wash, her bottom and sacral area is very red and breaking down in the cleft. She is described at 1930 as:

"Remains very sleepy. To encourage oral fluids. Urine output satisfactory."

Then on the 12th she is described as "much improved", she has sat out, but she is developing sacral bed sores. Over the page – and again, I am not referring to every part of every entry – G on 13 August she is seen by Code A and at the end of that, which seems to be her conclusions, she is still dehydrated. Hypokalaemic is?
A Low potassium in the blood.

Q And normachromic?
A It is a certain type of anaemia, often seen in chronic disease, rather than iron deficiency anaemias or other vitamin deficiency anaemias.

H

Q Then:

"Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at the present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement."

Code A: Might we just know what she said about ECGs and ischemic heart disease in that section?

Code A: Certainly.

"Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease and LVF have been problems recently."

A Atrial fibrillation is irregular heart beat. That puts patients at risk of having a stroke.

Q We can see that the physio notes underneath that:

"Unable to mobilise at present due to chest pain."

So that does not seem entirely to have resolved itself.

A No, it does not. She was still really quite medically unstable at this stage.

Q The following entry at the top of page 11, we can see she has had an unsettled night, she is still complaining of central chest pain and she is given a GTN spray. A GTN spray would be given to relieve any heart ...

A To relieve angina. It is a nitrate.

Q Then:

"Comfortable afternoon. Oral fluids taken. No [complaining of] chest pain. For transfer to GWMH next week."

Then on 14 August she is described by the physio as:

"Brighter today. Sitting out. Walked short distance with frame ... To gradually [increase] distance ..."

Over the page to page 12, she is reviewed and again it is recorded that unfortunately she has chest pain in her ribs through to her back since being manhandled. The ECG reveals nil change and no effect with GTN. What does that indicate to you, if anything?

A The doctor assessing her would be looking to see if there was evidence of any acute myocardial ischaemia, whether she was having a heart attack, or a prolonged period of angina at rest. The ECG was normal, there was no relief with GTN, which would be a sign often that it was a cardiac pain, so her differential diagnosis has become muscular-skeletal pain or alternatively pulmonary embolus, which is a clot to the lung; she has been dependent, so she is at risk of that, and he or she is still considering angina.

Q The patient is given codeine phosphate. Then at 0700:

A

"Some pain due to arthritis in left shoulder overnight. Had paracetamol to good effect."

We can all see what follows after that. Then I am going to take you through 17 August. She is described as sitting out in a chair. Then at 2015:

B

" ... Seemed confused this afternoon, reluctant to move herself from bed. ... paracetamol given."

Then on 18 August:

"Reviewed by SHO at Royal Hospital Haslar.
Well, comfortable and happy. Last pm spike temp, now 37.3°. Mobilising well. [To]
C GWMH today."

Again, "spike temp"?
A That means the temperature was elevated the previous afternoon on the 17th, which relates to that recorded temperature of 38.8°.

Q Now 37.3°?
D A Which is normal.

Q At two o'clock in the morning, there is a note that she has increased shortness of breath and oxygen therapy is recommended. She is then transferred, it appears, to Dryad Ward. We can see the transfer letter. I am not going to go through that, but can you have a look at the clinical note made by Code A ?

E

"Reviewed by Code A
Transfer to Dryad Ward continuing care."

Her history reveals she has had a fracture of the left neck of femur on 5 August 1998, she has had angina and CCF. What is CCF?
A Is congested cardiac failure, again, indicating heart failure.

F Q Then:

"Catheterised. Transfers with 2. Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death."

Are you able to comment, having looked at that whole background, on the state of this patient at this point of transfer?
G A Yes. In my report I commented that it was reasonable to transfer this patient when they were medically stable for rehabilitation and that was the plan, but she had had a really very medically unstable course and had multiple medical problems. I think certainly in retrospect one can say she was not really fit and stable to be transferred. So in retrospect, one would have perhaps said it would have been better for her not to be transferred. Code A note also suggests there has been quite a change in her mobility, in that the notes say she was mobilising well the previous day. So again, there is a difference in mobility recorded. The
H "happy for nursing staff to confirm death", again, this is a lady with multiple medical

problems who could die. I do not think there is a problem with that in itself. I think the issue is whether that is interpreted or seen to indicate an approach to treatment of any active problems that develop. This was a lady who has had infection treated, she has been assessed for angina, they were going to investigate if she had a pulmonary embolus and I cannot comment whether that statement is an indication that there has been a change in approach to this patient in terms of investigation and active treatment of any other problems.

Q I wanted to ask you about that. You deal with the quality of the medical assessment by Code A at paragraph 8 of your report.
A I comment there, I think particularly in a patient like this, where there has been a change in function, they are no longer mobile and they have been quite medically unstable, that it would be good practice to have baseline observations and an examination of, for example, the chest and heart. It would be helpful to have a baseline as to what the patient's condition was at the time of transfer and arrival at Dryad Ward.

Q What are the fundamentals of a baseline observation assessment? What are you looking for in the notes, if you are looking to know where you are starting from?
A One is the patient's level of function, and that is described. We have a description of the mobility. The second is some basic observations which are usually done by nursing staff, which would be pulse, blood pressure, temperature and often oxygen saturation. I think in this patient, who has had an elevated temperature, who has had problems with their heart, those I think are assessments that should have been undertaken. As I say, I would normally expect those to be done by nursing staff on admission. Then I think an examination of the patient's chest, respiratory rate and listening to the heart would be a reasonable baseline set of physical examinations.

Q Who would you expect to perform such an examination?
A I would expect the assessing doctor, who in this case was Code A

Q If we go over the page momentarily – we will have to come back to where we were – we can see that Code A has prescribed Oramorph, between 5 and 10 mg prn, and temazepam. I am going to ignore the rest for the moment. Do we also see underneath temazepam that bumetanide is prescribed?
A Bumetanide, which is a diuretic drug.

Q And allopurinol?
A Allopurinol is a drug to treat gout and lower uric acid levels in the blood.

Q How are those taken?
A Orally usually. I think they were prescribed orally. Allopurinol only comes as an oral preparation. Bumetanide comes as tablets or an injection.

Q So all of those drugs, the Oramorph, the temazepam, the digoxin, Slow K, bumetanide and allopurinol, all of those would be orally administered?
A Yes, they are.

Q Can we deal, before we move on to the box below, with Oramorph? You deal with this at paragraph 9 of your report.

A A Yes. I could not find in the notes a clear indication or rationale for prescribing Oramorph. This lady had not been on regular analgesia, if I am correct, and there is not a description of what the Oramorph is for.

Q In terms of the analgesic ladder, you have described Oramorph as being the third level. Where should [Code A] have started, in your view?
A It depends what is being treated. If it is pain from the sacral sore, paracetamol and B codeine would be reasonable drugs to start with.

Q What about the chest pain?
A I think this is more complicated. For any patient with ischaemic heart disease, it is often standard, because they often take nitrates themselves, to write up GTN to take if the patient gets angina type pain. This patient was a bit more unstable than that. There were concerns whether she was having a myocardial infarct at one stage and you would not write C up prn morphine for a patient who you were concerned might have severe coronary pain due to a myocardial infarction or acute coronary syndrome. That would not be good practice, the reason being that the patient needs an assessment as to the cause of the pain.

Q Can we move on, please? First of all, that Oramorph that was written up was in fact administered, 5 mg was given at 2.15 in the afternoon. Does what you say about the prescription apply with equal force, as it were, to the administration of it?
D A I thought the administration was not appropriate. It was given for anxiety and distress in the absence of any pain. That would not be an appropriate use of morphine.

Q Can we have a look at the basis of that? If we go to page 15 of the chronology, we can see that she settled and slept well from 10.00 p.m. until midnight. Then:

> "Woke very distress and anxious, says she needs someone with her. Oramorph 10mg E given 00.145 with little effect. Very anxious during the night. Confused at times."

If that were the basis for giving this lady Oramorph, what do you say about it?
A I think it can be criticised. The patient is anxious, they have come to a new environment, they have been quite unwell, they are saying they want someone to sit with them. The first response would be for a nurse to sit with the patient. Nurses would not necessarily be able to sit with her all night, but you would expect, unless there were major F staffing problems or other problems on that unit, a nurse to be able to sit with the patient for 20 or 30 minutes. If they were no better at the end of that, I think it would be perfectly reasonable to give either a hypnotic, temazepam, which I think she was written up for, or an antipsychotic drug such as thioridazine or haloperidol, but not morphine.

Q This appears to have been given at quarter past midnight, so I think we can take it that it has to be a nurse deciding to give that.
G A Yes.

Q Does that reveal anything about the nurse's understanding of how these drugs were meant to be used?
A I think it did raise to me concerns that the nurses had interpreted that prescription of morphine to be used to treat anxiety or agitation in older people, in the absence of pain. I think most nurses would look at morphine being used to treat pain. So I thought that was H potentially a confusion or maybe that was the general understanding of nurses, that morphine

was to be used for either pain or anxiety and I think that would not be an appropriate use in the majority of patients.

Q Can we look on to the prescription that was written at the same time at the bottom of page 16? At the same time as Oramorph was written up, Code A has also prescribed her a variable dose of between 20 and 200 mg of diamorphine and 20 to 80 mg of midazolam. Can you just help us, please? I appreciate you have dealt with this on a number of occasions, but with this particular patient, is she to be regarded as opiate naïve?

A Yes. When that was written up, she had not received – well, it depends on the exact timing of that, but assuming this was written up on the day of admission, she was opiate naïve and there was not a clear indication recorded as to why she might require diamorphine and midazolam as a continuous infusion.

Q I do not want to waste time by asking you again about what that increase in dose would be. I think we have your evidence about that and your comments about the wide dose range applied to this patient and this prescription.

A Yes, they do. The comments I have made before for other patients apply.

Q Can we go, please, to the top of page 17 of the chronology? We there see a note made by Code A

> "[Complaining of] chest pain, not radiating down arm – no worse on exertion, pulse 96, grey around mouth. Oramorph 10mg given. Doctor notified. Pain only relieved for short period – very anxious. Diamorphine 20mg midazolam 20mg commenced in syringe driver."

We are going to have to chop this up, I am afraid. First of all, "complaining of chest pain, not radiating down arm", is that an indication of whether this patient was in heart failure?

A Well, it would not be heart failure. The concern is that this lady has had chest pain before and there have been concerns that that might be due to a pulmonary embolus, that it might be due to coronary ischaemia. She is looking unwell. She looks too unwell for this to be likely to be muscular skeletal pain and you would expect a medical assessment. Obviously contact was made with whoever was the on-call doctor at that time.

Q Does any assessment appear to in fact have been done?

A I did not find a record of any assessment in the medical records.

Q We can see that at this stage the diamorphine which had been written up – I say "at this stage"; essentially in the afternoon at 4.00 p.m. – and the midazolam which had been written up were both started at 20 mg over a 24-hour period.

A Yes.

Q What do you say about the appropriateness or otherwise of that administration of the drug?

A I would consider it inappropriate. There has not been a diagnosis made. There were a number of assessments which needed to be done, as were done on previous occasions on this lady: an ECG, a heart recording, was obtained, you would want to know the oxygen saturations, the respiratory rate, listen to the chest, possibly get a chest x-ray, think about whether she was having a pulmonary embolus, all of which would have very different treatments. What has happened is that there has been a symptomatic response, in that the

A patient's chest pain is being treated now with a continuous infusion of diamorphine, which I would say is excessive both in dose and also in the decision to use diamorphine in the absence of a more detailed assessment, a working diagnosis, and there is no clear indication for midazolam, which has been started again at a high dose.

Q We can see that the next entry is 20 August at 12.15:

B "Condition appears to have deteriorated overnight. Driver recharged at 10.10. Family informed of condition."

Then there is a note:

"Night: General condition continues to deteriorate. Very bubbly. Suction attempted without success. Position changed frequently. Code A rousable and distressed when
C moved. Syringe driver recharged at 07.35 ..."

A patient being distressed in these circumstances can be the result of what; are you able to assist us?
A It could be the result of a number of problems. She may still be in chest pain, she may be confused, she may be hypoxic.

D Q What would be causing her hypoxia?
A She could have a chest infection or pulmonary oedema, or her respiratory rate could be being depressed by the midazolam and diamorphine. There are a large number of possibilities and in the absence of any more detailed nursing or medical assessments it is difficult to know what was the definite cause of deterioration at this point.

Q By this stage, would the syringe driver which had been started at 4 o'clock the
E afternoon before, be having any significant effect on her respiratory rate?
A I would expect it to with that dose and, her being essentially opiate naïve, she would not have developed tolerance. It is a reasonably large dose and the midazolam dose is a large dose.

Q Can we look at what happens thereafter. Over the page we are still on 20 August, the driver is recharged it seems at 09.15 and then the rate of the diamorphine is doubled to 40 mg
F and the midazolam is also doubled. That appears to be over, effectively, a 12-hour period. Looking at it globally, if we looked at 21 September, at 07.35 the diamorphine is put up to 60 mg and the midazolam is up to 60 mg, so over a 24-hour period, if you look at it from 9.15 on the 20th to 7.35 on the 1st, it appears to be a tripling of the dose.
A Yes, it is.

Q How should we be looking at these increases. We know that you have told the Panel
G that you can increase at increments.
A One would want to see clear rationale for these large increases. The increases are greater than those which are recommended in the Wessex protocols and other guidelines, which would be a 50 per cent increase. One would generally increase one drug at a time to treat a specific symptom, but the escalation of doses over that period in an older patient like this would be expected to cause very marked sedation.

H

Q The patient dies at 6.25 that evening. In your view, would the administration of the syringe driver potentially have a significant effect on that event?
A I was of the view that the doses administered over the period would very likely contribute to her death, yes, but again, because she had a lot of other medical problems, you cannot conclude that the drugs were the cause of her death.

Q I understand.
A I think the issue is, at this point, clearly she was being treated as somebody at the end of life. If there were clear justification to palliate symptoms and that was the agreed management plan, that might be acceptable and appropriate, but that information was not available in the notes to justify the escalation of the diamorphine and midazolam.

Q On 18 August, three days earlier than this, she is described as:

"Well, comfortable and happy and mobilising well."

If there was this sort of significant change in her health, would you expect a clear note to be made about it?
A Yes. This lady had been very actively treated right up to the day of transfer and was being assessed. If there was a deterioration, you would expect there to be a medical assessment and if there was a chest infection for that to be treated, if there was a pulmonary embolus for that to be treated. That, to me, would be appropriate unless you are accepting that it was entirely appropriate that she was being quite medically unstable and at the point of transfer to Dryad Ward there is a complete change in approach to management and that that was appropriate, but that is not clearly laid out in either Code A letter or justified in any other correspondence. There is a comment "gentle rehabilitation", so even on that initial admission to Dryad Ward, that was the plan which was reasonable and appropriate.

Q Going back to that note at page 78, which is the clinical record made by Code A the last note she makes is:

"Get to know. Gentle rehabilitation. I am happy for nursing staff to notify death."

The next note records Code A death. If there were any reassessments, would you expect them to be noted?
A If there was a reassessment I would expect it to be entered in the notes. With a lady like this I think you would have to consider it relates to what I described yesterday, that sometimes patients are transferred over when in retrospect they should not have been. She was very medically unstable and I would expect there to have been at least a discussion as to whether it was appropriate to transfer her back for further care because it was going to be very difficult in this setting if the agreed plan was still for active treatment.

Code A That is all I ask about Code A Again, perhaps that would be a convenient moment to pause for some reading.

THE CHAIRMAN: Yes, indeed. The new chronology for Patient G is just about to find its way to us.

Code A: I think we were going to suggest we hand out all the chronologies now to make sure we do not forget to do that at the end of the day.

THE CHAIRMAN: That is probably very wise, then we definitely have them for the next patients.

Code A: I will just ask for that to be done. (Copies distributed)

THE CHAIRMAN: Miss K, the Panel already have the new chronology for. There is a replacement Patient A.

Code A: We are trying to remember now what we have added, but I know it was something crucial.

Code A: 9 January.

Code A: I think L has been transmitted, but it is being produced at the moment.

THE CHAIRMAN: I understand it is with the print room and we hope to have it by the end of today. As far as Patient G is concerned, we have now received both updated chronology and we note that within the file of Code A statements there is a statement in respect of G.

Code A: About 20 minutes/half an hour?

THE CHAIRMAN: I think we will take a short break and combine that with some reading efforts. It is coming up to ten to four. If we say quarter past four, that will give everybody a chance for a quick break and give the Panel a chance to dip their toe into the paper.

Code A: Thank you.

(The Panel adjourned for a short while)

THE CHAIRMAN: Welcome back everybody.

Code A: The chronology in relation to Code A is fairly extensive. I expect you have been reading it again over the last few minutes. I am not going to spend any time going through all the early entries. The Panel have read them all and they reflect this patient's state on of health. There is reference to him suffering from Parkinson's and being a difficult man to manage; him losing weight. He was reviewed on occasions by Code A In July he found himself on Mulberry Ward, which we heard was the elderly psychiatric ward, or the ward for the elderly. Reviewed in September, and this was the first reference to infection, to sores being diagnosed, his weight being mentioned. This is page 7 of the chronology. His weight is recorded as 68.6 kg:

"Not eating too badly, sleeping reasonably."

On 21 September he is reviewed again by Code A at the Dolphin Day Hospital in respect of a sacral ulcer and he is admitted to Dryad Ward.

Can we look at page 8 of the chronology first. We can see that on 21 September when he is reviewed, he is shown to have a large necrotic sacral ulcer:

A

"Extremely offensive. Some grazing of the skin around the necrotic area, also reddened area with black centre on left lateral malleolus. Parkinson's no worse. Mentally less depressed but continues to be frail. Admitted to Dryad Ward with a view to more aggressive treatment on the sacral ulcer as I feel this will now need aserbine in the first instance."

Pausing there, this gentleman is being seen at the Dolphin Day Hospital?

B A Yes.

Q It is being suggested he be admitted to Dryad Ward for treatment?
A Yes.

Q What sort of treatment can be applied to this sacral ulcer?
A Essentially it is nursing care which is at a level which you cannot achieve in patients

C in the community. Admitting to a rehabilitation unit allows you to do more intensive nursing care, more regular dressings with staff that may be more experienced and would be more available than would be the case if he stayed in the community. Getting large pressure sores to heal in patients who are in the community is very difficult, so admitting them is an appropriate practice that is done.

Q If there is a necrotic area, with a reddened area with a black centre, would that

D indicate debridement?
A You would often consider debridement and various ways to do that.

Q Is it aserbine?
A Yes, I am not particularly familiar with that. It is a type of dressing to clean ulcers, I believe.

E Q If we go to the top of page 9, the patient is described as:

"Very frail. Tablets found in mouth some hours after they are given. Offensive large necrotic sacral ulcer."

I will not go through the rest of that. Can we look at the diagnosis first.

F

"Sacral sore.
PD."

A Parkinson's disease:

Q

"Old back injury. Depression and element of dementia. Diabetes mellitus - diet."

G

In other words it is diet controlled diabetes.

"Catheter for retention",

so he is suffering from urinary retention?
A Yes.

H

Q "Plan: Stop codanthramer"?

A Which is a laxative, and metronidazole which is an antibiotic which he was probably on because of the inflammation and offensive nature of the pressure sore.

Q "Dryad today, aserbine for sacral ulcer, nurse on site, high protein diet."

A Yes, because if you improve nutrition, one of the problems with achieving tissue healing is if you have poor nutrition you do not get good tissue healing, so, again, admission and ensuring patients take a good diet with high protein to help ulcer healing.

Q "Oramorph PRN if pain. Nursing home to keep bed open for next 3/52 at least. Patient informed of admission."

So that is admission to the hospital:

"Inform nursing home, Code A + social worker. Prognosis poor."

What is this gentleman's biggest problem, as it were?
A He obviously has lots of problem, but the main problem at the moment is the sacral sore. If that is not improved, he is likely to get infection and become more unwell and frail from the sacral sore itself.

Q The suggestion of PRN Oramorph, is that a reasonable suggestion at that stage?
A Yes, one would expect this to be painful. I cannot see what other medication he was on at this point, but if he has not responded to codeine or paracetamol, it would be an appropriate analgesic, yes.

Q Because he was not at that stage actually in hospital, he was visiting a day hospital, I do not think we know what pain killers he had previously been on.
A I think you should go up the analgesic ladder with someone like this, but if it is very severe some people would consider starting Oramorph. The other rationale for that might have been, I think it is mentioned, some of the concerns about swallowing tablets, so slightly easier to swallow syrup, but that in itself is not a strong indication to go to Oramorph.

Q At the bottom of page 9:

"Seen by Code A Pressure sore looks worse although NH [nursing home] felt it had improved. Plan: Admit Dryad Ward for treatment of pressure area. Ask Thalassa to keep bed for 2/3 weeks at least. Plan of care for ward written in med [medical] notes by Code A."

Code A: I am sorry. It is my fault, maybe I missed it, did you mention "Prognosis poor".

Code A: Yes.

A Code A: I am sorry, my mistake.

Code A: That is the plan for this gentleman, to treat his sores and he is being admitted to Dryad for that purpose.
A Hopefully, with the intent that after two or three weeks this sore will have improved enough that he can be discharged back to the nursing home.

B Q He is reviewed the same day by Code A and we have her note at page 647. This is the one where we have the note at 644 which is pre-transfer on 21 September and then the note from Code A on page 647 at the time of transfer. We apparently have a photograph which we cannot see, but it is in the notes if anybody wants to look at it. 21 September Code A writes:

"Transfer to Dryad Ward
C Make comfortable
Give adequate analgesia
I am happy for nursing staff to confirm death."

In terms of assessment and plan, how do you regard that note.
A I think it has to be looked in the context that he has already had a detailed assessment by Code A, so one would not expect that to be repeated. I do not think anyone would have
D any particular problems with any of that. There is a clear instruction about the type of approach to analgesia from Code A They are happy for the nursing staff to confirm death we have discussed before. In itself, this is a sick, frail man with many problems and he could die suddenly. That is not the issue. It is whether that has connotations around other aspects of his management.

Q I was going to ask you about that note and also the note "make comfortable". We
E have heard, as you appreciate having read the transcripts, quite a lot of evidence about that being a euphemism for a particular route.
A It can be a euphemism, but it can be exactly what it says. I would not like to speculate about what the specific meaning. I would acknowledge that it can be interpreted in different ways.

Q It is a question of how the nursing staff would interpret the note?
F A Yes.

Q Back to the chronology, please. We will find the drug charts, or the chronology dealing with the drug charts, at page 12. On the day of his admission, Code A has prescribed a PRN dose of Oramorph which we looked at earlier from 2.5 up to 10 mg of Oramorph.
A Yes.

G Q And you commented on that already. Code A then prescribes 20-200 mg of diamorphine. We are dealing with the prescriptions first before we actually deal with their deployment, and 20-80 mg of midazolam and hyoscine. In terms of this patient, at this stage of his life, how do you regard those prescriptions?
A I will not go through; the prescriptions are too wide and hazardous for that, but, yet again, I do not see a clear indication as to why he needs to be written up for continuous infusions. In previous discussions of this I indicated the benefits in somebody who might
H have difficulty swallowing, and there were some suggestions that he might well have

A difficulty swallowing, of having an alternate route which could be for PRN. Oramorph itself is subcutaneous or could be written as separate subcutaneous diamorphine. That would be appropriate, but not to put a high starting dose of diamorphine and midazolam when one has not established his response to morphine to begin with.

Q I am sorry. I just wanted to ensure I had not misheard you. Did you say that Oramorph could be given subcutaneously?
B A Sorry. Oramorph cannot. Morphine can be. Sorry. Thank you for correcting me on that. Morphine can be given subcutaneously but diamorphine is generally used, so what I am saying is, it would be appropriate and good practice if one was concerned about his ability to swallow to have alternate PRN opiates to give which would say, "Administer if unable to take Oramorph".

Q Before we come back to the actual administration of those drugs, I think we need to
C go to page 13, which reveals a note from the evening before so the day that that prescription is written out, we then see this note, which is made the following day:

> "Code A *has telephoned, Explained that syringe driver commenced yesterday evening for pain relief and to allay his anxiety following episode when* Code A *tried to wipe sputum on a nurse saying he had HIV and was going to give it to her. Also tried to remove catheter and episiotomy the bag and removed sacral dressing throwing it*
> D *across the room, finally he took off his covers and exposed himself.*"

That in any setting, I suppose, is challenging – what is nowadays described as challenging behaviour?
A Yes. One does come across older people who are confused and agitated, or can occasionally be difficult, of course. The history suggests there were difficulties with his behaviour in other settings.

E

Q Then, if we now go back to page 12 of the chronology, do we see that night, at ten minutes past eleven, the diamorphine and the midazolam which Code A had prescribed, is started? Sorry – you are nodding?
A Yes. I do apologise.

Q That is all right, but it has to go on the transcript. Unless Code A was attending the
F hospital that time it appears that that was or may have been a nurse-led decision?
A Yes. It appears in my initial report to Hampshire Police; I indicated it might raise concerns that the midazolam and diamorphine infusions were commenced to control his behaviour and sedate him.

Q And how appropriate or inappropriate would that be?
G A He is taking Oramorph, so he is getting morphine to control the pain, so there is no need to change that unless he is refusing to take medication, which this note does not say. Midazolam is not a treatment for behavioural difficulties and agitation in older people. It is, to remind ourselves of the Wessex protocols, a treatment for terminal restlessness, so it would be quite reasonable if one was going to use pharmacological measures to control his behaviour – one does not always have to resort to that – to look at a dose of haloperidol or thioridazine. One would start with an antipsychotic as a rule for these sorts of symptoms. One might consider a benzodiazepine but for this sort of agitation and behavioural difficulty
H most geriatricians would not choose a short-acting benzodiazepine but you would not choose

A to give midazolam or some continuous infusion when that is recommended for use with the management of terminal restlessness.

Q This was a patient who, it appears, was able to swallow his Oramorph, at least because we know that was being administered. Is there any other indication as to whether this gentleman needed a syringe driver as opposed to any other form of delivery?
A I am trying to find it. There is a record that he swallowed a drink of milk, if I have it B correctly.

Q There is. I think he took two glasses of milk. It is page 10, the bottom of page 10.

> "Driver commenced at 23.10 containing diamorphine 20 mg and midazolam 20 mg. Slept soundly following. BS at 23.20. 2 glasses of milk taken when awake. Much calmer this [morning]."

C Can we look at how this administration went on. First, if the nurses had started diamorphine and midazolam inappropriately and the doctor treating this patient comes across that, what in your view could or should the doctor have done?
A At this point, the first thing is there was a recognition that the patient should have pain treated, so the first thing to assess is are they in pain, and do they have any adverse effects from the diamorphine that they are now receiving, recognising that because you started a D continuous infusion it is going to be some time before the maximum effects of that infusion will occur. It might be up to 24 hours. That might likely require adjustment or conversion back to oral morphine, in the sense he is able to swallow. I really would be very critical about the continuation of midazolam because this is highly likely at this dose, if one continues it, to produce marked sedation, particularly in the context of giving a large dose, starting dose, of the 20mg or 60 mg of oral morphine equivalent.

E Q If we go on in our chronology please ---
A Sorry, can I just add a comment to that?

Q Yes.
A Partly that is because behavioural disturbances often are intermittent and people have behavioural problems and agitation for a short period. You treat that and then you withdraw the drugs. The trials which have looked at behavioural disturbances in patients with dementia F and psychotropics show, for example, a very high response rate in the placebo group, the group in a trial who do not receive any active treatment, about 40 per cent, and 60 per cent with treatment. That is a broad generalisation. You would always review drug management for agitation and behavioural problems unless, obviously, we are now in a position where it has been decided he is dying and for terminal care. This again does not seem to be explicitly articulated. It does not seem to be the reason it was started by the nursing staff. It seems to follow his behavioural problems and it is trying to palliate those symptoms, but it is not clear G that there was an intent that he was for terminal care.

Q We can see on page 13 that the driver continues. Over to page 14, at the top, it continues on the 22nd and is administered at twenty past eight in the evening, or re-started at twenty past eight in the evening. Then, on the morning of 23 September, he is reviewed by Code A. This comes from the significant events in the nursing plan. There is no note, I do not think, made on the 23rd of any review by Code A, but we have one on the 24th at page H

645 of the file notes. Can we just look at the bottom of page 14 before we go to that. In relation to 23 September:

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

I do not think we have food or fluid charts for this patient?
A No, no.

Q The only entry we have is the two glasses of milk that we have looked at?
A At this point my interpretation of the notes was that he was not receiving any hydration or nutrition.

Q And the comment "syringe driver boosted with effect": can you just help us with this. The syringe driver can be boosted, I think, with a button on the side?
A I interpret this to mean the infusion rate was increased. That is my interpretation.

Q Let us have a look at the top of page 15. We can see that in the morning of 23 September, at 9.25, the 20 mg dose of diamorphine is continued and then re-administered but at the same dose at 8 p.m. The midazolam appears to start at 20 mg and then there appears to be a three-fold increase?
A Yes. And I think that is what the term "boosted" means, so it is a threefold increase in the infusion rate of midazolam. That is a very high dose for this man and a very, very large increase.

Q It may be obvious but what effect is that going to have in terms of sedation?
A This dose would be definitely expected to produce very marked sedation in a man of this age.

Q We heard evidence from Code A – Day 6/8 – that on the 23rd, the day that this boost took place, he found him (he called him Code A) unconscious and unrousable. He says he went berserk, got very angry and he demanded to see the people responsible in the hospital, and he had a row with Code A He asked for the syringe driver to be removed so that he could speak to Code A Now, obviously one does not have to follow, I suppose – you have indicated yesterday – the wishes of relatives.
A Yes. And that is in the best interests of the patient. One of the problems of using sedation therapy is exactly this. It sedates people and they are unable to communicate at the end of life, and that is why, irrespective of any effects it may have on shortening life, it has to be weighed up very carefully if you introduce sedation therapy because it means you have somebody dying who is no longer alert who might otherwise be. Good quality end of life experience for many people might be to be alert and to be able to hold a loved one's hand. These are the potential problems with using sedation therapy. It is not just the risk of respiratory depression. It is that you are rendered less conscious which, by definition, is what sedation therapy does.

Q If he is described as unconscious and unrousable on 23 September, first of all is that a state that the patient should be in?
A It would be a state that he would be in if he had a clear indication and his symptoms were uncontrollable through any other means except by going to that level of sedation; but

this was a very large dose, a very large increase, and there was no attempt to titrate or adjust it. What could have been done was to reduce the midazolam at this point, and see what happened. He was variable in his agitation and, of course, we had the problem that it possibly was the diamorphine and its metabolites that might be worsening his agitation. It is a very difficult situation. The good palliation at the end of life, you try and adjust and optimise drug therapy, so you minimise side effects. You keep a patient's symptoms in control, but you keep them as alert as possible. The aim is not to render patients unconscious through high doses of sedation therapy.

Q Even if you do not feel that the nursing staff, or the doctor does not feel it appropriate to remove the syringe driver completely the dose could be reduced?
A Yes. If you have somebody who is over-sedated, or has excessive amounts, and that is your judgment, of opiates or sedatives, it is best to initially stop for a few hours and then see what happens to the patient, and then re-start the infusion at a lower rate. That is best practice if someone is clearly overly treated. It is reasonable if they are not in an immediately life-threatening situation to reduce the infusion.

Q If we have a look at Code A note on 24 September – it is page 645 if anybody wants to turn it up but it is revealed in our chronology at page 15:

> *"Remains unwell. Son has visited again today and is aware of how unwell he is: sc analgesia is controlled pain just. Happy for nursing staff to confirm death."*

And over the page, at the top of page 16, Code A

> *"Report from night staff that Code A was in pain when being attended to, also in pain with day staff, especially his knees. Syringe driver renewed at 10.55 with diamorphine 50 mg, midazolam 80 mg and hyoscine 800 microgram. ... Code A seen by Code A this afternoon and is fully aware of Code A condition."*

Can we just look at the drug charts set out at the bottom of page 16 of the chronology:

> "Diamorphine: 40 mg/24 hrs administered at 10.55"

This is all on 24 September. Then, on the same day:

> "... increased to 60 mg/24 administered...".

A Yes.

Q So within a 24 hour period, unless I am misreading it, just looking back at page 15, on the 23rd he had been on 20 mg diamorphine and by the end of the 24th he was on 60 mg of diamorphine?
A Yes.

Q The midazolam, he had been on 20 mg on the 23rd, and we have already looked at that – there was that threefold increase.
A Can I comment? I find it difficult to know how the nurses could assess the pain was in his knees at this point. He had a very marked depressed conscious level so I find that comment slightly surprising. I would have thought it would be difficult for them to gain an

idea where his pain was. I can only assume when he was being moved he was making noises which led nursing staff to believe he was in pain.

Q Can we carry on, please, we see at the bottom of page 16 that the syringe driver continues. Over the page, now on 25 September, we can see that the driver is recharged with 60 mg of diamorphine and 80 mg of midazolam. At the bottom of the page, Code A has re-prescribed the diamorphine, this time with a higher starting dose, of 40 – 200 mg. Midazolam is prescribed again, as is hyoscine. The diamorphine continues to be given at 60 and the midazolam at 80. Over the page, at page 18, we are on to the 26th, the note is:

> *"Condition appears to be deteriorating slowly. All care given. Sacral sore redressed. ... Driver recharged ..."*

and, again, it has gone up to 80 mg of diamorphine and 100 mg of midazolam. If we go back to the notes at page 647, we can see that there is a note on 25 September by, I think, Code A ?

A Yes.

Q

> "Remains very poorly on syringe driver
> For TLC."

By this stage, what sort of condition is the patient going to be in?

A He is dying. With those doses of midazolam in particular and diamorphine, he is bound to be deeply unconscious. It is a very high dose of a potent sedative drug.

Q This patient, I think we all understand, is not being hydrated.

A Yes. At this point, the decision has clearly been made that he is dying; he is not for hydration or nutrition. He is moved into this at that early period. Once he has a depression of his consciousness level, it would seem he is on at that point an end of life pathway.

Q So from the point on 21 September, after his agitation, he is put on the syringe driver and it is increased either with diamorphine or midazolam on I think a daily basis. By this stage on 26 September, in your view is he going to be saying anything, is he going to be rousable?

A No, he is not. I just think it is an unusual approach to managing the problem. I think most geriatricians faced with this type of problem would have carried on with intermittent prn morphine at this stage and would have given a prn variable dose of an antipsychotic, such as haloperidol or thioridazine would have been used, and one would have observed the response. One would not have started an infusion at this point.

Q We can see that the patient died at 11.15 p.m. on 26 September. In your view, would these drugs have had any significant effect on that event?

A I actually think it would be difficult to conclude that the drugs did not play some part in his death through causing deep sedation and respiratory depression, but equally the literature is unclear about people who are clearly having palliative care – this is often cancer patients – as to whether sedation therapy significantly shortens life. But in this patient, who was not initially in that setting, I think the fact that he became unconscious, it is very likely that drugs contributed to respiratory depression and him getting bronchial pneumonia. But he

was at high risk of getting bronchial pneumonia and dying anyway, so again you cannot conclude that the drugs definitely caused his death.

Q At the time that he was transferred on 21 September, he was supposedly destined by Code A for a high protein diet.
A Yes.

Q Does any of that plan in fact appear to have been put into action once he had got to the GWMH?
A No. The plan appears to have been changed by the behavioural problems and the institution of the diamorphine and midazolam infusions at that point. When he was admitted, Code A note still indicates there was a plan to try and improve this man's function and his pressure sore.

Code A That is all that I ask about this patient. I suspect that would be a convenient moment to break.

THE CHAIRMAN: Yes, particularly as there will be a need for certainly the Panel and I guess yourselves to be organising those papers which you need to take out of the room tonight, since it will not be available to us tomorrow. Thank you. We will resume on Friday at 9.30.

(The Panel adjourned until 9.30 a.m. on Friday 10 July 2009)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 10 July 2009

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

Chairman: Code A, LLB JP

Panel Members: Code A

Legal Assessor: Code A

CASE OF:

Code A

(DAY TWENTY-TWO)

(Proceedings in private)

Code A of counsel and Code A of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

Code A QC and Code A of counsel, instructed by the Medical Defence Union, appeared on behalf of Code A who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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(Proceedings in private)

Code A: Sir, I mentioned Code A by name. I realised what I had done moments after, but I thought it best to carry on rather than cause a fuss then which would highlight any problem. I do not think there is any need to do anything about it because I do not think the press will make any link between that revelation of a name and the witness we have heard from ---

THE CHAIRMAN: No. I had received a note from an alert Panellist on that very point. My view was that you had before Dr X first gave evidence on a number of occasions referred openly and I took the view that this was not probably a slip on your part, but merely the need not to refer to the doctor by other than the acronym was restricted only to the time when she was actually giving evidence and around that period when the press might have picked it up.

Code A: I am very grateful. It was a slip. I was not thinking, but I do not think it matters and I think from now on we can refer to Code A

THE CHAIRMAN: Thank you for that. Code A, any view on that?

Code A: I agree on that.

THE CHAIRMAN: Thank you. We will take 20 minutes now, so just after eleven o'clock, please, ladies and gentlemen.

(See separate transcript for proceedings held in public)

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THE CHAIRMAN: Welcome back, everyone. I hope everyone has been able to get their files back to the position they were in before we had to break. I know there were some concerns that some pieces of paper had migrated, but on our side we are now all back firmly as we should be. Over to you, Code A

Code A, Recalled
Examined by Code A, Continued

Q Code A we were just going to move on to deal with the case of Code A Patient H. You are still on oath of course.
A Yes.

Q I think everybody has received the new chronology for this patient. So far as Code A is concerned, this is the gentleman who had been diagnosed with alcoholic liver disease.
A Yes, correct.

Q We will look at that in more detail in due course, but you revealed to us when you began giving evidence that that may have an effect on the use of opiates.
A Yes. Two reasons. One is that a reduced dose is recommended in patients with cirrhosis established damage to the liver, because there may be less metabolism of the opiate drugs by the liver. Secondly, patients with liver disease can develop confusion due to hepatic encephalopathy and opiates can precipitate that. So for those two reasons, it is mentioned as a reason to proceed cautiously in terms of using opiates in patients with liver disease.

Q This gentleman we know had a fall. He fractured his left humerus on 21 September 1998 and he went into the Queen Alexandra. As we see on 22 September, an x-ray revealed some displacement of the fragment, but he was not keen to undergo surgical intervention. Indeed, that is what happened: he never had that arm fixed?
A Clearly I am not an expert in this areas, but it is a fracture that is not always surgically repaired, but my understanding was that in his case it was thought desirable to repair it to obtain a better healing result and to reduce pain, which was significant.

Q We see with this gentleman, as time went on, that in fact it did cause him pain when he banged it or moved.
A Yes.

Q On 24 September we see that he was given diamorphine for his pain at a rate of 2.5 mg. So that would be a single injection, would it?
A It would.

Q Then he was given a further 2.5 mg, a total of 5 mg, he was given codeine phosphate and then from then on, as we look through the chronology from 26 September 1998 onwards, he is in general given co-dydramol and then moving on to paracetamol. There are occasions when he refuses the paracetamol. On 31 October we see there is an entry on page 12 of the chronology, "Discomfort continues on movement". And there is reference there to a pressure area to the sacral, red but still intact. He is boarded, which presumably means prescribed, morphine.
A Yes.

Q 2.5 mg for his painful arm, because oral analgesia was refused. On 5 October there is a remark that he had knocked his left arm, that he was not very alert am, but in the afternoon he was very alert, his speech was clear, he was in some discomfort but he was still refusing paracetamol.

Code A (Speaking off microphone, in audible)

THE CHAIRMAN: Please use the microphone, Code A. I should say that I have noted there are one or two occasions where the transcript reads "Inaudible" as a result of somebody from the other side of the room speaking without the microphone. It really is useful if we can have the words recorded.

Code A I think Code A was just trying to give me a prompt.

Code A It is my fault mostly I think. Might I just invite my learned friend to draw attention to the fact that on 4 October there is morphine? He had moved on to the 5th. That is all.

Code A There are occasional references throughout I think to him being given morphine on occasions when he had pain.

A Yes.

Q The amount of morphine that he was given on 4 October was 2.5 mg. Then we can see he was given 2.5 mg on 5 October. Again, I am trying to skip through it quite quickly. There are comments about his left arm being bruised and sore and he is still being given paracetamol. Then on 8 October, he was reviewed by Code A and we heard from her.

> "Had impaired rental function, active alcoholic hepatitis and hypothyroidism. Was treated with IV fluids and gradually improved. Now eating and drinking well, appears much brighter in mood."

Then towards the end of that entry we see:

> "Left hand grossly swollen and bruised. Marked oedema of both legs. Mobility remains poor. May have developed early dementia. Might be early Alzheimer's Disease of vascular type dementia. Also depression."

At the bottom of the next entry, we can see – this is page 17 – there is a nursing note:

> "No longer requiring acute bed. At risk of self injury, hand very oedematous + at risk of breakdown due to low albumen."

Then three lines down:

> "Very chatty and funny ... Sacral cleft quite red .... "

Then right at the bottom, we can see:

A "Communicating quite well although varies according to mood. Asked doctor to consider stronger analgesia. Now prescribed codeine phosphate .."

We can see that that was administered together with paracetamol. Over the page, at the bottom of the page, codeine phosphate and paracetamol were administered. That continues. On 13 October we see that his weight was up to 114 kilos, which by my reckoning is about 17½ stone. Then we can see at the bottom of page 23, he is on codeine phosphate 30 mg and
B paracetamol, and he is then transferred to Dryad Ward for continuing care.
A Yes.

Q I am not going to turn them up, but we have the clinical notes of Code A at page 180, when he was reviewed. "HPC", is that history of presenting complaint?
A Yes.

C Q

"Fractured humerus ..."

Then there is a date –

"[Past medical history]: alcohol problems, recurrent oedema."

D

What is CCF?
A Congested cardiac failing.

Q Then:

"Needs help with activities of daily living. Hoisting. Continent. Barthel 7. Lives
E with wife Code A . Plan gentle mobilisation."

So there is a reference there to alcohol problems. We do not know if the notes were with her at that time or not, but she was plainly aware of an alcoholic background.
A Yes. That might mean alcohol problems in terms of abuse and the effect on his mood and depression or it could obviously also mean alcohol problems in terms of liver complications or indeed both.

F

Q We can see, if we go to pages 24 and 25 that Code A prescribed Oramorph 5 to 10 mg four hourly. We can see that there is a nursing reference on page 24 in the middle of the page:

"Restless at time. Used urinal with assistance as he wanted to stand. Oramorph 10 mg given for pain control."

G

So this is on the day of his admission to Dryad.
A Yes.

Q His last morphine by my reckoning was on 5 October, when he had had 2.5 mg. Now he is given 10 mg for pain control on the basis of Code A prescription. Can we have a look at that prescription at page 25 of the chronology? She has written him up for 2.5 to 5
H mls (5-10 mg) four hourly as required, but it is actually given to him twice on the day of his

admission at a rate of 10 mg. So 20 mg on the day of his admission. Just pausing there for a moment, I think you dealt with this both in your police report at page 5.11 and also in your GMC report at paragraph 11. What is your view, please, about the appropriateness of that prescription at that time or Oramorph?

A I think it would have been preferable to establish him on regular moderate opioid analgesia with paracetamol. He had been getting, if I have interpreted the prescribing correctly, intermittent doses of codeine at 30 mg and I think it would have been most appropriate to continue paracetamol regularly and increase the dose of codeine to say 60 mg four times a day. He had not had that level of regular moderate opioid dosing prior to his admission to Dryad Ward as far as I could tell. The dose is a large increase on what he had been having before of intermittent doses of 2.5, so I think it would have been reasonable, if one had decided he was unlikely to be controlled or had not been controlled on the moderate opioid, to start with a more cautious dose of 2.5 to 5 mg, given his liver disease and given that is what had been given before. But I think best practice would have been to go through the analgesic ladder through a moderate opioid to begin with, with paracetamol, and then add in prn available the morphine. So I think the 10 mg is in my view an excessive dose, given his age and liver disease.

Q Does it make any difference that this is to a one-off dose, as it were? It is 10 mg four hourly.

A Yes, because he has only had intermittent doses, much lower doses, so far, so there is a high risk that 10 mg four hourly is likely to potentially produce problems in terms of the adverse effects we have talked about before.

Q I will not ask you to go through them again. In addition to that prescription, as we can see from the chronology at page 25, Code A wrote up a prescription for 20 to 200 mg of diamorphine, 200 to 800 mcg of hyoscine and midazolam of 20 to 80 mg. Just dealing with the diamorphine – again, I am not going to ask you to deal with the range – does what you have said previously in relation to the range apply equally or with more to this particular patient?

A It applies with I think more force for this particular patient because of the risk of precipitating an encephalopathy in a patient with established chronic liver disease.

Q In relation to midazolam?

A Again, patients with cirrhosis are at risk of developing hepatic encephalopathy, liver failure, from benzodiazepine drugs, including midazolam.

Q On the day after his admission, 15 October, if we turn over to page 26, we can see that he was commenced on Oramorph 10 mg four times daily. Oramorph 20 mg was given to him at midnight with what is described as "good effect". Then the note – I take this to be the morning of 15 October – Oramorph 10 mg was given at six o'clock. Then:

> "Condition deteriorated overnight. Very chesty + difficulty swallowing medication. Incontinent urine ++"

Do you have any view as to what may be causing this patient's deterioration overnight?

A I think one would have to consider that it was due to the opiates, because he has just been commenced on those and he has deteriorated after a few doses of morphine at a higher level than he has received before. So that would be the key concern, the most likely cause of deterioration. Clearly there could be other causes: he could have developed an infection or

A other problems, but one would have to consider the opiates as in my view the most likely cause of his deterioration overnight.

Q We can see at the bottom of page 26 that in fact on 15 October, he was given what I think is a total of 50 mg of oramorphine, the maximum dose he had been on at the previous hospital had been 5 mg daily.
A Yes.

B

Q At the top of page 27, he was reviewed by Code A. We have this in our clinical notes again. This is a Friday, 16 October 1998:

"Declined overnight with ..."

Is that shortness of breath?
C A Yes. I would interpret it as that.

Q Then:

"[On examination] bubbling. Weak pulse. Unresponsive to spoken orders."

Although this patient had been in pain previously from his arm when he had knocked it on
D occasions at the previous hospital, this is the first time we have seen this sort of note about this patient.
A In terms of his - ?

Q Unresponsiveness.
A Yes, that is my understanding. At no point before has he been described as unresponsive that I could see.

E

Q Then there is a significant event raised by a nurse:

"Seen by Code A am as deteriorated overnight. Increased frusemide to 80 mg daily."

Frusemide is not going to be having a sedative effect, or is it?
F A No. It should not do. Again, diuretics can sometimes precipitate encephalopathy in patients with liver disease, but ---

Q Encephalopathy. Can you just explain that?
A This is liver failure. The liver normally rids the body of breakdown waste products and if you have damaged liver, these accumulate and they can cause a confusion and drowsiness because they are not eliminated from the bloodstream. But I think frusemide
G would not be likely to be a precipitating factor in this patient.

Q Then we can see that the decision is taken apparently by a nurse, but this may have been in conjunction with a doctor:

"Syringe driver commenced. Wife informed ..."

H Can you see any basis here for commencing a syringe driver with this patient?

A A No. I could not see a basis for prescribing the initial as required infusions of diamorphine and midazolam and I am critical of the assessment by Code A in not perhaps considering the role of opiates and undertaking more investigation. Whether he or she considered this patient was not for active treatment and investigation beyond giving frusemide is not entirely clear.

B Q The note we see by the doctor following "Seen by Code A" is "For ANC". All nursing care. Then the syringe driver is started. The syringe driver was started, as we can see over the page at the top of page 28, following 30 mg of Oramorph having been given to the patient up until two o'clock that afternoon. Then at 4.10 the syringe driver is started apparently with 20 mg. That is the lowest dose possible, as it were, on Code A prescription.
A Yes.

C Q But, as you have told us, I think it is actually equivalent to the 60 mg dose of ---
A On the usual conversion, yes.

Q Then we can see the next entry is a review by Code A, from whom we heard:

"Comfortable but rapid deterioration. N/S to verify death if necessary."

D We have heard about that. Then the syringe driver is renewed, this time by Code A We can see at the bottom of page 28:

"Slow deterioration in already poor condition. Requiring suction very regularly – copious amounts suctioned. Syringe driver renewed at 15.50 with diamorphine 40 mg midazolam 20 mg ...."

E So that perhaps obviously is a doubling of the diamorphine and now midazolam is added. Can you see any basis for this?
A I could not. The notes - both medical notes do not provide any description of the symptoms and whether he is in pain, and the nursing notes do not either, so on the basis of the information in the medical notes there is no clear justification for the escalation and increase in doses.

F Q In fact, the note by Code A is "slow deterioration in already poor condition".
A Yes. I think none of the doctors who saw Code A or the nursing staff appeared, on the basis of the information that is available in the notes, to have considered that the drugs he had been started on could, in fact, be the cause of his deterioration. Instead it was assumed to be heart failure or other problems not described, and that he required more palliation from these drugs.

G Q On page 29 we can see the record of the dose being increased, and then the following day, 18 October, Code A records:

"Further deterioration in already poor condition. ... Syringe driver renewed ..."

This time with 60 mgs of diamorphine and 40 mgs of midazolam. We have seen the addition of midazolam earlier, but what would be the purpose of adding midazolam?

H

A A Well, as described in the Wessex protocols it is for the treatment of terminal restlessness. I think it is important to emphasise that a patient may be deteriorating but that does not in itself act as an indication to increase doses of opiates or sedative drugs. Those should be increased for specific control of pain or terminal restlessness, not because a patient is slowly deteriorating in itself.

Q Then moving on to the following page, page 30, we can see that that syringe driver was
B recharged. It is administered at 1450 at the higher dose of 60 mgs diamorphine, and a doctor at the same time has prescribed 1200 micrograms. That is to deal with secretions?
A Yes.

Q And the midazolam has also been administered and then that evening, eight hours later, the patient dies.
A Yes.

C

Q The cause of death is given as congestive cardiac failure, renal failure and liver failure. In your view what contribution, if any, would diamorphine and midazolam appear to have made to this patient's death?
A Well, in my view, I considered the drugs had led to his deterioration and contributed to his death. Clearly he had other serious comorbidities, including liver disease and clinically evidence of heart failure, so one cannot say that the drugs were the only cause of his death,
D but in my view they were most likely a contributory factor.

Q As this patient deteriorated, in your view, certainly potentially because of the drugs he was being given, if there had been concern about what was causing that deterioration, what could Code A have done? Or what should Code A have done?
A Obviously, if drugs are considered to be a cause of deterioration one discontinues them and observes if you see a response, and you also examine the patient for signs of toxicity due
E to the drugs, so one could examine for signs of encephalopathy, although he may not have been well enough at this point to see if he had a liver flap, which is where the hands shake due to the accumulation of breakdown substances. Clearly there were opportunities; a number of times he was seen to look at this, the first time by Code A and also I think particularly the second time when Code A saw him.

Q That is all I am going to ask you about that patient. We are going to move on, please,
F to the case of Code A. This patient we see was born in February 1907 and was admitted to the Royal Haslar on 19 March 1999. She had had a fall and she had fractured her right hip. She had had a fall because she had been walking her dog, it would appear, and had been pulled over by her dog. She is described on page one of the chronologies as living alone, self-caring and independent. On examination at the hospital she was "well alert + orientated". I do not know if that means "and orientated" or ---
A It means "and". "Alert and orientated".

G

Q "Abraded right forearm/elbow", so it looked like she had grazed her elbow in the fall.

"Plan: Admit... Takes no drugs and has no other health problems. Non smoker. Has a brandy and ginger every morning at eleven."

Indeed, later I think we see that actually prescribed at the hospital, which is rather a nice
H touch, but in any event she had no difficulty breathing, a small appetite, loved to walk her

dog and do the garden, slept a lot, always falling asleep in the chair, and is described as alert and understands everything, although a little deaf. She is given diclofenac and paracetamol. Diclofenac is?

A A potent non steroidal anti inflammatory drug.

Q And she is operated upon. She was given morphine and at the bottom of page 2 we can see that she seemed to have reacted to that by having hallucinations. There is a note "therefore nil further opiates". We know, in fact, she was given opiates at that same hospital later on.

A Yes.

Q But hallucinations from morphine, is that a fairly well-recognised side effect?

A Yes. It is one of the manifestations of confusion produced by opiates in some older people.

Q We can see that at page 3, the patient was complaining of discomfort in leg and pain on palpation, otherwise nil else. We can see that she was given paracetamol and 2 mgs of morphine and then 5 mgs administered twice. On 21 March Code A is described as being able to get into a chair. "Please give her morphine before moving" because "there is a lot of pain on movement. Push fluids as much as possible ... urine output poor", but then it is described as improving. Then she is reviewed late in the evening by Code A "Urine output abysmal but patient not complaining of thirst", and then this:

"Clinically this lady is slightly dry but not excessively so but when UO" ---

Is that --- ?

A I would determine that to be "urine output".

Q "Taken into account she is in acute pre renal failure. Urgent U + Es requested."

Acute pre renal failure. What is the significance of that?

A It means the clinical assessment is that she is dehydrated, she has reduced blood volume, this obviously is a common problem following surgery, and the kidneys are not being adequately perfused so they are not doing their job as well as usual, and the urea count may be increasing, so the treatment for pre renal failure, renal failure in the early stages, is to correct the hypovolaemia and to give the patient more fluids.

Q "Note: right hip painful +++ no ooze but thigh enlarged."

Ooze would be an indication of infection?

A I do not wish to comment outside my area of expertise. Blood leaking through the wound I would have thought would be the reference here, the concern that she is bleeding, and the ooze would be a reflection of blood coming out of the wound, perhaps suggesting she is bleeding into the wound would be how I would interpret this as a non orthopaedics specialist.

Q And we can see the thigh is large: "Possible bleed into thigh but no evidence of hypovolaemia."

A There is a slight contradiction there. The clinical impression by Code A is that she may be in pre renal failure due to hypovolaemia, and then his assessment appears to be that

A there is no hypovolaemia. I think he would be making that judgment but the blood pressure chart, would be my impression.

Q She is given paracetamol and morphine again, and we can see the following day: "Poor oral fluid intake".

> "Sat out by physios. Drinking and eating much better today. Oral fluids pushed. ... B Urine output monitored. One hourly measurements satisfactory. ... large amount of ooze. Paracetamol."

Page 6: She removed her catheter. "Patient has difficulty and pain ++ with mobility." She can wash her face and upper torso. "Redressed ulcer on right leg, "Transferral and mobilising not well. No ooze on wound". I think she was reviewed by Code A on that day but I will not go to that for the moment. Paracetamol administered, and then over the C page we see she is referred to Code A and reviewed by Code A, where we can see in the first row: "Has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult. [Her] quality of skin, especially lower legs, is poor, and at great risk of breaking down."

And then in the next entry:

> D "Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful",

and he described to us how what that meant was simply lifting the leg without the patient putting pressure on it herself. That would cause the patient pain?
A Yes.

E Q And then Code A writes at the top of page 8 of that chronology:

> "Still in a lot of pain, which is main barrier to mobilisation ... could her analgesia be reviewed?"

She is given paracetamol. At the bottom of the page in the chronology:

> F "Skin tissue-paper thin + very fragile. Haematoma developed + broken down".

Paracetamol again, and then we can see on page 9 on 26 March she is transferred to Dryad Ward, and the transfer letter revealed that,

> "She is now mobile from bed to chair with two nurses and can walk short distances with a zimmer frame. No urinary catheter. Sometimes incontinent at night. Skin on G lower legs paper thin. Right lower leg very swollen and has a small break on the posterior aspect. Needs encouragement eating and drinking but can manage independently. Her only medication is analgesia (paracetamol) PRN".

She is then reviewed on arrival at Dryad by Code A

H

A

"[History of presenting complaint]. Fractured [neck of] femur [right] 19 March 1999. [Past medical history]: Nil of significance. No weight bearing. Tissue paper skin. Not continent. Plan sort out analgesia."

We can see that there is a nursing note.

B

" ... complained of a lot of pain for which she is receiving Oramorph regularly now, with effect."

And we will look at the prescription written out by Code A but while we are on this page at the bottom we can see: "Requires much assistance with mobility ... Oramorph given 10 mgs at 23.15 + 5 mg [the following morning] at 06.50".

C

If we now look to the prescription, page 11, Code A prescribed 2.5-5 ml (5-10 mgs) "PRN subcutaneously". I do not think that can be right, can it?
A It may be as a - it probably would be - let me just check. I had it recorded as "subcutaneous" when I reviewed the notes.

Code A: I do not think it is "subcutaneous", in fact.

D

Code A: Can you just help us with that? "Oramorph subcutaneously". I think you have mentioned that previously but can you just help us ---
A Well, Oramorph is oral morphine, it is the trade name for oral morphine, so it cannot be given subcutaneously, so I suspect that was a prescribing error by Code A But obviously that would be my assumption, unless the intention was to prescribe morphine subcutaneously, in which case one would just write "morphine".

E

Code A: If we look at page 160 I think, I may be wrong, that is the prescription.

Code A: We are just trying to get the original so we can read it better.

Code A: The hole punch of mine is obscuring what I think may be "oral", but we will see.

F

Code A: Can I pass it to the witness so he can give us some evidence about it?
A Looking at this I think it is "oral", re-looking at it, and I think I have misread that because it is not entirely clear if it is "subcut", but as I have indicated certainly page 160 is "oral", I think.

Q The other document you have been given is our copy of page 164, which starts with Oramorph at the top.
A As I say, I am sure that is correct, because one would not prescribe Oramorph subcutaneously. So I think I must have misread that, because it was slightly unclear in the copy I have.

G

Q Can I suggest for the moment we put a bracket round "subcutaneously"? We will hear evidence about it in due course.

H

Code A: May I suggest we just put a line through it, because it is not subcutaneous.

Code A: I agree. It is simply I heard Code A said it was subcutaneously so I presumed those were his instructions. We can put a line through it. (To the witness) Let us stay with that prescription now for the moment. Bearing in mind the previous opiates that this lady had received – she had been on paracetamol for the days leading up to her admission – it is right to say that there had been that comment by Code A, "Please review analgesia".
A Yes.

Q Just staying with this for a moment, Oramorph 5 to 10 mg as required and a regular prescription of 5 mg four times daily and 5 mls at night, or 10 mls at night. An appropriate prescription in your view for this lady, or not?
A Again, if she is in pain, one would want to try regular analgesia with a moderate opioid to begin with, such as codeine or similar opioid drugs. As was discussed in some of the previous evidence, there is a conflict or a change between her description of how she is at her preceding hospital, where she is apparently mobilising without pain, although Code A had noted there was pain on moving her hip, and then on arrival at Dryad Ward, where she is not mobilising and reported to be in pain.

Q Would that require a review by Code A or a doctor as to the reasons for that change?
A I state in my report that I could not see a record of a physical examination of the hip and that would be the first thing one would do if there has been a change in function and pain has increased, to examine the hip and see if there is any evidence of a change in the hip function.

Q We have seen previously that there have been examinations of the hip, there have been references to it "not oozing, but it is swollen", et cetera, et cetera. How long would such an examination take?
A If a patient is lying on the bed, one would examine – the patient would need to be undressed of course – you would examine the leg and see if it was shortened or externally rotate it of course and one would then generally see if the patient could move their leg voluntarily and then one would lift the leg oneself and you would see if lifting up the leg, bending the knee and doing internal/external rotation would elicit any pain or symptoms and one would expect the wound, because there had been a concern about infection, one would ask the nurses to check the temperature. It would not take particularly long. Often, the delays in examining patients in this setting are if they are not in bed and you need to ask the nursing staff to come along and get the patient ready and undressed and onto the bed. That actually can often take longer than undertaking the examination itself.

Q We can see on page 11 that three doses of 5 mg are administered and one dose of 10 mg. That is 25 mg given apparently on the day of her arrival. How significant an increase is that compared to what she had been receiving?
A She had only received – sorry, I am looking to where I referred to this in my report.

Q I think it is paragraphs 9 and 10 of your GMC report and.
A We are referring now to the prescription on - ?

Q On the day of arrival, 26 March, and the fact that she is actually administered 25 mg on that day.

A A It is a high dose to start with. She is very elderly and one would start with 2.5 to 5 mg. That is what one would wish to start with.

Q Can you see what happened the next day? If you go to the top of page 12 of the chronology, the drug chart indicates 2.5 mg was administered or Oramorph and then discontinued. Then Code A re-prescribes and this time it is 10 mg four times daily, plus 10 ml, meaning 20 mg, at night. So that is actually a prescription for 60 mg on the second day.
B What is administered to the patient is two 10 mg doses and a 20 mg dose, I think we can presume that was at night. So she is given 40 mg on day 2.
A A lot would depend on her clinical state and whether she had had any response to the previous doses of morphine and if this was a lady who was in pain, severe pain, and it was not controlled by those previous doses, it would be reasonable to increase the dose, but the notes do not contain a clear description of her pain control.

C Q There is a comment we see in the middle page 12:

"Having regular Oramorph but still in pain. Used commode, passed urine. In some pain, needs two nurses to transfer."

A I think I have commented it is appropriate, even if the original dose might not be what
D was recommended, if she is in pain and she has not had any major adverse effects from that, it is reasonable to increase it, but one needs to monitor any response to the increased dose.

Q To what extent does there have to be a set-off between the sort of pain that a patient is willing to undergo to deal with in order to mobilise and making the patient completely pain free? What is one's aim?
A One's aim is to achieve analgesia and pain control without producing adverse effects
E which produce other problems. If you make a patient drowsy or confused from opiates, they are not going to mobilise because of the confusion or drowsiness. So there is a balance that has to be struck.

Q We can see at the bottom of page 12 that Oramorph was continued, but then over the page, we see a reference to this patient having vomited Oramorph. I suppose that might be consistent with the patient's adverse reaction.
F A Yes. Nausea and vomiting are common and the usual response to that in the first instance is to prescribe anti-emetics to control nausea or vomiting.

Q What Code A actually did was to prescribe metoclopramide. That is - ?
A That is an anti-emetic.

Q So that is to deal with the vomiting?
G A Yes, and that is an appropriate response.

Q Then we can see that in fact the next day she is brought down, as it were, to using co-dydramol.
A Again, I think that is an appropriate response. It was really what I was indicating would have been the preferable response initially, but I think where there has been adverse symptoms secondary to the morphine, that is exactly the correct approach to take: to re-
H evaluate and try and see if you can get pain control on a milder opioid.

Q Then on page 14, we see that she has a small area near the top of her wound which is oozing, she is sat out in a chair for assisted washing and dressing. Then we can see on 31 March that she is back on the Oramorph, a small amount of oramorphine, co-dydramol and then MST is prescribed. Those are the slow-release tablets.
A Yes.

Q Because they are slow release, they act over what, a 12-hour period?
A A 12-hour period usually, yes.

Q Is there a period where they are building up to their effectiveness, or do they have an immediate effect?
A As I explained before, because they release it more slowly, you would not want to treat somebody in acute pain or start with sustained release morphine, but of course this lady has had intermittent doses of opiate, or Oramorph. There has been an assessment of her response to that and so that is a reasonable approach.

Q Then we can see at the top of page 15:

"Walked with physiotherapist this am but in a lot of pain. Physio demonstrated ...

I suspect to the nurses –

" ... how to get Code A from chair onto zimmer frame."

Then there is further reference to having pain on movement in the penultimate entry. She then remains on MST. I am not going to go through these in any detail until we get to page 18 and 7 April.

Code A: Perhaps we can just note any complaints of pain on page 16 and any others.

Code A: She is still complaining of pain on movement on 3 April.
A I think the key issue in this lady at this point was that one would not expect her to be having severe pain after surgery at this time point. So the treatment of the pain is appropriate, but the question should be being asked is why she has severe pain. One should not be requiring strong, potent opioid analgesia this long after hip surgery.

Q Her surgery was back on 20 March.
A Yes.

Q So we are almost three weeks on.
A Yes. So the concern is that there is a complication and a problem, as has been discussed previously.

Q Which should lead to what?
A To an evaluation, x-ray and discussion with the orthopaedic team.

Q Can we have a look at page 18 of the chronology? This patient is seen by Code A on 7 April and reviewed by Code A notes:

A

"Still in a lot of pain and very apprehensive. MST [increased] 20mg [twice a day] yesterday"

So that is up to 40 mg of painkiller?
A Yes.

B Q Then it says, "Try adding flupenthixol."
A This is an antipsychotic drug. It is actually a depo preparation, so if you give it, it will have sustained effects for probably at least two weeks.

Q Then there is this note:

"For x-ray [right] hip as movement still quite painful – also, about 2" shortening [right] leg."

C

Is that a significant note?
A Yes. Obviously Code A had reviewed the hip, because of the continuing pain and the shortening suggests there may be a problem in terms of dislocation or fracture or, as was discussed by him, problems with infection and destruction of the head of the femur or acetabulum?

D

Q So the purpose obviously is to find out what is causing this patient's pain and see if it can be fixed?
A Yes. Absolutely.

Q On 8 April, we see the MST continued, this time we are now up to 40 mg daily, on 9 April there is a note:

E

"To remain on bed rest until Code A sees x-ray of hip ..."

Obviously if there is a disintegration of the hip or there is a collapse of the operation for any reason, presumably they would not want her mobilising.
A No. There would have to be a discussion with the orthopaedic team as to what the appropriate future management would be.

F

Q At page 20 we have the note "Appears to be leaning to left". As we will see later on, there seems to have been an inference drawn from that, perhaps among other indications, I do not know, that she has had a CVA.
A A stroke, yes. As a stroke specialist, we would not say that was specific enough to give a high possibility or even moderate possibility of a patient having a stroke. One needs to have a neurological examination performed to see if there are any focal neurological deficits to support the impression that there may be a stroke diagnosis. But there are many other reasons why she might have been unsteady on her feet, of which one might be the opiates she is receiving at this point.

G

Q We can see on page 20 underneath that:

"Does not appear to be as well and experiencing difficulty in swallowing. Stitchline inflamed and hard area. [Complaining of] pain on movement ..."

H

Does "stitchline inflamed" indicate potentially a stitchline infection?
A I would take it – again, not as an orthopaedic expert – to indicate signs of a wound infection.

Q At page 21 of the chronology:

"Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way. Did settle for long periods.

... In pain on movement. Oramorph 5mg given."

Then there is a review by Code A on that day. This is noted not I think in the clinical record, but it is noted in the significant events by a nurse:

"Nephew telephoned at 19.10, as Code A condition has deteriorated during this afternoon. She is very drowsy – unrousable at times. Refusing food and drink and asking to be left alone. Site round wound ... inflamed ... Code A denies pain when left along, but complaining when moved at all. Syringe driver possibility discussed ..."

She is reviewed by Code A There does not appear to be any note about whether the x-ray has been taken.
A Yes.

Q What are Code A duties, if any, at this stage?
A As the doctor responsible for day to day care of the patient, that would include responsibility for ensuring the x-ray had happened and finding out the results of that x-ray.

Q We can see that a syringe driver is now being discussed. We can see that she is given I think a total of 45 mg of morphine, 5 mg by way of Oramorph and then two 20 mg doses. She is reviewed by Code A

"Now very drowsy (diamorphine infusion established)"

Let jus just pause for a moment and go to page 23. What appears to have happened is that prior to Code A seeing her, Code A has prescribed, following the discussion about a syringe driver, a variable dose of between 20 to 200 mg by subcutaneous infusion together with hyoscine, together with midazolam at 20 to 80 mg and the syringe driver has in fact been started at 80 mg administered at eight o'clock in the morning together with midazolam at 20 mg. That is the starting dose.
A Yes.

Q What do you say about that as a starting dose via a syringe driver?
A Just before I comment on that, obviously this patient has a number of problems. She is drowsy, almost certainly due to the opiates that she is on, and there is evidence that she is in pain when she moves. So you have adverse effects and you also have evidence that she is still in pain. So this is a very difficult position, because it is clear if you are going to increase her opiates to try to control her pain, she is going to be – a depression and conscious level is going to be even more depressed. So one would first of all want to have a clear agreement about what the management plan is: is there any attempt to investigate further what the

underlying problem is and treat that? Has a decision been made that there is no further effective treatment and one is in the end of life palliative stage? But one would want to be particularly cautious about increasing the opiates. So one would want to only do the 30 to 50 per cent increase and hope tolerance came to the drowsiness in a patient who is experiencing the probable adverse effects and the opiates are the most likely cause. So reviewing the notes at this point, she has had 45 mg of oral morphine a day. I think that is 20 and 20 and the 5, which is equivalent to 50 mg of diamorphine, over 24 hours. So if one increases that by a third or a half, on the basis she has some pain, one would reasonably give 20 to maybe 25 mg of diamorphine over 24 hours. So the commencement of 80 mg is clearly much, much greater than one would administer if one were going by the guidelines. In this patient, because she has evidence of adverse effects already, I think one would have to have very good reason not to follow the generally accepted guidelines of a 30 to 50 per cent increase.

Q You mean you would go less?
A Certainly less. As I say, a reasonably appropriate dose to give to control would be somewhere between 20 and 25 mg of diamorphine over 24 hours in the first instance and then review response.

Q What would be the likely effect of this, which is I think a four to five-fold increase?
A That she would become very drowsy and it could suppress respiratory function.

Q That prescription is in fact reduced by Code A It is administered via a syringe driver between eight o'clock and 1640. Then at 1640, that is discarded and he has halved it down to 40, but that is still above what you thought would be an appropriate dose in any event.
A Yes, it is. My view was that that reduction probably was not sufficient to prevent the toxicity she was experiencing at this point in terms of having a depressed conscious level. She is described as very drowsy and unrousable at times.

Q The midazolam. Can we deal with that for a moment? It is originally prescribed at 20 to 80 mg. Again, I have not asked you about the variable range; I do not want to take more time doing that. She is administered 20 mg of midazolam coupled with the 80 mg of diamorphine. Dealing with that first of all, from what you have told us already, that is going to have an effect on her sedation.
A Yes, it is. Whilst there is an indication that she is clearly in pain and requires analgesia, again, going back to the indication for midazolam, it is for terminal restlessness and it will clearly depress conscious level. It is a large starting dose for a very old lady.

Q Code A having reduced the diamorphine, what appears to have happened is that a nurse has followed his directions on the diamorphine, but for one reason or another has increased the midazolam, doubled it.
A Yes. Again, without the notes clearly describing the rationale for doing that or a clear protocol or consideration of the potential consequences of that, looking at this, one assumes at this point that the staff are considering she is at the end of life and these drugs are being given to palliate, but there is still a need to document the symptoms one is palliating and to justify particularly the use of very high doses of drugs for patients of this age.

Q Code A described that increase as "astonishing".
A Well, it is. It is a huge dose for an older person. It will induce deep sedation and coma.

Q The nurse of course is allowed to do that because of the prescription that has been written.
A There is a prescription that has been written. Yes, it is open to interpretation. In the lack of any clear policy or application of guidance, there does not seem to have been – there is reference to the Wessex protocols, but they do not seem to have been implemented in what they recommend and the notes do not record the assessment and the thinking of the nurse in the decision to start this very high increase.

Q Death is recorded for this lady at 0115 the following morning. In your view, to what degree, if any, have the infusions of diamorphine and midazolam and hyoscine had an effect upon that?
A I think it is very difficult to conclude that that combination of the diamorphine and midazolam did not contribute to her death through sedation and respiratory depression. As I discussed, there clearly was an indication for the opiates and the dose was excessive, but there were clear indications for the opiate infusion. The issue is, was the dose appropriate? But I did not find recorded in the notes a clear indication for the use of midazolam and certainly the doses given were very excessive in my view and there was not a clear justification that there were symptoms that required the very early use of a very high dose.

Q We see that the cause of death is written on the certificate by Code A as being "cerebrovascular accident". What basis, if any, does there appear to be for that?
A This is an elderly lady, she was unwell, she could have had a stroke, but I would say there is no clear documentation or assessment to support the diagnosis. There was not an examination showing focal neurological signs, which is the cardinal finding to support a diagnosis of stroke, and there are other causes for her being unsteady on her feet. It could have been a general infection, sepsis. Most likely in my view was the opiates she was receiving at that point. But in the absence of a detailed physical examination, one obviously is limited in the conclusions one can draw.

Q If in fact the doctor's view were that the cause of death were over-sedation by opiates, would that ever be written on a death certificate and, if it were, what would the reaction of ---
A Of course, in people who are dying, for example, the doctrine of double effect is well accepted. If there is a clear indication to give the opiates at the doses that were given and they may have contributed you would not – I think most doctors would not – consider putting that on the death certificate. The issue of course is if the drugs were not indicated and were thought to contribute to death. In that case, there would be a need to discuss the case with the coroner and not issue a death certificate.

Code A: Would that be a convenient moment to break?

THE CHAIRMAN: Yes, certainly. We have come to the end of this patient.

Code A: Sir, there is a matter I need to raise with you in camera very briefly.

THE CHAIRMAN: Thank you, Code A You can go and take a break and we will take a break shortly thereafter. We will say we will be back at 11 o'clock, please.

(See separate transcript for proceedings held in private.)

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Code A?

Code A: Can we move on, please, to the case of Code A, Patient J. Again, I am going to concentrate entirely on the chronology, and we may not need to go to the notes. This was the unfortunate gentleman who was very obese indeed and effectively got stuck in his bathroom on the lavatory. That was on 6 August and as a result he had been admitted to the Queen Alexandra Hospital. He is described as having multiple medical problems and not for CPR in the event of arrest. If we go to page 4 of the chronology, there is a comment that the wife was very stressed because she had her own medical problems unfortunately.

> "Discussed that Code A" - as he was known - "would probably need rehabilitation/long-term care. He is on antibiotics for his cellulitis",

Ad at the bottom of page 6, we see he has leg ulcers and pressure areas on his lower back. If we go to page 7, he has continuing leakage of serous fluid, and there is a reference to "slight leakage" of serous fluid from his "sacral sores". And no question, his sacral sores would have been painful to him?

A Yes, absolutely.

Q At the bottom of page 7, "All dressings changed. Slough +++." Is that dead skin?

A Dead tissue and secretions coming off an ulcer.

Q "and necrotic areas observed. Malodorous and exuding from all areas of skin breakdown".

So clearly he was having very significant problems from his sacral sores?

A Yes.

Q Page 8, 18 August 1999:

> "Reviewed by registrar. Wounds look better. Stop antibiotics from tomorrow".

Then he is reviewed by Code A. "P sores"?

A Pressure sores.

Q Thank you. "Extensive", and then "Feeds himself. Not mobilising. Black stool overnight", and then "nil today". Now, a single event of a black stool might be an indication of what?

A It could be that there has been an onset of what is called melena, which is blood in the gastrointestinal tract turns black and turns the stool black, so that would be the concern and why she would have recommended examining his abdomen and checked if he had abdominal pain and checked his haemoglobin to see if there had been a fall in his haemoglobin.

Q Then on page 10 of the chronology we have a review by Code A and I think we most probably have noted that was a review by Code A actually on Dryad Ward, once he has been transferred to the Gosport War Memorial, and Code A has set out his problems as being:

"Obesity, arthritis [bilateral in his knees, immobility, pressure sores. [He is] On high protein diet. MTS" --- ?

A Mental test score.

Q --- "very good. No pain. Better in himself: Legs [Unclear], chronic skin change. Ulcers dressed yesterday. Need review later this week."

We have heard from Code A that that followed an examination of the patient, and is that the sort of examination you would normally expect?
A As we have discussed before, it is good practice to examine somebody if you have not assessed them personally yourself beforehand when they come to a new environment.

Q Now, if we go to page 11, the drugs that Code A prescribed, and I am not going to go through them all, included Clexane. I do not think we have included it in the chronology but there is certainly reference to this patient having been on clexane at the Queen Alexandra Hospital for some time.
A Yes.

Q And that we know is an anticoagulant?
A It is a heparin drug, an oxypurine, which is given in low dose to reduce the risk of developing deep vein thrombosis and pulmonary embolae, and he would have been at high risk because of his obesity and immobility.

Code A: Can I just add the reference that has just been referred to is page 182.

Code A: And provided his signs and symptoms are watched, no reason not to give this patient clexane at the beginning?
A On the contrary, guidelines now strongly recommend the use of low dose heparin to prevent pulmonary embolae, so it is entirely appropriate that he received it.

Q But as we will see there comes a point where there is reference to blood per rectum and the clexane was stopped and that also would be an appropriate response?
A Yes, if you have bleeding you would stop any anticoagulant drug or antiplatelet drug such as aspirin.

Q And just focusing at the moment on his pain and his analgesia, this patient no doubt would have been in a degree of pain from his sacral sores but up until this point I think the most he had been on was paracetamol and we heard from his wife that he did not really tend to take analgesia in normal life, but he was on paracetamol and, or rather he was prescribed paracetamol by Code A. Is that an appropriate step?
A It is very reasonable. Paracetamol would be, again, at the bottom of the analgesic ladder, and would be an initial starting point.

Q Right. We can see that Code A the next week, 24 August, prescribed temazepam. We have all heard of temazepam. Is that a hypnotic?
A Yes, a hypnotic to help people sleep.

Q And we can see that there is a note at the bottom of page 11 to the patient passing fresh blood which we have looked at; Code A says to withhold clexane, and that was absolutely the right thing to do.
A Yes, correct. Sorry, can I comment there? Obviously withholding clexane is the right thing to do, but in a patient where there has been a concern about possible gastrointestinal bleeding one might have wanted a more detailed assessment. That I think would be best practice.

Q I was going to take you on to the following day, the 26 August. We know that there is a review by Code A and we have actually to look at page 56 of the clinical notes for that.

> "Review by Code A Called to see male. Clammy, unwell. Suggest ? MI [myocardial infarction]. Treat stat diamorph and Oramorph overnight. Alternative possibility GI bleed but no hematemesis. Not well enough to transfer to acute unit. Keep comfortable. Happy for nursing staff to confirm death".

Can you take us through, please, what is happening with this patient and what should have happened, if anything different?
A He is clearly unwell, and Code A notes indicates that was her assessment, and he is clammy which can suggest a number of problems, and certainly a myocardial infarction might be one. In the context of previous concerns that he might have had a gastrointestinal bleed one would also be concerned that he might be clammy because he has had a gastrointestinal bleed, and again that was considered by Code A in her notes. So, the assessment describes a man who is unwell.

I would have expected some other observations in this context, certainly a blood pressure and heart rate recorded by nursing staff in somebody who may have had a myocardial infarction or gastrointestinal bleed. I would have expected more details of a physical examination, such as abdominal examination, and whether the patient looked anaemic, and best practice would say to also do a rectal examination to be sure there was no altered blood in the rectum, but given he is clearly unwell and at this stage there is no suggestion in the notes from what is recorded that he is for end of life care, certainly I would have expected the appropriate response was to contact the acute hospital, either the on-call medical doctor depending on the structure, medical registrar or the coronary care unit if one thought that the main problem was a myocardial infarct.

If there was an ECG machine available on the ward I would have expected an ECG to have been obtained by the nursing staff as well, and for him to be transferred back for further active management. He is clearly unwell and one cannot treat as effectively complications of a myocardial infarct, if that is what he has got, and one certainly cannot adequately treat him if he is having a gastrointestinal bleed on a Dryad Ward environment.

Q What this note says is "Not well enough to transfer to an acute unit"?
A I cannot really follow the logic of that. It indicates he is very unwell and that is even more of a reason why he needs to be in an acute hospital. One would have to ask obviously Code A what her meaning was by that. The only situation I could see would be if you have someone who you think is highly likely to die, not for active care, and the process of transferring them could lead to them dying in transfer. We do not like to have patients dying in transfer. But this was not a man where the notes record he was not for active treatment, he is recorded as being not for resuscitation, and I consider that was reasonable because the

likelihood of success if he had had a cardiac arrest given his other problems was low, but I find it very difficult to think that he would not be considered appropriate to receive a blood transfusion, for example, if he was bleeding, or if he had a myocardial infarct and developed a ventricular fibrillation, arrhythmia, to have a defibrillator applied.

Q If this note were to reveal, and we will have to wait until we see if we hear from Code A about this, but if this note were to reveal that, in fact, there was a decision here that this patient was effectively at the end of his life, that this was a palliative care route, and that is revealed by the words "not well enough to transfer, keep comfortable, happy for nursing staff to confirm death", how appropriate or inappropriate would that decision at this stage of the patient's life have been?
A The decision that he is ---

Q --- for palliative care only?
A Well, here we have a man, he has severe obesity and problematic pressure sores, he is 67, he has normal cognitive function, there is no suggestion that he has indicated he wants limits to the care he would receive. I cannot see it is an appropriate response.

Q We then need to look at the prescription, I think, that is provided. He is given 10 mgs intramuscularly. That would presumably be a response to the suggested myocardial infarction?
A Yes, one would normally give it to people complaining of chest pain with myocardial infarction but I think if that is the working clinical diagnosis, although the absence of an ECG, if that could have been obtained, there is some question over it, I would not consider that is unreasonable if that is the working diagnosis.

Q And Code A then prescribes 40 mgs, four hourly 10 mgs, of Oramorph, and then 10-20 mgs, is that four times a day, QDS? And then 20 mgs nocte?
A Well, there is no record or description of him being in pain in the notes to justify commencing regular opiate analgesia, and if we were treating a patient with myocardial infarction, I do not treat this patient group now but I used to, one would not establish regular doses of opiates. Usually one gives 1 or 2 doses of diamorphine at the beginning.

Q And the level of these doses, the prescription for 10-20 mgs four times daily plus 20 mgs at night would allow at maximum, I suppose, for 100 mgs to be given?
A Working it out, yes.

Q Do you have any comment to make on the size of that sort of ---
A Well, this is a younger man, this is the youngest patient of the ones we have reviewed. He is 67. He is, one could say only, just into the older age group and he is a big man, although weight does not have necessarily a large impact on the dose required. Again, one would want to start with the usual suggested dose of I would have thought 10 mgs but not 20 mgs and observe the response, but I am not clear from the notes what the opiates are treating because he is not being described as being in pain at this point.

Q Well, he is given his intramuscular dose and then at night he is given the 20 mg dose, and then the following day he is reviewed by Code A according to Code A

> "Some marked improvement since yesterday ... to continue with Oramorph ... same given, tolerated well. Some discomfort this afternoon, especially when dressings

being done. Wife has visited this afternoon and is aware that condition can deteriorate again. Still remains poorly",

and that day, 27 August, by my reckoning he is given 60 mgs, depending on the four doses administered but from the day before that was, I think, 10 mgs four hourly?
A Yes. I think I was unclear what the administered dose was. I had trouble reading the prescribing chart.

Q Over the page, again, the same is administered the following day, and the day after that, 29 August. If you go to page 17, please, 30 August, Code A comments:

"This mane, 30/9 [complaining of] left abdominal pain. Condition remains poor. Syringe driver commenced at 14.45. No further complaints of abdominal pain. A very small amount of diet taken, mainly puddings",

So he is still eating at this stage.
A Yes.

Q "Recatheterised. When possible encourage fluids. Dressings renewed".

We then need to look at the prescription. We are still on the same Oramorph, and then diamorphine has been prescribed at a rate of between 40, which is the lowest dose, 200 mgs and midazolam 20-80mg, and the nurses start that at 40 mgs administered at 1445. Now I am not going to ask you to go back through the maths, as it were, but do your comments apply equally to this starting dose?
A Yes, it is very high and, again, there is no - he has got abdominal pain, he seems to have been placed on an end-of-life care pathway, if one wants to use that phrase at this stage. His abdominal pain is being treated with high doses of opiates. It would seem, but there is really little description or clear justification for continuing the opiates, and again, going back to the indication for midazolam of terminal restlessness, there is no clear description that he had those symptoms. The fundamental issue here is that there has not been an approach, an assessment, to try and treat the underlying problem, and then there is not a clear justification for the prescriptions or the subsequent doses administered of the diamorphine and midazolam.

Q And then on 31 August we can see a reference to the patient in the morning having passed a large amount of black faeces. You have dealt with that I think already and then at night time he is continuing to pass tarry black faeces. Is that an indication, as we have heard, of a potential GI bleed.
A I think at this point it is very clear he is having a large GI bleed and that must have been, one would have thought, the working diagnosis.

Q For which one could do what, or one should do what at this stage?
A Well, for a gastrointestinal bleed standard management is to resuscitate the patient if they have low blood pressure by putting an intravenous line in and then starting fluids, checking the blood count, sending blood off for cross-matching blood and replacing blood with a blood transfusion, that is the initial action required, and then normally one would refer, if it was a major bleed, for an urgent endoscopy.

A I used to practise as a registrar in gastroenterology but I am not a gastroenterologist; there are therapeutic approaches which may or may not have been available in terms of endoscopy such as injecting adrenalin to stop a blood vessel and an ulcer bleeding if the patient has an ulcer in the stomach. Sometimes patients may be suitable for surgery to tie off a bleeding ulcer. One has to say it would be I would say extremely unlikely that a surgical team would have intervened in this man because of his obesity. Now we would also give the intravenous acid suppressant drugs, I cannot recollect when they came into use, I think they were starting
B to be used in the late 1990s, but the key issue is to provide blood replacement through transfusion ---

Q Just stopping you there for a moment, on Dryad Ward this patient is not going to be able to get blood replacement?
A No. These interventions could not be undertaken there.

C Q So what needs to happen to him?
A He should be transferred back, or at the very minimum a discussion had with the on-call medical team to accept him for management that cannot be provided and interventions on the Dryad Ward site. If there was resistance to transferring the patient back, and I cannot see why there should have been for a 67-year old man with normal cognitive function, that I would expect to be raised, if there was a consultant geriatrician rota, with the consultant geriatrician, or more likely, as I would expect, the on-call acute physician, but
D there would have to be a clear senior decision in a man like this in my view to make a decision not to undertake active intervention for his problem, be it a myocardial infarct, or, as it obviously transpired to be, very clearly a gastrointestinal bleed.

Q Let's move on to the last few days of this patient's life. On 31 August he is given diamorphine 40 mgs, and midazolam 20 mgs. On the following day on 1 September he is reviewed by Code A and described as rather drowsy but comfortable. The syringe driver is
E renewed at 7.15 in the evening with 60 mgs of diamorphine and a trebling of the dose of midazolam. This patient was seen by his wife that day who described him as completely out of it, unable to talk, and unable to move. That deterioration in this patient would, in your view, be brought about by what in this case?
A The higher doses of particularly midazolam that were infused, and also the diamorphine.

F Q We can see on the following page that actually the diamorphine was also increased at 7.15, and I have dealt with that already, it went up from 40-60, and midazolam went up within the 24 hour period from 40 and then to 60 at 7.15 in the evening. Then on 2 September, bearing in mind his wife had described him as completely out of it and unable to talk, and Code A had described him as rather drowsy, on 2 September the diamorphine is increased up to 90 mgs and the midazolam was increased up to 80 mgs. Is there any basis that you can see for these increases?
G A Well, again, it is like many of the other patients we have discussed, there is no clear record of symptoms and monitoring of patients, which you would expect to be in the nursing notes, which provides justification for the increase in the doses. Clearly this is a difficult area; there are concerns about the use of potent opioid drugs and sedative drugs in patients who are at the end of life if they are not being given for control of symptoms. I am not saying they were not given for control of symptoms here but I am saying the notes do not provide that information to indicate that they were appropriately increased.
H

Q And there are no notes, I do not think we have seen any notes anywhere in any of these patient files about respiratory rate, levels of consciousness, et cetera. Is that something that can be noted, if appropriate?
A It should be in good end-of-life care. As I have talked about before, the aim is to keep the patient comfortable and keep them alert. The only indication for sedating patients is if their symptoms are intolerable. When patients are at the end of life they still require appropriate monitoring and adjustment of their treatment to control their symptoms without excessive adverse effects. Because somebody is near the end of life is not a justification in itself for escalating opiate and sedative drug doses.

Q And then on the last day of this month, 2 September, we can see that the drugs that are administered are 90 mgs at 1840 of diamorphine; 8mgs of midazolam at 1840. Hyoscine was not administered, although it had been prescribed, and the patient died the following day about 22 hours after that administration had started. We do not in this case have a death certificate but, in your view, do the drugs have any contributing - are there contributing factors?
A I think there is little doubt, given we know that his haemoglobin dropped precipitously from 12 down to 7, the main cause of death in this man was his gastrointestinal bleed. I think, as that was not treated, that was – we do not have further haemoglobin levels, but that was very likely the main cause of his death, because he was passing melena after that and that blood count of 7, I think the drugs may have contributed to his death through producing respiratory depression and sedation.

Q Can we put that file away, please? I am going to move on to our penultimate patient, Code A, Patient K. This was the patient who had under the care of a Code A, who is a consultant haematologist. She had been diagnosed with nephrotic syndrome. There was a suggestion of myeloma. At the top of page 3, Code A found insufficient evidence of myeloma or lymphoma. That does not necessarily mean that she did not have that disease, does it?
A I interpreted it to mean she did not. There are diagnostic criteria by which one makes a diagnosis of myeloma and the appropriate investigations had been done. Again, I am not an expert in this area, but Code A concluded that the findings did not meet the diagnostic criteria for myeloma, but there are paraprotein levels which you get secreted which are, if you like, almost pre-myeloma type states. So she has clearly had paraprotein in the blood that was not normal, but did not meet the criteria for myeloma.

Q What we do know – and we have heard a bit about this – is that her creatinine levels seem to have increased through the period of her treatment from 160, as we can see on 8 June, and then in July they go up to 192. What is that an indication of?
A That her kidneys are not working effectively, that she has a degree of renal failure. That is likely to be related to the paraprotein and other problems that were being investigated.

Q Then on 9 October she is admitted to the Queen Alexandra Hospital – this is at the bottom of page 4 of the chronology – with an episode of acute confusion. She is described as:

"Confused, aggressive and wandering. Diagnosis: multi-infarct dementia. CRF."

What is CRF?
A Chronic renal failure.

A

Q Can renal failure lead to an infarct in the brain? Are the two related, or are they completely separate?
A Patients with renal failure are at increased risk of developing vascular disease and that would include multi-infarct dementia, but multi-infarct dementia is generally due to the consequences of damage to the brain through hypertension and other vascular risk factors.

B

Q If we go to the top of page 6, we see transfer was arranged to the GWMH. She is described as:

> "Moderate chronic renal failure. Admitted with history of [urinary tract infection]. Quite alert. Can stand. Rather unsteady on walking. Chest clear. No evidence of cardiac failure. Suitable for a rehabilitation programme. Will arrange transfer to GWMH."

C

Two days later, on 21 October, she is transferred to Dryad Ward and Code A makes a note:

> "Continuing care. [history of presenting complaint]: acute confusion. Admitted to Mulberry Ward to QA and then to Dryad. [Past medical history]: Dementia, myeloma, hypothyroidism. Transfers with one, so far continent, needs some help with [activities of daily living]. MMSE ..."

D

What is that?
A Mini mental state examination, which is an assessment of cognitive function.

Q The result of which was 9 out of 30. So quite low?
A Yes. She has dementia and this score would be in keeping with severe dementia.

E

Q Her Barthel, however, is 8, which is relatively high in comparison with some of the patients we have seen.
A Probably reflecting the fact that she has had some mobility.

Q Then:

F

> "Plan: Get to know. Assess rehab potential. Probably for rest home in due course."

Then over the page:

> "Needs minimal assistance with ADLs."

Then we can see the prescription she is given: thyroxine, frusemide, temazepam and Oramorph as a prn prescription, 5 to 10 mg as required. At this stage, is there any basis for that prescription?

G

A I could see no basis for the prescription on the information in the notes. She is not in pain. Certainly if one has agitation and confusion in a patient with dementia, in the vast majority of cases it is not due to pain. It is a common problem that one sees in patients with dementia.

Q Is Oramorph a suitable medication for confusion or dementia?

H

A It is not at all a suitable medication.

Q She is described by Code A on 1 November, if you go to page 8, as "quite confused and disorientated". There is a note above that she is in chronic renal failure. On page 9 she is described as being:

> "Confused during the night, wandering around ward. Refused night sedation."

She is given temazepam, as we can see. Then over the page, she is then given on a regular basis thioridazine, prescribed by Code A Can you help us a little bit with thioridazine?
A We have mentioned this drug before. It is an anti-psychotic. It is a very appropriate prescription in terms of this lady's problems.

Q The 10 mg that she is given is a relatively low dose.
A Yes. We do not use it now, so I am just remembering back. This is now not used, but it was an entirely appropriate prescription at this time.

Q On page 11, we can see she is seen by Code A

> "Request for review by Code A Very aggressive at times. Very restless."

Is that a function, as it were of dementia?
A Yes. The note suggests the main problem with this lady is behavioural disturbance and restlessness due to her dementia and that was why a referral was made to Code A who is an old age psychiatrist.

Q If we go to page 13, please, things move on. She is described on 18 November – and you deal with this in your GMC report, if that helps, at paragraph 11 – as having deteriorated and:

> "... has become more restless and aggressive again. She is refusing medication and not eating well. She doesn't seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward ..."

That is the psychiatric ward for the elderly.

> "Code A now at Dryad GWMH. Transferred 21.10.99. Aggressive, wandering, moving other people's clothes, refusing medication, poor appetite. Reviewed on ward. Happy, no complaints,. Waiting for her daughter. Says tablets make her mouth sore. Plan – Transfer to Mulberry C when bed available."

We can see underneath that that on that day, although I think Code A has made no notes then of why, she makes a note the following day, she prescribes the patient with fentanyl. Help us, please, with your view on fentanyl. I am looking at paragraph 12 of your report.
A Again, the medical and nursing notes do not indicate that the patient is complaining of pain. There has been a decision made to transfer her to an old age psychiatry ward, which is recognising that the main issue in the management of this patient is behavioural disturbance related to her dementia. As we have discussed with other patients, a fentanyl patch is a very high dose of opioid to give in terms of its equivalence to morphine. This lady is also in significant renal failure, so she is particularly susceptible to adverse effects of opioids because of accumulation of the metabolites. There are two issues about the fentanyl

A prescription in my view. One is that there is no indication, appropriate indication, recorded in the notes. If she was in pain, there is no indication that it would not have been feasible or appropriate to give either an oral or subcutaneous small dose of opiates, but I could not find any evidence she was in pain. Secondly, the use of a fentanyl patch, because of the very high dose in an elderly patient with moderate renal failure, was highly likely to result in adverse effects.

B Q I just want to step back from this and try and look at the problem that the nursing staff and the medical staff had with this patient. This is a patient whose mental condition seems to be deteriorating. She wanders about, she is aggressive at times. This is not a secure ward, so they cannot presumably keep her in the ward.
A I do not know if Dryad was a ward that could be locked. Often it is necessary to lock a ward. I suspect this ward very possibly was locked at night, but obviously I do not know. You would need to really "special" the patient, because of their potential risk.

C Q That is what I wanted to get to. She has not yet been transferred to Mulberry and they do not know presumably when she is going to be transferred to Mulberry.
A Yes, correct.

Q You have an aggressive, confused, wandering patient, who may not want you to inject them
D A No. You would try and give more antipsychotic drugs to improve the behaviour. That would be a standard approach, either orally or by injection. You would, as an accompanying measure, try and ensure the patient was in as safe an environment was possible and have a nurse accompany them on a one to one basis.

Q Is one approach to stick a fentanyl patch on her?
A I cannot say that. I have not seen that used as a practice. It is not an indication for the
E drug. If you give a dose that renders a patient unconscious, that will stop them wandering around, but that is unacceptable and a dose of opiate that does not produce that is actually just as likely to make their confusion worse potentially. So opioids are not an appropriate treatment for behavioural disturbance in patients with dementia. If there was thought to be a problem of underlying pain, one would expect to see a medical assessment to support that assumption in terms of finding a problem in the patient which might be producing pain.

F Q Let us look at what happened in the last few days of this patient's life. That fentanyl patch was put on her at 9.15 in the morning of 18 November. It is going to last for three days. She is reviewed the following morning, 19 November, by Code A, who makes a note "Marked deterioration overnight." That is having been on fentanyl for 12 hours or whatever it is.
A Yes.

G Q Then we see, "Confused, aggressive. Creatinine 360." That is a marked increase.
A Yes.

Q Then:

"Fentanyl patch commenced yesterday. Today further deterioration in general condition. Needs [subcutaneous] analgesia with midazolam. Son seen and aware of
H

A

> condition and diagnosis. Please make comfortable. Happy for nursing staff to confirm death."

We will look at the prescription that she writes out in a moment, but "marked deterioration overnight, confused and aggressive". In your view, that may be an indication of what?
A Well, I think the most likely cause of this undoubtedly is the fentanyl patch that has been applied. As I indicated, it can make problems worse.

B

Q What about the fact that her creatinine has---
A Well, as I comment in my report, that could be because she has become dehydrated or because she has got a concurrent infection such as a urinary tract infection, but the timing is highly suggestive that a deterioration from the day before - I mean, obviously she was agitated and confused the day before, which could have been due to a urinary tract infection - the further deterioration is almost certainly in my view due to the fentanyl.

C

Q Before we go to the next entry can we look at the prescription that Code A writes out, at page 15, following the day on which the fentanyl is put on to the patient. She prescribes chlorpromazine 50mg by injection administered at 8.30, and we will go back to look at why that happened; diamorphine starting off at 40 up to 80mg, effectively by syringe driver, subcutaneous infusion; and midazolam starting at 40 up to 80mg by syringe driver. Now, can we just go back then to see how that was used. Page 14:

D

> "Marked deterioration over last 24 hours. Extremely aggressive this am. Refusing all help from staff. Chlorpromazine 50mg given [intramuscularly] at 08.30 – taken 2 staff to special."

If we pause there for a moment: chlorpromazine, would that have a relatively immediate---
A That is an antipsychotic and I think that is a perfectly reasonable treatment approach
E to take for the agitation, which could have been taken earlier rather than using fentanyl.

Q So that is given to her at 8.30. This is probably testing you, how long does chlorpromazine last?
A Usually you would expect it to last, and it depends on the dose and the individual patient, but certainly for 12 to 24 hours.

F

Q "Syringe driver commenced at 09.25. Fentanyl patch removed. Son seen by Code A at 13.00, situation explained. He will contact his sister Code A & inform her of Code A poor condition ..... Daughter has visited" et cetera.

Now, the syringe driver is started at 09.25. I think we know that the fentanyl patch was not taken off until a little later, but it may not matter, because imagining even for a moment that the fentanyl patch is removed immediately, you have told us already that fentanyl is going to
G continue having an effect for quite some period.
A Correct, as listed in the BNF.

Q What do you say to the administration of 40mg of diamorphine and 40mg of midazolam for this patient; first of all, the reasoning behind it, and, secondly, the dosage itself?
A Well, again, the approach appears to being taken to increase the opiate dose to deal
H with her symptoms of agitation, behavioural disturbance, and I say that is not appropriate and

is not an indication for opiates. There may have been a lack of appreciation about the extent to which the fentanyl effects would continue, so you have got the background fentanyl effect which is going to be there for quite some hours, and then you are adding in another 120mg equivalent of morphine. I mean, this is a very, very large opiate dose in an elderly lady with renal failure. Then, looking at the use of midazolam, so going back for the treatment of terminal restlessness, well, she is certainly restless, we know that, that is part of the problems with her dementia. Is she terminal? Well, a decision seems to have been taken that she is now having terminal care, but even if one were to accept that that decision was appropriate and therefore she had a terminal restlessness, the dose used is extremely excessive, in that, you know, the recommendations are to start with 10mg for 24 hours in an elderly person, and this will result in profound sedation. There has been no titration up to that to see if it was appropriate, and I do not believe it was appropriate. To start at 40mg over 24 hours was a very high, excessive dose.

Q The day before, when this patient had been reviewed by Code A was arranging for her hopefully to go to Mulberry Ward.
A So she would not have arranged that transfer if she was thought to be for terminal care at that stage.

Q If this decision has been made by Code A that this patient has changed so significantly that she is now for effectively end of life care, terminal care, would you expect her to discuss that with anyone?
A Well, I would, but I---

Q Sorry, you would discuss it or you would expect---
A I would expect, as a responsible consultant, for it to be discussed with me, but I suppose the question would be did the consultants who Code A was working with expect such, you know, change in status to be discussed with them. If they thought it was appropriate for Code A to make these decisions on her own, clearly she would then not discuss it with them, but personally I think a major change in a patient like this should be discussed. I think it certainly would be now, and I would have expected it with my patients then, but the role and responsibilities that Code A was given by the consultants is clearly an issue here, and that is not something I have commented on because I have only just examined the medical notes, I have not seen statements that have really gone into that, so my statement is what I would expect to see. This is a lady who has had a major deterioration who was expected to be transferred, and the consultant is responsible for this lady's care.

Q The Panel will have to make a decision about whether there was a particular culture on this ward in relation to whether consultants would be consulted or not, but dealing with your experience of how a normal average hospital ward runs, would you expect a doctor in Code A position to have consulted with a senior consultant?
A Well, we must not compare it to normal wards in large acute hospitals with resident staff, and also we definitely would expect juniors, training staff, to discuss it, and I think this is the issue; the role and responsibilities of clinical assistants clinical assistant can be highly variable in the way it is set up, so I did not have a clinical assistant working in the similar hospital set up I had, and I would have expected my registrars to discuss such changes with me. I would have expected a clinical assistant to discuss such changes in a patient's status with me, within usual working hours, but, you know, I have not had a clinical assistant working in this sort of environment. I have had a clinical assistant working in a day hospital, but not for this sort of patient group.

Q I will move on. We will look at what happens with this patient hereafter. At the bottom of page 15, 20 November, that prescription actually continues to the end of the patient's life. Code A remarks, at the top of our page 16 of the chronology:

"Condition remains poor ..... Skin marking. Position changed".

Again, another note in the care plan:

"Peaceful night. Position changed ..... Skin marking. Extremities remain oedematous. Oral care given."

21 November:

"Condition continues to deteriorate slowly ..... driver satisfactory."

This patient is not being hydrated at this stage. She has got kidney failure and she is on a, you have described it, very high dose of diamorphine.
A And midazolam, yes.

Q The deterioration---
A I think the deterioration was undoubtedly due to the drugs she received. There may have been other factors contributing, but the deterioration occurred in such close relationship to the commencement of the opioids and then the sedatives, I think it is difficult to conclude they did not contribute to her deterioration and death.

Q I was going to ask you, does the same apply to her death?
A As with these other patients, she is an elderly, frail lady with advanced dementia, and sudden death can occur in this patient group.

Q I am going to move on to Patient L. This patient, Code A, I think on any view was very unwell at the time that she was admitted to the Gosport War Memorial. She had been admitted, as we can see at the top of page 2 of our chronology, to the Royal Hospital Haslar after experiencing chest pain, collapsing at home. There is a note on a CT result of "Probable rt non-haemorrhagic infarction rt parietal lobe". Is that effectively a stroke?
A That is a stroke, yes, confirmation of brain imaging that she has had a stroke.

Q I am not going to go through a great deal of the notes. She remains in hospital for a longish time. If you go to page 7, 4 May she is described as "Still not speaking", and then on 5 May she began taking food orally, and we can see that she is referred to Code A with this comment:

"Could you give your opinion as to the best path for rehabilitation for this 73 [year old] female. She is improving slowly. Nothing more we can do for her on acute medical side."

Realistically, it is not a very bright outlook for this unfortunately lady?
A No. as I comment in my report, she has had a severe stroke, she is elderly, she has got co-morbidities, there are a lot of complications that can happen, and she has got a high risk of

A dying from complications, and certainly she will be left with significant disabilities in the long term.

Q If we go to page 8 of the chronology, there is a large nursing entry in the middle of the page: she is agitated, she is given some intravenous morphine; "unable to position her comfortably"; she is aspirating her fluids and soft diet, therefore is it "nil by mouth"?
A Yes, nil by mouth.

B

Q "[nil by mouth] until further review. Family spoken to. Aware of poor prognosis. Remains for 444". That is a notation I do not think we have come across before. You may not know---
A I assume it is a variation of 555. Different hospitals use it. It is the phone number for the resuscitation team, meaning the team have decided she is for resuscitation. I have to say I think many medical teams would have decided this lady was not for resuscitation.

C

Q Well, I can cut you short, I think, because on the following day that is exactly what happened. She is discussed with the consultant, and the decision was then made "Not for resuscitation". I suppose it may be that in the evening the nursing staff spoke to the family, and then obviously the following day there was discussion with the consultant.
A Yes. Sometimes if there is not a consultant, there is a conservatism and patients are kept for resuscitation.

D

Q She is described on 6 May as being:

> "Too unwell for transfer to GMWH. Overall prognosis poor. If [she] survives and is stable next week, happy to take her to a slow stream stroke care bed".

Over the page we see no further deterioration. Top of page 11, and this is 10 May 99:

E

> "Reviewed by Code A ..... Appeared to improve over weekend. Barthel is zero ..... Can ..... obey simple commands ..... Don't think stable enough to transfer to GWMH".

Bottom of page 12, she is now being fed through a nasogastric tube.

F

> "Spoke to Code A husband and daughter. Explained prognosis and rationale behind why [patient] would be allowed to die naturally".

Page 14, please:

> "No incontinence this am. Settled and slept very well without diamorphine. Feed continues as per regime."

G

She is reviewed on 18 May:

> "sitting in chair. Obs stable. Blood test results".

Then this:

H

"Liaised with GWMH. Happy to take Code A with above results. Tolerating [nasogastric] feeding well. Seems to have recovered from aspiration pneumo---"

A "pneumonitis" – pneumonia.

Q "Slow improvement in orientation, speech and strength. Still faecally incontinent and requires catheter".

If we go, please, to page 17, so this is two days after that note, she is indeed transferred to Daedalus Ward:

"Upon transfer, patient receiving aspirin, enalapril---"

A Enalapril; it is a blood pressure lowering drug.

Q We can see:

"PRN subcutaneous diamorphine ..... Diagnosis and treatment in hospital: Stroke. For rehab".

Then there is a nursing referral:

"Admitted following [right] CVA".

I am not going to go through all of that. She has got pressure areas intact, very sore, diarrhoea present. So although she has, according to the notes at least, improved to the point where she is transferred, we are still looking at a fairly sick lady?

A Yes. You want to transfer these patients when they are what we refer to as medically stable, so they have significant deficits and disability, but you only want to transfer patients to a ward for rehabilitation off the acute site when they have not got active ongoing problems such as pneumonia, and I work on a stroke unit where we have an off-site rehabilitation ward, and this is an important issue, that you try and ensure patients are medically stable before you transfer them to an environment where there is not the same level of medical support and investigative facilities. Sometimes one thinks a patient is stable, and they are, but then when they get to the unit they become unstable, so this can happen, but one tries to minimise that.

Q I am not going to read all the way through the review by Code A She sets out the history of presenting complaint. She records:

"Barthel: Needs help with ADL".

Barthel is zero. "[nasogastric] tube in situ" and she transfers with a hoist."

Now, you deal with this assessment by Code A at paragraph 12 of your GMC report.

A Yes.

Q Is there any indication of a physical examination of the patient, first of all?

A The notes do not record there was a physical examination.

Q Again, on the basis of the notes, because you can only go on the basis of the notes, does there appear to have been an adequate clinical assessment in view of this patient's transfer and her poor state of health?
A Well, again, I think ideally one would – I mean, the summary of the problems is certainly adequate and describes all the main issues. I think ideally one's routine observations, which again would not be done by Code A but would be done by the nursing staff, but some note of those, that they had been looked at, and it is best practice to have neurological examination to show extent of the weakness, but I would not say it is a failure of good medical practice not to do that detailed examination. I think the issue is around if this lady was complaining of pain should she have been examined, and particularly around the issue of the abdominal pain, which is referred to around this time.

Q If we have a look at page 19, I was going to take you to that, in the middle of the page we can see:

> "Requires assistance to settle and sleep at night. Oramorph 2.5mls (5mg) given. [complaining of] pain in stomach and arm. Condition poor".

Above that we can see:

> "Poor hearing in [right]. Poor vision – wears glasses most of the time. Speech slow and slurred at times. Orientated ..... Pain: Not controlled ..... [complaining of abdominal] pain due to history of bowel problems."

I think this lady had had abdominal pain for a significant period.
A I mean, reviewing the notes, this had been very extensively investigated by at least, I think, two consultant teams, and it was thought to be either due to irritable bowel syndrome, or a functional abdominal pain problem, or to adhesions from previous surgery.

Q I think very early on she had had abdominal surgery, had she not?
A Yes, but it was not quite clear what the final diagnosis was, but this abdominal pain, certainly in the past there had been no suggestion that it should be treated with opiates, and you would not treat chronic abdominal pain with opiates?

Q Why not?
A Because with chronic pain, opiates you try to avoid because they are not particularly effective, and you do get problems of dependency and difficulty getting people off opiates for non-malignant chronic pain, and certainly for irritable bowel syndrome you would not give opiates. I mean, that is not an appropriate indication.

Q Being realistic with this lady, the question of getting her off opiates probably is not going to be a significant issue, is it?
A No, but it is a lady you are intending to rehabilitate, you want to avoid the adverse effects of opiates as well. Just because she has a severe level of disability from her stroke is not an indication, or lessens the issue of giving her opiates. We would not in any circumstances start approaching this sort of problem in a patient with a severe stroke who is complaining of abdominal pain by prescribing opiates.

Q Well, let us look at what Code A did prescribe. If you go to page 20, which deals with the prescription written out on the day of admission, I am not going to deal with all of

A the drugs, but we can see that Oramorph was prescribed, 5-10 mg as required, and that was actually administered at a rate of 5 mg three times on the day of admission.
A One of the things I was not able to determine from reviewing the notes was what Code A prescribed the morphine for, because this patient had been transferred on PRN subcutaneous diamorphine for chest pain and cardiac problems, and it was not clear to me if the Oramorph was being prescribed potentially as a replacement for the diamorphine or for the abdominal pain, or for some more general palliative pain relief reasons.

B Q Well, diamorphine was also prescribed in a rather different way. We can see that she prescribed 20-200 mg, midazolam 20-80 mg by syringe driver. Again, I am not going to take up time, you have commented extensively on these sorts of prescriptions, in your view appropriate or inappropriate?
A Inappropriate, because this lady has been transferred because it was thought she was medically stable, she has got a stroke, she is coming for rehabilitation, her outlook, as
C I describe in my report, is poor. I mean, this is a lady who is going to require care either in a nursing home or with considerable care package from her family and other carers if she were to be able to return home after what would likely be a very prolonged period of rehabilitation, but she is not in any way expected to be dying within the near future, from the information presented in the notes.

D Q Let us look at what happened to her the day after her admission.

Code A Can we just note the prescription on page 20, at the top, the other drugs.

Code A Yes, certainly: digoxin; enalapril; aspirin; isosorbide. Isosorbide is?
A Is a nitrate for angina.

Q Is it "Suby C"?
E A I am afraid I do not know what Suby C is. I have not looked this up. I believe it is a wash-out solution for a nasogastric tube.

Q We will have a look. Can we go then to see what happened the next day. Can we go to page 21, please. At 11.30, this is the bottom entry on page 21:

F "To have GTN spray PRN. Now on regular ..... oramorph 10mg" four hourly.

Then Code A made a note at 18.00 hours:

> "Uncomfortable throughout afternoon despite 4hrly oramorph. Husband seen & care discussed, very upset. Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medications given should not shorten her life."

G Bearing those words in mind, "Agreed to commence syringe driver for pain relief", can we just look at the drugs that she had been on and to see whether she was given an equivalent dose and whether it was necessary in your view at all. She was on Oramorph and it was actually administered to her, 7.35 in the morning she gets 5 mg, and then at 10 o'clock and 2 o'clock in the afternoon she gets 10 mg each time. Yes?
A Yes.

H

Q So she gets 25 mg on that day. The day before she had had just, I think, 5 mg, and then at 7.20 in the evening, 19.20, she was put on diamorphine of 20 mg via a syringe driver and midazolam of 20 mg.

Code A: I am sorry to interrupt again. Maybe I have got it wrong, but you said the previous day, looking at page 20, the Oramorph, I may be getting it wrong, but it looks like three administrations of ---

Code A Code A is absolutely right. I missed that.
A I think I had estimated in my corrected report that she had received a total dose of 35 mg of oral morphine, three doses of 5 mg and two doses of 10 mg.

Code A: Thank you very much. Then she started on 20 mg of diamorphine coupled with 20 mg of midazolam. In terms of sedative effect on this particular patient, what effect is this going to have?
A Well, I have already commented that I, from reviewing the notes, was not of the opinion that the opiates were indicated, but if we accept we are at this point and she has had 35 mg of oral morphine, the diamorphine equivalent would be around a third, 12 mg, over 24 hours, and if one wanted to, say, increase that, if one thought she was in increased pain – an equivalent is 12 mg, to answer your initial question.

Q Yes.
A A 50 per cent increase would be 18 mg. So it is a bigger increase than what she was on. She is receiving more than the equivalent. We are starting at 20 mg over 24 hours.

Q Coupled with midazolam.
A Then the midazolam. My comments are the same, that this is a high starting dose and there was no clear indication that this lady had terminal restlessness, which would be the indication.

Q The patient is described, top of page 22, as:

"Remaining poorly but comfortable."

She remains on the same rate of diamorphine and the same rate of midazolam until she dies that night at 10.30 in the evening. Again, with this patient, she has died effectively, I think, within two days of transfer.
A Yes.

Q In your view, is the diamorphine and the midazolam likely to have had any significant effect upon her?
A Again, this was a lady with a severe stroke. She could have died suddenly from a pulmonary embolus or other problems, but the timing is very suggestive that the drugs contributed to her death.

Code A Code A, that is all I ask you. Thank you very much.

THE CHAIRMAN: Thank you, Code A I was going to announce a break at this point anyway. It is a matter for you. We can either take that break and then come back

for half an hour before lunch, or you might prefer to merge the two so that we take an early lunch and return for you to start in an hour. It is entirely a matter for you.

Code A: Sir, thank you for the discretion, as it were, for me. I think, bearing in mind our time constraints, whatever arrangement means that we get on with Code A evidence as soon as possible, that would suit me, so it sounds as if one break now would ---

THE CHAIRMAN: Would merge the two.

Code A: --- assist in terms of everybody needing some time.

THE CHAIRMAN: Yes, indeed. It would make a net saving of about 15 minutes.

Code A: Right. So let us go for it.

THE CHAIRMAN: Very well. We will break now, Professor, and we will take an early lunch, so we will return, please, at 1.15, when Code A will start his cross-examination. Thank you very much indeed, ladies and gentlemen.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Code A?

Cross-examined by Code A

Q Code A, obviously I have a number of questions to ask you. I am going to try not to repeat points where repetition can be avoided, but may I make two things perfectly clear at the outset: although I may be challenging some of your assertions, I am not seeking to cast any doubt upon or aspersions upon your expertise. Secondly, I am not seeking to cast any doubt at all upon your integrity as a witness.

A I fully understand that and I equally understand your role.

Q There are two major disadvantages in terms of the situation in which you find yourself, neither of them of your making: firstly, because the note-keeping in this case in relation to these patients was inadequate, which of itself presents you with a number of difficulties in trying to assess what the appropriate course of action might have been.

A I recognise that and I agree with that.

Q Secondly, again it could hardly be your fault, you yourself never had any opportunity to observe the patients in question.

A That is the nature of being an independent expert, of course.

Q Of course. That is a very important consideration to take into account when trying to see why it was a doctor did or did not do certain things.

A Yes.

Q You are aware that Code A has accepted that her note-taking, I am speaking just generally, her note-taking was inadequate.

A Yes.

Q You are aware too, I think, that she has accepted, not in every case but in most of the cases where it applies, that the range of dose in relation to her prescriptions, the typical one we have seen many times 20-200, was excessive.
A Yes, I am aware of that, yes.

Q You are also aware that there has been no evidence that her lack of adequate notation meant that anybody, either a doctor or a nurse, was unable to follow what it was were the requirements of Code A. Nobody has said, "I could not understand what to do because of inadequate note-taking", or anything like that. You are aware of that?
A From my reading of the transcripts, I have not heard any complaint of that.

Q I appreciate you certainly have not been through every word of it, but that is the general picture. Similarly, there has been no evidence called, and no allegation made, that any nurse within the latitude of the range did something absolutely out with the possibilities in that range. There is one case where a nurse appears to have made a mistake, because it was not prescribed and nobody instructed her to do so, elevating a dose of midazolam; where it should have been 40, she actually administered 60.
A My understanding is all the nursing actions were within the prescribed drug ranges, yes.

Q Also, we have to bear in mind when we are considering the ranges that, in respect of the patients generally, the position is this: that I think only one patient – I am just trying to refer to a note that summarises this – that only one patient received as much, by the time of his death, as 120mg of diamorphine, and that is Patient A.
A That was the maximum dose received over a 24 hour period, yes.

Q We just have to bear in mind that there is one example of a patient receiving 100 – I am not asking you to pluck figures out of thin air, but I am just putting it to you – two patients, a maximum of 80 by the time they died; two patients, a maximum of 60 by the time they died; four patients, a maximum of 40 by the time they died; one patient, a maximum of 30 by the time she died; and one patient, a maximum of 20 by the time she died.
A This is a diamorphine infusion, and I am sure that is correct, yes.

Q Just to give us the general picture.
A Yes.

Q Before I ask you something about your experience in relation to an approximately equivalent situation, may I just ask you one thing about note-keeping, to try and get it out of the way: are you able to give any informed opinion about the standard of note-taking with regard to GPs, or GPs in the same situation as Code A during the period in question? If you are not, I am not going to ---
A I have answered this. I gave a view of the standard of note-keeping I would expect in that setting where junior doctors were operating, and I have not seen any survey of note-keeping by GPs in that period, so in essence I would say no.

Q I am not going to trouble you with that topic again. May I, however, ask you about the experience, and I may have misheard the name, or what the name was, was it Walkergate?
A Walkergate Hospital. It is still an active hospital taking patients for rehabilitation, but, as I indicated, I no longer practise there, but did do so in the 90s.

Q I appreciate that. That is the hospital we are talking about.
A Yes.

Q I wonder if you would just help, because looking at your CV, I may have missed it, I do not think it is mentioned. Maybe it is covered by another---
A That hospital is not specifically mentioned, no. I talk about my involvement in care of the elderly services. I did not give a full detailed description. I am happy to enlarge on that if you wish.

Q Do not worry. It is not the same as Freeman Hospital, which is the one hospital I had noticed?
A No. It was part of the same hospital, and in fact part of a larger hospital Trust, and it was part of the service that I was head of service for.

Q Again, without going through all the detail, you gave us certain figures about the acute medical unit, and so on, acute geriatric, rehabilitation, continuing care.
A Yes.

Q At one point I think the total involved in that hospital in Newcastle, I think you were saying at one point about 120 patients?
A I said there was a situation where, as a consultant – sorry, are we talking about the beds at Walkergate Hospital?

Q Yes, when you were talking about beds in general, you said at one point 120 patients.
A There were actually more than that, but, as I started, the beds were being slowly reduced as continuing care wards were closed. So we started off with seven wards and we ended up with four, which was about 80-something beds.

Q All right, something like that. Continuing care, I think you gave a figure for about 20 beds.
A By the time we had made the changes, of changing continuing care beds, some continuing care wards into rehabilitation wards, there was one ward left of 20 continuing care beds, and there were three rehabilitation wards of 22, 20 and 17, and the smaller ward became a nurse-led unit in the late 1990s.

Q None were palliative care wards, is that correct?
A No.

Q In terms of your dealing with patients, very, very roughly speaking, that would fall into a similar sort of category to the patients we are dealing with at Gosport War Memorial Hospital, in terms of your time, as I understand it, you as a consultant would be doing a weekly round?
A Yes. As a senior registrar I probably visited the similar ward twice a week for just under three years, and then as a consultant, as I indicated, each consultant did a ward round once a week.

Q So in terms of medical care, the provision of medical care, in relation to patients of the sort of category we are talking about, what was available in terms of doctors being there and doctors being available?

A Yes, I thought I had briefly explained that, but I will go through that again. I understand why you are asking. Each ward was overseen by one consultant, and that consultant would go down once a week and do a ward round, typically, I think, very similar to what I could see was happening at Gosport War Memorial Hospital, with a multidisciplinary team, meeting with the nurses and any therapists that might be available, and would go round the patients, and then the rest of the week the problems on the ward would be covered by the registrar, which would be a group of three or four doctors who would go down there usually once a day, so there would be some input of a round, and they would do their ward round and then deal with any issues on the other wards.

Q Again, maybe I got the figure wrong when I made a note, how many sessions of medical cover from the registrars? I think you said five or six.
A From my recollection, there would be at least one registrar going down once a day, sometimes twice, and they would clerk new patients in, for example, who were transferred, so I estimated it would be about – it was not ten sessions, but it was probably six or seven I suspect were covered.

Q In terms of your activities when you were acting as a senior registrar, what sort of period of time are we covering in that post?
A That was 89 till 1992, in August.

Q So three years.
A Yes.

Q About how many patients of a similar kind to the kind that we are dealing with in this case, this may be an impossible question to answer, but can you give us any idea as to how many patients of this kind you would have encountered?
A You mean, elderly patients in this environment?

Q Yes.
A Well, again, as was common in that period, often the supervision of the wards was actually delegated to a senior registrar, you would not see that now, so I would be down there once, twice a week to review patients and undertake ward rounds.

Q Who might be palliative care sometimes, might they?
A Well, as you rightly point out, it was not a palliative care ward or service. We would care for older people there who were dying, and, similarly, that would also happen, sometimes not infrequently, in the acute geriatric or acute medical setting as well.

Q Then when you were a consultant at the same hospital, about how many patients of a similar kind to the kind we are looking at in this case would have come under your remit, or whatever the appropriate phrase would be?
A Well, initially when I started I had responsibility, trying to remember, for at least of one continuing care ward. I think it was one continuing care ward, which eventually closed, and the ward I took over, which became a rehabilitation ward, had mixed function, I mean, similar to how the wards have been described, and many units, as I explained, changed their continuing care beds into rehabilitation beds. So I had a 22 bedded ward, which I set up half of the beds to be stroke rehabilitation, and the other were general elderly care rehabilitation.

Q At that period, acting as consultant in that sort of way, covers from 92 to---

A A To about, if I remember correctly, 1998. I think another colleague started then and the stroke rehabilitation beds transferred to a combined stroke unit/rehabilitation unit on another site, and at that point I transferred that ward to the care of a new consultant geriatrician who was appointed.

Q I think that is all I need to ask you about that particular topic. Thank you. I want to ask you about general matters with regard to palliative care, and I appreciate that expression is not absolutely precise, and that there are obviously times when one might well be embracing end of life care, or terminal care at the same time, but just using that as a broad brush expression, I want to ask you some questions about that, which of itself will throw up various topics which you have already given evidence about. Some of them we may have to come back to in relation to individual patients, but in terms of these general matters I wonder if you would be kind enough to look at a particular document that we have heard about in this case, and it is in file number 1, and in file number 1 if you go, please, to tab 6, and in tab 6 page 27.
A Yes.

Q I do not know if you have had an opportunity to see this. I would rather doubt it.
A I do not believe I have read this document.

Q It does not matter. It is pretty basic and it is not throwing up any sort of complicated slant on things, but the Panel have heard evidence about it and I want to use this as a starting point. So that you know what it is, it is a note made by a Code A, who was a consistent geriatrician – it was not Gosport War Memorial; it does not matter – one of the other local hospitals.
A I understand.

Q He is making a note in relation to a meeting which was held in 1991, at which he spoke about various matters to do with the use of syringe drivers and so on, and I just want to draw your attention to it to see whether there is any disagreement that you would express with the views he expressed back in 1991. If you look, please, at the second paragraph, you can see how he recalls that he was invited to talk in general terms about the use of opiates in long-stay wards. He expressed the view that it was often very difficult to know what was best for very frail, elderly patients who could not clearly express their symptoms, and that one could only do one's best in interpreting them. I take it we can be in agreement about that, as between you and Code A?
A Yes, I would agree with that.

Q These are very general. He said:

> "I felt when there was any question that the patients had pain then they should be given the benefit of analgesia."

Well, obviously no dispute about that.

> "Unfortunately there were no really very useful middle range drugs between Codeine and Dihydro-codeine and Diamorphine."

In general would you agree with that?
A Could I just make one comment on the previous statement?

Q Yes.
A I mean, of course, if there is a significant concern about pain, I would word it slightly differently, people should be given the benefit of trying analgesia to see if that relieves their symptoms, and I think there is a question about what we mean by any question; is that responding to any view, is it the doctor's view, so I would be slightly just cautious in the interpretation of that, but the principle I agree with. I do agree we would go, in general, on the analgesic ladder, you have got a choice; if you are giving people adequate doses of codeine, the next step is stronger opiates, unless you try another approach, such as with non-steroidal anti-inflammatory drugs or treating the pain with a different approach, but that statement, yes, I agree with.

Q He goes on:

> "I also explained that, besides their pain relieving properties Diamorphine and Morphine had very useful psychological effects producing some psychological detachment and euphoria which can do much for a patient's tranquillity."

A I would agree with that, but in the context of patients who are in pain. I would not agree with that in broad terms that they are a treatment for producing euphoria in elderly, frail patients who are not in pain.

Q So there has to be, in your view, some element of pain to allow for the fact that besides their pain relieving properties they have those other effects?
A When you read the BNF or most guidelines, that is the context; where they talk about the additional benefits is in the context of producing this detachment and euphoria ---

Q Forgive me, Code A I do not mean to interrupt you, but I am asking you for your view.
A My view would be they do have that effect in the context of pain, but I do not think it is general accepted practice to, for example, give it to frail older people who are not in pain, who are miserable for other reasons. As a very last resort, if you have tried other approaches and you cannot work out if someone is in pain, you might consider it, but I think that benefit, in my view, is mostly in the context of patients who are in pain.

Q I am going to come on to an issue relating to that later, but that is your view.
A That is my view. I am not saying there are not geriatricians out there, and other people, who might express a view to use it for that purpose, but it is not in the palliative care literature and guidelines promoted or recommended in that context, which may be being implied.

Q He goes on:

> "I said that it was, however, vital for us to make sure that there were not more simple reasons for the patient's pain or distress, such as a full bladder or faecal impaction that could be quite simply dealt with."

No disagreement there.
A I think I made those points myself in earlier evidence.

Q "Having established that and being content that the patient was distressed and probably in pain, then one should not hesitate to use opiate analgesia if necessary."

Would you agree with that?
A I agree with that. The challenge is its interpretation when patients cannot communicate whether their behaviour indicates they may be in pain, and that is, I think, the difficulty in management in general of this patient group.

Q Perhaps I can touch upon that, because it embraces one of the things I was going to come back to. With patients who cannot communicate it presents particular problems, for obvious reasons?
A Yes.

Q And it may very well be extremely difficult, if not impossible, for a doctor to determine precisely what it is that is causing the agitation and distress?
A I agree with that.

Q It may be essentially pain, it may be essentially mental distress, it may be a combination of the two?
A It very much depends on the individual patient and their context.

Q And once again that is an illustration of the importance of actually seeing the patient?
A Yes, and in taking account of their previous behaviour, the way they have expressed themselves, what their usual behaviour is, the nature of their underlying condition.

Q That also embraces something you have already mentioned in your evidence but I would like to deal with it now. It is very important indeed for a doctor in these sort of circumstances, the circumstances we are considering in this case, to have information from the nursing staff?
A I think most geriatricians would consider that nursing perspective is absolutely critical, and also I have to say the perspective of relatives and carers, who would know the patient much better from before their admission to hospital. So those would be two perspectives you would always try to obtain in any case where you have difficult symptom control in patients who cannot communicate.

Q And assuming your nursing staff are experienced and competent and all the rest of it, they, in your experience, become very experienced, indeed, at assessing the sort of stage that a patient is at in terms of a palliative care route and an end-of-life route?
A Experienced nurses are very good at recognising when patients are deteriorating. I think this opens up a broader issue about what the general approach to end-of-life management was in the Gosport War Memorial hospital by the nursing and medical teams as a whole.

Q And it follows, too, that one has to look to, in trying to assess the importance of the doctor's opinion, the doctor's experience, obviously, in that sort of field?
A Yes. I think most people practising in this field would say experience and training and interaction with peers and experts in the same area is important in developing one's expertise in this field.

Q Yes, and over years you would expect a doctor who had been involved in care for patients of this kind to develop a particular expertise in making a judgment about the state of the patient's medical condition, leaving aside all the tests and all the rest of it?
A I would, but I do think the interaction with other experienced clinicians, particularly if we are talking about Code A with other geriatricians and one's exposure to general thinking about management of the elderly in terms of continuing education, going to meetings, is important in developing one's expertise. One does not necessarily gain expertise alone from having exposure to a patient group. It has to be accompanied by specific training or working with peers and developing one's skills interactively in that context.

Q I am not taking issue with you about that, but I was trying to look at a slightly different aspect, and that is the experience of seeing patients, the hands-on experience of seeing patients in this sort of situation. It aids considerably, does it not, to the weight to be attached to a doctor's judgment about the sort of state a patient is in?
A I think very much so. There is a tendency for many other groups of doctors who are not practising in geriatric medicine to think that because they see old people there are no specific skills about how you manage and treat. It is, as I have indicated in my earlier evidence, a very challenging area and group of patients to look after, and exposure to the area and experience is very important.

Q May I just go on with a little bit more of what Code A was saying after the passage I just put to you. He goes on, having said that one should not hesitate to use opiate analgesia if necessary:

> "Obviously the oral route is the best if the patient can manage it, but if not, as is often the case, then injections or subcutaneous infusion were perfectly acceptable ..."

Yes?
A The oral route is preferred, yes. One thing he does not mention there is the use has to be accompanied by an observation of the response. Since you have a working hypothesis in the diagnosis the patient may be in pain, it is important to review that when you initiate the treatment.

Q I am going to miss out the next passage, as he is talking about how vital it was for a team effort and so on, and in the next paragraph a particular nurse raised a particular point. Can I just deal with what he said three lines in because the nurse was saying it appeared to her that it was routine for patients to receive opiates before they died and she questioned whether this was necessary. Code A said:

> " ... I agreed entirely, it was not necessary for the patient who was tranquil and apparently asymptomatic. On occasions a patient would only become distressed when disturbed, for example when two hourly turning was necessary. I explained that I felt in these circumstances the patient should have this pain dealt with even if it was only transient and intermittent".

A Unless the indications are the pain is not severe and troubling the patient, I would fully agree with that.

Q That is all I need to ask you about that general statement because the Panel have heard some evidence about it already. I want to ask you about a proposition with regard to

A Code A in relation to her time and her responsibilities in terms of her working in relation to those two wards, Daedalus and Dryad.

You are aware from evidence that you have either read or been told about, it does not matter, what the general picture was. Code A had, I think, a job involving her devoting five sessions a week to her work in that way, and were you aware that of those five sessions one and a half of those were apportioned to out of hours cover and commitment. In other words, B her practice would deal with one and half hours?
A Yes. I was not aware had that been agreed but I was aware that was the split stated.

Q And I am not worried about precisely because that is just to give us the general picture. So therefore, sticking to the terms of the contract, she would be in effect doing three and a half sessions, and we think of a session - forgive me if I get this wrong - as being three and a half hours, is it, in general terms? Or was it then?
C A I actually thought it was four hours, but if you state it is three and a half hours, I will accept that, of course.

Q I think it may have changed.
A It is four hours we work with now and I do not know what clinical assistants' jobs were, but if it is three and a half hours, it is three and a half hours.

D Q And, as you know, and the number may have varied a bit, 40 plus beds under her care?
A Yes.

Q And that I think - one can say generally - was an unreasonably excessive load, was it not, for a sole clinical assistant?
A In my report I was not persuaded in comparison to my own experience that it was necessarily - I forget the exact phrase used - clearly excessive. I think it was a lot to do. It E would depend on the extent to which the consultants when they visited the ward, put in input, and this is the whole problem. It depends on the framework. As I indicated in my report it certainly would not allow documentation of every contact with patients or relatives.

I think also the way Code A had to put that input in which, as I understand, was visiting in the morning and then going back later and then sometimes again, has the advantage of being able to respond at frequent intervals to problems throughout the day but it does have F a disadvantage, in my view, that you cannot focus on, for example, going round all the ward in one period and dealing with everything. Now, I am just making an observation about the nature of doing multiple, relatively short, visits within that constraint period of 12-14 hours that we are talking about.

My view was that a proportion of the patients would continue in care, and one would expect them to be reasonably stable; often these patients would not need any input on an individual G week so many of the patients depending on the proportion would not need to be seen every week, but clearly there would be the new patients to see, and I am talking in my report about the typical time that would take, say half an hour for each patient, and there would be the problems that arose and then there would be the extent of communicating with patients themselves and families and relatives. So it is potentially quite a lot to do: it has not got a full medical team one might have in an acute unit, so you would have to be prioritising what you were going to do

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Q It is very far from being the sort of medical cover you would get on an acute unit, is it not?
A Yes, but I think this level of cover was very typical for many units like this. I indicated it was analogous for all ours for the number of beds to our own unit.

Q And that workload, that pressure, would be increased if there was not within the terms of what was on offer, full consultant cover?
A Undoubtedly. I think the extent to which consultants were going round, dealing with the non acute problems, talking to relatives would be critical. If there was not a lot of that input, clearly more of the burden would fall on Code A

Q Yes, and I don't know whether you are aware of this or not: were you aware of the fact that in terms of 1998, Code A, who was Code A predecessor, was away on maternity leave and there was a decision not to provide any locum cover for her until she returned in February 1999?
A I was not aware of that when I wrote my report; I have become aware of it since listening and reading the transcripts.

Q So, therefore, there was a significant resource problem?
A I would agree that would make a difference and an impact, yes.

Q Well, you know what the general pattern was in terms of the evidence that was available as to how Code A worked, and the times she would visit the wards and so on. Were you aware of the fact that in 1991 she had raised the increasing workload difficulty with the Trust?
A I was aware in broad terms that the issue was raised. I did not know when it was raised. I did not know, for example, it was 1998: I was just aware at some point between 1998 and 2000 it was raised, and I had no information to refer to that in my report.

Q I am not trying to test you: I am trying to set the scene in a general way, and some of this you may not have been specifically aware of.
A I think you are aware of the fact that during the period of time that she was at Gosport War Memorial Hospital, more than ten years, there were no changes suggested to her in terms of her mode of work or her prescription habits or her abbreviated note-keeping. You are aware of that just in general terms?
A In general terms, yes. If I can make a comment?

Q Please do.
A I do think this issue is quite an important one. I do not really comment on it in my report because I did not feel I had the information and background to be able to comment, but my impression was that Code A was in some ways in quite a vulnerable position if the input from consultants was not strong, if there was not an audit programme or strong programme for looking at the quality of care in the service. When things are inadequate in terms of patient care, in my experience it is rarely that it is due to the actions of one individual, there is usually a system problem, and I think there was evidence from what I could see of some, if you like, system problems in Gosport War Memorial hospital. I made some comments about that in my original reports to the Hampshire police but I did not comment on it because I did not feel I had the full information and picture to really make an informed comment on it, but I will say that there seemed to me to be other factors which contributed to the pattern of prescribing.

Q It is not your function in general in this case to be brought in to express a view about management and resources but it comes up and I must raise it with you in terms of trying to look at the practicalities in terms of her medical care on these rather important issues that have come up in this case.
A I agree it is very important.

Q In general terms, when one is looking at the general issues, and you have covered in your evidence a number of general issues - we have looked at the BNF, we have looked at what the Palliative Care Handbook has to say, you have given a number of pieces of evidence about what should or should not in general terms apply, and I am not taking issue with those general precepts, but in reality, bearing in mind all the generalities, the only way to judge accurately a particular patient's needs for analgesia is by careful, clinical observation over time in the ward?
A Absolutely.

Q And obviously one cannot judge that by simply using abbreviated medical records?
A Well, I think you are raising a more general issue about can one look as an audit exercise or as an expert at the quality of care from the information recorded in medical notes. It is an accepted principle that we often do this in medicine: we audit the quality of care by looking at the information in medical notes and I think I and others have said before, if something is not recorded, there is an assumption that it was not done, and that is the way one approaches this issue. Now, if you have a culture which accepts that one does not record one's findings, and I am not just talking about the medical notes but the nursing notes, the fraternity of notes in terms of observations, if the contention is that there were a series of observations done, these were carefully considered in the treatment decision, clearly one cannot judge that from looking at a review of the medical records. One can only judge, and this is what I have done, I have not made any inferences about what may or may not have been done, I have tried not do, I have tried to draw my conclusions on what I have seen as being recorded in the medical records.

Q As I said, there is no criticism of you, what else could you do?
A Exactly.

Q But we have heard this expression more than once in this hearing that if there is not a note of it or it is not recorded it did not happen.
A I did not say that.

Q That is my broad brush. You put it in the way that you would think appropriate, if I misspoke.
A Well, one makes an assumption that it did not happen which is not the same as saying it did not happen, which is very important, and if my reports at the time did not make that clear then that should be corrected. I have genuinely tried to say in my reports if I did not see something that there was no evidence in the records that a particular assessment happened, if I did not see it.

Q It may be a jolly good thing to hammer home particularly to medical students and others in training, "Make a note", because the assumption may be that if there was not a note it did not happen. But we cannot apply it in this case again, it is not your fault, because the Panel are going to be hearing evidence about when Code A, for example, clerked a patient

in, of course she examined the patient and of course the nurses took blood pressure and so on and so forth, but it is not recorded on occasions.
Another matter one has to consider, and this is again by way of generality in relation to what nowadays is always called a generic report but the general approach, is the wide individual variation between patients to opiate need.
A Yes.

Q That is there as a given, in terms of the issues we are considering in this hearing. Also one has to consider the balance between effective psychological support through good nursing care and drug therapy to relieve anxiety and distress.
A Yes, I fully agree with that.

Q They are two routes, or two methods, two ways and there has to be some sort of balance between them. If there is not the adequate nursing care, that side of it suffers.
A I think most doctors would wish to see these as entirely complementary. You do not use more drugs because you cannot give the psychological and spiritual support. If you look at the end of life care pathways at Liverpool Care Pathway now, they are emphasising points of providing adequate input for both of those.

Q The degree of nursing care available and the degree of time available for medical care might influence the actual drug therapy, the amount of it and the regularity of it to relieve anxiety and distress, might it not?
A It might do, but it should not.

Q I am not suggesting it should, but the situation might force that on somebody.
A If we are saying – and I understand where you are leading with this and this has been a general issue of controversy and concern in the management of, for example, older people with dementia and behavioural disturbance in nursing homes – best practice is to use as little drug therapy as possible and to provide as much support and an appropriate environment and personal input. There is the opportunity, particularly where one has as required doses for nursing staff, if they feel they cannot provide the input that is needed, to give more drugs. So I accept what you are saying, but there can be situations where the lack of skilled nursing time may lead to the prescribing of more drugs than might be desirable.

Q We will come on to this in another aspect in due course. I think again, without asking you to act as someone who has conducted a thorough examination of all the history of this case in terms of what went on, you are aware of the fact that the evidence shows that the clinical workload of the Gosport War Memorial Hospital changed very significantly during the time that Code A was there?
A Yes. I think that mirrors again – I am aware of some of the figures and I think that also mirrors what generally was happening in these sort of hospitals in the 1990s. There was quite a radical change in moving from a culture of continuing care where there was actually very little input, into producing rehabilitation units which required a higher level of both medical and nursing and therapy input.

Q That again having its inevitable knock-on effect on the responsibilities and workload of Code A
A Yes. One of the issues of good management of services is to argue the case for the additional resources in terms of therapists and medical time that is needed when you change a unit. As I indicated, hospitals do not offer this out easily; you have to repeatedly make a

strong case to get the necessary resources and it can be quite an arduous time – I will not say battle – to get the necessary resources in this sort of clinical setting.

Q In general terms, is the general picture this so far as you can judge it on the information you have? Code A really had inadequate clinical consultant support, would you say?
A I am hesitant to comment, because all I have seen is the 12 cases which have been presented before me.

Q May I interrupt you? I am not going to try to ask you to make a comment about something where you may not feel you are fully equipped to do so and you are not here as a kind of committee of inquiry into the running of the hospital. It is a view that ultimately the Panel will have to take.
A I think my review of these 12 notes to me raised concerns that there was inadequate consultant, or let us say suboptimal consultant input. I am not going to use the word "inadequate".

Q Let us leave it there, unless you want to add anything in particular.
A I think there is a whole issue of oversight of Code A practice, which is in my view a consultant and hospital responsibility, and I think there was evidence that that was suboptimal. I do not want to go beyond where I should be commenting as an expert witness, but I am commenting as somebody who ran a similar service, as head of the service, and my impression from the very limited picture of these 12 patients.

Q It is obvious that so far as we can judge and you can judge, the staffing model at the War Memorial Hospital did not really change, despite the changing patient mix and so on.
A There is no question that the workload of Code A must have been greater in 1998 to 2000 than it was in the first seven years she worked there. I think there is no question about that.

Q We can leave it there. Would you agree with this? Where good nursing care – and I stress this – with adequate staffing ratios and regular patient supervision is lacking, the use of drugs earlier and at a higher dosage to control symptoms can help to ease the distress of patients and indeed their relatives.
A I think I do have trouble agreeing with that. I think I understand the argument you are putting forward, which is when you do not have enough skilled nursing staff and time, you cannot adequately, for example, titrate the drugs you are using to the best response. So in that context, where you may be concerned that if you start a lower dose with the nurses to adjust it, they will not adjust it. This has been a concern about treating older people, that they were not being given adequate analgesia – there is the opposite aspect as well to consider – and that therefore to give a higher dose is all you need to do to keep the patient comfortable. The problem with that is of course the problem of inducing unnecessary adverse effects. That is the problem with the approach. Of course, if you have an environment with a low level of nursing time, you will not get equally the monitoring for that and so you are ending up with a situation where you are having to use potent drugs in a very undesirable, one can say more risky way. So it is a difficult situation you have there. If you have people at the end of life, where that is agreed, I think one would definitely want to make sure they were comfortable and you might be willing to accept a higher degree of adverse effects, but if you have patients who are not at the end of life care, you have a very risk strategy, a very risky approach, one has to put in place as a doctor who has to make prescribing judgments.

Q The other risk being if you do not do that, in other words, aim higher rather than lower – and I do not mean out of reasonable ranges – the patient is going to suffer.
A Yes. What the response to that should be of course is that that environment, even more than a well-staffed environment, needs guidance and protocols to be implemented, because that is the only practical thing you can do in that environment in the short-term, if you have short staffing, to try and make sure people are working to at least some protocol which reduces the risk of either under-dosing or giving excessive drugs.

Q Ideally, a protocol in writing.
A Yes. And I do not think it would have been the responsibility of Code A for example, to create that protocol. I would say that as a comment.

Q May I just ask you about this as well, which touches upon what you have just been saying? It may well be the case in terms of the administration of opiates to patients of the kind we are talking about that doctors may legitimately disagree, have understandable reasons for disagreeing about the particular starting dose in a particular case.
A They may. Certainly within the starting range that is recommended by the standard guidance in the BNF, I do not think there is any problem. I think where the disagreement goes beyond what is recommended in the BNF or in appropriate guidance, the individual doctors, they may certainly disagree, but they have to justify their variance from the standard guidance.

Q Of course. One is assuming that the approach is rational and there is a reason behind it. I cannot remember whether you were present when Code A was giving evidence about the sort of variation you might encounter, because I was putting it to him that you might get two doctors genuinely disagreeing as to whether an appropriate starting dose was 10 mg of diamorphine or 20 in a particular case and he accepted you might.
A Yes. It is not even a disagreement; it is a difference in judgment as to what the appropriate starting dose is. Clearly whenever you ask a range of doctors what they would do, you get a range of responses. Unless you have a very straightforward problem with very clear trial evidence and very clear guidance, you inevitably get a range of different responses that individual doctors would take.

Q That covers the point I was going to raise. Just dealing with that particular fact, in terms of the figures – and I am hitting on 10 and 20 because 20 is a figure we have come across an awful lot in this case – one appreciates of course there is a difference, but the difference between 10 and 20 in relation to a starting dose, assume the patient has been on some form of opiate already, the difference between starting at 10 or 20 is not really that significant, is it?
A The answer is, it can be or it may not. I am sorry to be not giving simple answers.

Q Fair enough. It might be, it might not be.
A Could I say, I think the issue here is not merely the selection of the initial dose; it is the monitoring and actions that are taken in the light of the patient's response to that dose. That I think is in a sense the more important issue than the choice of initial dose, because even in the recommended doses, one will see patients – and we have seen evidence here today where small doses within the recommended range have resulted in serious adverse events in individual patients. A patient has had 2 mg of morphine and was hallucinating and confused. We talked about that earlier toady. So it is the response one takes when that

A happens which is the key and the mechanisms in place for nurses to report that and for appropriate action to be taken.

Q Of course. Again we come back every time to the particular patient. That is inevitable. Can I put it in this way? It would not be a surprise, would it, if a doctor had formed a view after some years' experience that where a patient had been on some form of opiates already, a starting dose of 20 was one that was rather more effective and sensible than
B a starting dose of 10, which would appear to have little or no effect.
A 10 mg of diamorphine does not sound a large amount, but it is not the number that matters. As we talked about, it is the equivalence in terms of where you are at. So I think, if I understand you, you are saying that through their own experience they may have found that starting people on 10 mg over 24 hours did not produce the desired effect and that they used 20, I can see that might happen. I think, as I have said in some of my earlier evidence, one of the issues is when you use a syringe driver and how you start using it. If a patient is not
C already stable on a previous dose of oral morphine or injected subcutaneous morphine or diamorphine, you will not see the full effect of that infusion until quite some time later, 20 hours or more. It is the case that many doctors do not understand the principles of clinical pharmacology – and I am not talking particularly around what Code A may or may not have known – but actually we know that most doctors do not understand the principles of clinical pharmacology very well and so do not appreciate often the delay in getting to the steady state and the response you are going to see. That is why guidance is there to help
D guide doctors, for example, when they are switching to an infusion pump from using another route of oral medication.

Q May I just ask you something relating to that? The question as to what is actually going on when a patient is receiving subcutaneous analgesia – I will stick with diamorphine for the moment – without getting too involved in half lives and things of that kind, in particular because I confuse myself when I go into that sort of topic, dealing with, let us say,
E subcutaneous diamorphine administered at the rate of 20 mg in 24 hours. You have already indicated that of course you have to allow for the fact that that is going in slowly over that period and therefore it is going to take a bit of time to take effect. If you have an immediate, acute pain problem, very often the best solution is an intravenous injection or I suppose an intramuscular injection.
A Yes.

F Q To get the effect straightaway. We have seen cases in the histories of some of these patients where they have been given intravenously say 2.5 or whatever it might be in a hospital.
A We call that a loading dose as an approach.

Q I would just like you to help us with this process. Taking 20 per 24 hours as an illustration. A syringe driver administers the diamorphine at a steady rate.
G A Yes.

Q Morphine as I understand it will reach its peak in general terms four hours after it is administered. Is that right or wrong?
A Not with that injection route. It will be substantially longer than that, because ---

Q Can you stop there? I do not want to waste time on that.
H A It is longer basically.

Q Four hours for morphine on a single injection, is it?
A Sorry, that was the average half life. A rule of thumb is four or five half lives. So you will reach the maximum effect and then you have, with the metabolite at about 20 to 24 hours, about a day after you start you will be at the maximum effect.

Q On a single injection?
A One single injection?

Q Yes.
A No. You will absorb that within half an hour to an hour. You will have the maximum effect at around half an hour.

Q You were giving these ranges ---
A It is a single injection under the skin. You will absorb it within about half an hour or an hour and you will have a maximum effect at about one hour.

Q Going back to 20mg subcutaneously, the diamorphine is going in at a steady rate, what sort of rate is actually going in per hour? Do we simply divide the 20 by 24?
A Yes. I do not want to make this even more complicated than this. Of course, you are injecting it under the skin, and then it has to be absorbed from under the skin, so there is even a lag there. So there is a lag of it starting to be absorbed of an hour or so, and then it is going in 20 divided by 24, just under a milligram per hour, yes.

Q Right. Is this right in terms of the way to think of it: since it is being administered at a steady rate, there is not, apart from the initial achievement of the level, there is not actually a peak, or is there a peak?
A No, there is a peak, and it is a peak at five half lives, which is around 5 x 4, for example, 20 hours, and then to further complicate it you have got the morphine 6 glucuronide active metabolite, which is also accumulating, and then they have a lower half life, and this is a particular issue in patients with renal impairment, for example, where the metabolite is excreted through the kidneys, so it will be even lower than that, but certainly you would not get the maximum peak of morphine until about beyond sixteen hours.

Q All right, something like that.
A I mean, in textbooks it is shown with diagrams and it is much easier to understand. To describe it all verbally, which I know is what lawyers always do, it makes it more difficult.

Q Lawyers occasionally use diagrams and things as well, but that is enough for our purposes. Can we just in general terms think of this issue in terms of fentanyl.
A Yes

Q Does the same principle apply in terms of it being administered into the body at the same steady rate, or not?
A Through the transdermal patch the administration absorption is, but it has got a much lower half life, so it takes longer to get to the peak effect and it takes longer for the effect to work. So that is the important difference between fentanyl and morphine and diamorphine.

Q Thank you. That clears that up. The fentanyl patches we are concerned with in this case were three-day patches, I think---
A Yes.

Q ---in terms of the general picture. I suppose it is a complete truism, and I think you have already covered it, that it is impossible to determine in advance the opiate dose required to control pain in an individual.
A Very difficult.

Q That is a given.
A Particularly difficult in older people, because their range of responsiveness is greater.

Q As you have already made the point, in dying patients there is not a problem; you do not have to worry about drug dependency, and large doses of opiates are often required.
A You do not worry about the adverse consequences of necessary opiates in people who are dying to control symptoms.

Q Obviously, pain and distress are also enormously variable?
A Of course.

Q Would you agree with this: the severity of pain depends on the clinical situation and its perception varies with anxiety, fear, other symptoms and whether the patient himself or herself has come to terms with the fact that they are dying?
A I would fully agree with that.

Q It is impossible to determine clinically the causes of deterioration in elderly patients with multiple co-morbidities. Would you agree with that?
A I think in all the comments I have made about individual patients I have said it is impossible, to use a legal phrase, to be sure beyond reasonable doubt about the cause of deterioration in most of the patients we have seen, because these were frail individuals, they were in hospital for the most part because they were unwell, and they are at high risk of developing acute medical problems, and I hope I have acknowledged that in most of the statements I have made.

Q Code A I am just trying to get down to some basic propositions to see whether there is a disagreement. Would this be right: the only certain way to determine the contribution from symptom control medication, in this case opiates, is to stop it completely for at least 24 hours?
A Yes, or give an antidote, which I have not suggested, I do not think, in any of these patients should have necessarily have been done. You know, one can give naloxone, and that is what we do, if we have got somebody and we are not sure if opiates are the cause of their depressed conscious level or reduced respiratory rate, we give them the antidote and we see what happens.

Q In patients of this category, patients who are in this situation, it would be unethical, would it not, in this patient group, simply to stop the administration of opiates subcutaneously just to see what the effect was – stopping it for 24 hours?
A I have seen that comment from one of the experts. I do not agree with that. It is over-simplifying the issue. It depends on whether these patients are at the end of their life, and it depends whether they were clearly in pain or had another symptom that has responded to the

intervention you have given. If they clearly had severe pain and you started opiates, one knows that if you stop it completely they will get severe pain back. I mean, I do not think it is a matter of ethics, I think it is a matter of good medical practice you would not do that. I mean, ethics is not the approach I would take to it. It might be appropriate, and again I know some experts have criticised my comments on this, to stop until the opiate level has gone down, if you think that is the toxicity, and then start at a lower infusion rate. What would generally happen is one would reduce the rate of the infusion if you think the balance of benefit and adverse effects is not right, if, you know, you have got over-sedation or you have suppressed the respiratory rate more than is necessary. It very much depends on whether they are in this end of life management phase, and I think the issue with some of these patients is there is a question mark over whether they were there or should have been there.

Q All of this, all of those aspects that you have just been telling us about, show the difficulties of making judgements about these matters with regard to particular patients.
A In an individual patient, and of course it has been looked at in another context, to conclude that drugs definitely caused their deterioration or death is very difficult.

Q Yes. It may be that even then it is still impossible to tell one way or the other.
A Yes.

Q Would you agree with this, if I can just put it to you in a bald way: diamorphine and other opiates are extremely useful not only for pain control but for alleviating the secondary anxiety and distress caused by the fear of death?
A Well, I think I have answered this with my earlier response, that opiates are very good in patients who have pain at reducing these other symptoms. In patients without pain - and I think one is in a difficult area here; we do not routinely look to opiates to reduce anxiety and distress in people who are pain free who may be near death.

Q I am not suggesting "routinely" used, but it is something that would be legitimate to do in a particular case, would it not?
A I think there is a reasonable body of medical opinion, despite the indications for opiates in BNF, and despite guidelines not mentioning this, there would be a body of opinion out there – I have to say I do not think it is certainly palliative care guidelines, and palliative care physicians in my experience do not hold this view, that they would use opiates for this purpose – but there are people who would, and might consider using opiates in that context, but I think palliative care specialists would seek to deal with fear and anxiety in people without pain through other approaches rather than using opiates. Now, that may be best practice, it may be very specialist care, and I am trying to answer your question to reflect the range of opinion in this area.

Q If I may say so, quite rightly. (To the chairman) Sir, I have got one more matter on this topic which I was going to ask the witness about, and then it might be convenient to have a break.

THE CHAIRMAN: Yes, I think it would. Excellent.

Code A: Just one more matter touching upon that same issue. I am using a passage from your report. For your assistance, and you probably will not need to turn it up, but in relation to Patient C, Code A, the lady who was suffering from carcinoma.

A A Yes, I think I recollect what I said in that report.

Q You said, in relation to the prescribing of opiates by Code A, and we will come back to this when we take a look at this particular patient, you were saying there did not appear to be any evidence she was in pain---
A I did.

B Q ---and you indicated that you thought the reason might have been to provide relief for Code A anxiety and agitation, and just to give you the whole quote, "This is a reasonable indication for opiates in the palliative care of a patient with known inoperable carcinoma". So there is an illustration of a set of circumstances which, in your view, would justify the administration of opiates to relieve anxiety and agitation?
A There are two things: I am well aware of that statement, and I am very happy to stand by it. It is not an approach I would take, but I think there are two things: first of all, a patient
C with no malignancy, I think one has to say most doctors have a lower threshold for using opiates if there is any suggestion, and that was where Code A I think, is different from other patients; and, second, I did believe and do believe certainly at that time there was a reasonable body of doctors, even though it would not have been necessarily my approach, or palliative care specialist approach, who would use opiates in that sort of context.

D Code A: Then that is as far as I can take that topic. Sir, that covers that aspect. Thank you.

THE CHAIRMAN: Thank you very much indeed. We will return at quarter-to three, please, ladies and gentlemen. Thank you.

(The Panel adjourned for a short time)

E THE CHAIRMAN: Welcome back, everyone. Yes, Code A

Code A one individual matter relating to what sort of number of terminally ill patients on a long-stay ward receive opiate analgesia. This is not a test of your amazing powers of recall, but you will be aware that there are studies relating to that in terms of the number of terminally ill patients on a long-stay ward who receive opiate analgesia.
A I have not seen those studies actually. My own experience is we do use opiates in a
F proportion of patients, frail older patients, in a long-stay continuing care ward setting. My estimate from my own personal experience is that probably less than a third, probably around a quarter would be my experience, but I have not looked at the published literature, and I suspect it varies quite widely between units would be my prediction.

Q I am sure, and I do not want to give you homework over the weekend, but may I just mention to you a study, and if we need to pursue it we can: this is Code A et al on
G palliative medicine, and I will make sure you get the reference, 1987, 149-153, a percentage of over half; but if I simply give you the reference at the end of the day, if you would be kind enough, it does not matter if you cannot, but if you just check it, the percentage, I understand, was 56, but as you rightly say it may vary from---
A I do not think it is out of keeping with my own experience of a third from recollection, so I am very ...

H

Q All right. Now, just some individual topics, if I may. I am sorry if they are a little bit miscellaneous, as it were, but it is the only way of tying these aspects up. It is apparent in this case, I think, even on your own view, that there were cases where patients were sent to Gosport War Memorial Hospital who were not medically stable on admission.
A Oh, yes, I agree with that. There were at least two patients, I think, who clearly in retrospect were not medically stable.

Q One has to be aware in real life of the possibility of doctors on acute wards either overstating a patient's clinical abilities and potential for rehabilitation, or maybe perhaps understating the patient's post-operative pain.
A Whether overstating or understating is the issue, I mean, certainly I would agree with statements made that non-geriatricians, non-rehabilitationists, may over-estimate, because it is not their area of expertise, the likelihood of recovery, and they may do it both ways actually: they may underestimate likely recovery, and they often may give an overly optimistic picture, and that is part of geriatric practice of adjusting patients and their families to the likely outcome, and families often may have a belief about what they have been told which is not necessarily what the doctor on the referring unit has told them, so it is a very complex issue, the one of expectation of recovery.

Q I just want to put this: would you agree in your experience that pain is often under-recognised and under-treated on acute hospital wards?
A I think there is no doubt about that. I think a number of studies, and I cannot quote them to you, but have undoubtedly shown that under-treatment is well recognised.

Q Thank you. May I just ask you about deterioration generally, and we appreciate that we have seen "deteriorated overnight", whatever it might be, in a large number of cases, and sometimes there may be no detail as to quite what that means, but it would be right, when looking at the patients in question, I suppose, in any case when one is considering what happened at the end of a patient's life, one must not close one's mind to reasonable possibilities that significant and progressive co-morbidities contributed to worsening clinical states?
A In the patients, I absolutely acknowledge that, and I hope that was reflected in my report.

Q It is. You certainly refer to it in certain cases, but I am flagging it up as a very important matter. It may be very difficult if not impossible to tell in cases where the balance lay between those and the effect of opiates.
A I would agree with that. In some cases, my view, and it is an opinion, is that drugs may have placed a bigger part, and in other cases patients were clearly going to die in the near future, and whether the drugs played any part, it may have played no part, I would fully acknowledge that.

Q In some cases, in terms of treating patients in these sort of situations, it is just not possible to control pain without the patient becoming drowsy, or even sustaining a depressed conscious level.
A No, and again I hope in some of my previous evidence, statements, I have acknowledged that point, and sometimes one has to accept to achieve pain control you do get some adverse effects. The point is one tries to minimise the adverse effects, but in some cases you may have to accept sedation and drowsiness as the price for controlling pain.

Q That very often is the price in general terms, is it not?
A Yes. I think it is further complicated by the fact that end of life patients become drowsy even without drug treatment, so it is not even clear always that it is the drug treatment.

Q You are dealing with something I was going to proceed to clarify with you and I think you now already have, that that may be part of the end of life process?
A Yes.

Q May I just come to double effect. I know you have touched upon it and I am not disagreeing with what you have said, but is another way of expressing the proposition with regard to double effect in this way: if measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable, provided the doctor's intention is to relieve the distress and not to kill the patient, putting it in very blunt terms?
A I agree with that statement. My only qualification is it applies to people who it has been agreed are at the end of life. I mean, clearly, if we have people who have got a reversible, treatable condition, and their pain is difficult to control, we would not in that circumstance give them treatment which might lead to their death. So, yes, I agree with it. I am just putting it in the context that the principle of double effect is usually discussed.

Q I am putting it in the same context myself in the way you have already indicated. You in your evidence put it in this way, I think: when giving opiates it is important to be aware of the adverse effect of respiratory depression; if the patient is at the end of life it is not the same issue. It may be a necessary consequence of end of life---
A Yes, absolutely.

Q It follows, I think, in terms of post mortems, or anything of that kind, in relation to patients, it may well be that toxic doses of drugs and their metabolites could well be present at the time of death in patients who have been appropriately treated.
A Yes. I do not think drug levels would have been particularly useful, and I do not believe I comment on them in any of my reports. Drug levels are more of help where one is uncertain about what has happened or the cause of death in unusual circumstances. So I do not think they would have provided any particular insight into these cases.

Q No, I am not suggesting they would, but that is a fact, is it not, that that is what you may well find as a result of---
A You may well find high levels of opiates in patients at the end of life. Indeed, you would expect to in certain cases.

Q Yes, as you have already indicated. Although in fact the administration of opiates, subcutaneous analgesia obviously in this case, may have played a part in a sense in the patient's death, it is not something that people normally put on death certificates.
A I think I acknowledge that in the discussion of one particular patient, yes.

Q I think you are aware of the fact that the view was, in terms of increasing doses of opiates, that doubling the dose, in general terms doubling the dose, where an increment was needed, appears to have been a generally accepted rough guide?
A Generally accepted incorrect view compared to the guidance that was apparently referred to, but, yes, I have heard statements to that effect, so, yes, I would accept that those

A statements were made, and I also believe again people did hold that view, although it was not what was recommended best practice, but I agree with that, yes.

Q I am mentioning it specifically because it is one of the things Code A talks about when he gives his evidence.
A I understand, yes.

B Q In terms of the conversion I appreciate you have been saying one has to try and keep track of which one is the right one to use. You either use a third or a half, and I think you would probably be aware of the fact that in the Wessex Protocol or in the Palliative Care Hand book it says the conversion rate is a third to a half depending, in effect.
A I thought it actually said it was a quarter to a third ---

Q Shall we just check?
C A I did check on this point specifically. I think the half I did put in my reports, but I could not find a guideline which specifically recommended a half, unless I have misread the Wessex protocol.

Q I may have got it wrong, so shall we just check, while we are at it?
A I think it is page 9. Opioid equivalents was where I took it in the Wessex - yes, sorry, page 9 of the labelling of the guideline itself, where it says: "Broadly equivalent to
D Oramorphine 30 mgs diamorphine subcutaneous 10 mgs".

Q Would you look at page 8 of the guidelines on that same page, on the left hand side, where the column is headed "Use of morphine". If you look at item 7 that is where I have got that figure from.
A Sorry, yes, you are indeed right, it was there. So there is a conflict between what it states there and what it states on the page, but in my reports I did include the half. I have
E corrected my reports to allow for that reference.

Q You do and you have done in your evidence, and when we get to cases where one has to go into the conversion figure, you will forgive me if I use a half.
A It is perfectly reasonable to, yes.

Q Anticipatory prescribing, just as a general topic; we will be looking at it with regard to
F individual patients. The fact of anticipatory prescribing is not something you would criticise?
A It depends what drugs we are talking about and in what context, but I discussed how anticipatory prescribing is done for some drugs all of the time.

Q Yes, I am concerned obviously in this case with the opiates that we are considering. In general terms there are perfectly sensible reasons for doing it.
A There are circumstances in which to make a prescription for an opioid on a purine basis
G would be reasonable. I think when we get to discussing subcutaneous infusions, I may have a particular view about that.

Q Well, I am going to confine it to that, if there is no further qualification in relation to analgesia other than subcutaneous. I am asking about subcutaneous analgesia. I think you may have been present when Code A gave his evidence where he said he had come across it elsewhere and he said we do so, or they do so, on the palliative care ward at Queen Alexandra
H today. Do you remember that evidence being given? It does not matter if you do not.

A A I do not particularly recollect that statement from him, but, of course, I accept it.

Q And he indicated that, of course, his view was that that was good practice, if there was somebody who was very frail or had been seriously ill, and the doctor did not know what direction their course was going to take. Would you agree with that view or disagree?
A My experience from talking to palliative care physicians is certainly most palliative care settings where a patient is on oral opiates might well put in the provision to move to
B subcutaneous infusion at the equivalent rate if the patient becomes unable to swallow. That is an appropriate prescription and strategy. I think the issue is around opioid naive patients who are put on PRN subcutaneous infusion prescriptions of diamorphine and midazolam. Where I indicated this was not a practice I was familiar with or had seen or heard of in elderly care ward settings, I did certainly think there might well be a case for one-off PRN doses of subcutaneous drug, I indicated in an opioid naive patient indeed why starting an infusion would not really be the best strategy because you would take some time before you had
C a response, so I think one has to differentiate between patients who are taking opioids orally already and those who are opioid naive.

Q There is no difficulty if, in fact, the intention is that the prescription written for subcutaneous analgesia is only going to actually be administered when the appropriate stage has been reached.
A And if there is discussion with a doctor - yes.
D

Q And obviously - and I do not see any dispute about this, whether it is best practice or not the objective is to prevent the patient suffering unnecessary delay in the administration of subcutaneous analgesia?
A Yes, and the whole issue then becomes it is not just a prescription it is the environment and the framework in which that prescription is going to be used and how it is going to be used which is the issue as to whether it is a safe prescription or not.
E

Q But if that is the understanding, that it is only going to be administered if the doctor is able to authorise it, for example, if the doctor is not available but can say "Use the anticipatory prescription I have written up, no problem"?
A No, absolutely. But I emphasise this was not a practice I had seen in the sort of elderly care rehabilitation ward ---
F

Q You have said that. In connection with the same topic, if you like, of anticipatory prescribing or proactive prescribing or whatever phrase one uses, is this something which does occur in relation to cases of patients who are terminally ill either at home or in a nursing home? That an experienced practitioner, a doctor, would have to make an assessment of the appropriate starting dose of opiate to control the symptoms until their next visit?
A Now you are asking me to comment on an area I do not practise in in nursing homes or the community so all I would say is that again that seems to me a sensible strategy, to have
G anticipatory prescribing which can start with some check with the doctor. That would be safe, sensible prescribing.

Q It may be perhaps common sense; I appreciate your expertise. And of course in such cases the actual appropriate starting dose, because of delays and the problems that go with those sort of situations, it might by necessity be a larger dose than would actually be used in a hospice or a palliative care unit?
H

A I have some trouble with this in applying it to this setting because there was one and a half sessions of out-of-hour support where the staff could, at the very least, get what should be fairly quick phone contact to discuss an issue, and I would have thought, even for a general practitioner on call with their other duties, one would expect them to be able to attend within a period of, say, four hours, maybe slightly longer, depending how busy they were with other patients, if that were needed

B Q There may be a lot of practical problems associated with it and one cannot, without running a film, as it were, of everyday life at Gosport War Memorial Hospital, be precise about that, but there is a perfectly reasonable issue to take into account in terms of trying to ensure that patients do not suffer unnecessary pain and that their pain relief is not unnecessarily delayed?
A Yes, but if one has set up this system of anticipatory prescribing to relieve pain quickly, you should not need larger doses than one would be starting if one had immediate medical
C attention. That surely is the point of it.

Q No, not in anticipatory prescribing in that sense. You are using an anticipated starting dose, alright?
A OK.

D Q It is important to bear in mind, and this is another general issue with regard to patients in the sort of conditions or situations we are dealing with in this case, that pain and restlessness, once controlled, do not remain at a static controlled level, do they?
A No, they vary, and that is the whole point of why one needs to monitor symptoms and adjust treatment upwards or downwards.

Q And in general terms the patient's condition continues to change as death approaches?
A Yes. You would expect it to, in fact.

E Q Part of the process of dying?
A Yes.

Q And the few days before death are anything but a stable situation, for the reasons we have just discussed?
A Things can be stable with a steady slow deterioration or they may not be, and I would
F fully acknowledge that point.

Q We are all operating on the basis that things can be very different with different patients, and the deterioration might be very sudden; it might be unexpectedly prolonged?
A But you need a system to be able to monitor and adjust treatment to relieve symptoms.

G Q Of course. That is the importance of nurses, keeping observation on the patients when they are the only treatment staff in a general sense available, because as the body symptoms shut down changes occur which require constant monitoring?
A Yes.

Q Another generality I think, that has probably already been covered by you in your evidence, is that poorly controlled pain is more difficult to overcome and control than inadequately controlled pain.
H A Yes ---

Q May I just add one thing for you to deal with? I think you were indicating yourself in your own evidence, unless I have got my recollection wrong, that analgesics are more effective in preventing the development of pain than they are in the relief of established pain, is that fair?
A I am not sure I put that forward in my own evidence but there is work that certainly supports that concept in terms of the basic theory of pain and in practice of anticipated pain, if you are going to do a painful procedure on someone you give analgesia beforehand, so it is a well-established principle and there is evidence to support that. I am not a pain specialist. In this area of practice in the elderly again there is no specific data about it but the general principles we would apply to a frail elderly group as well.

Q And then this: in terms of transfer it is another general topic I want to address in this way before we move on to individual patients. You have already indicated how the event of the transfer itself may cause a deterioration in a patient, and you also indicated that, generally speaking, patients would recover to their former state having got used to their new surroundings after two, maybe three days. It depends. It is not every patient who, as it were, continues to go downhill as a result of the transfer. But there are patients on whom the transfer can have that effect, are there not?
A It can do, but I think it is important to emphasise you are certainly trying to minimise this and this is one reason for not transferring medically unstable patients or patients who are at high risk of deterioration on transfer, and this is an important part of the selection. You do find patients who have deteriorated on transfer and I could talk through whether that was the transfer itself or something that happened during the transfer, or just that they would have deteriorated, and I think we saw that in some of these patients, if they had not been transferred because of their underlying medical problem, so it is again a complex range of causes for deterioration.

Q And we have obviously got one case in this case where a patient was transferred in such a hamfisted way, or whatever the right expression be, that that itself caused a problem?
A Yes. Absolutely.

Q But it is something that doctors receiving patients would obviously be aware of as a possible problem as regards a deterioration?
A I think everybody working in this setting would be aware of this issue, yes.

Q Whether with a sigh of relief or a sigh of despondency I am now going to turn to the individual patients.

Patient~A, please. Sir, what I am going to do is stick to the same order. It may be that issues will be thrown up in the course of this but I am going to try and go through it in the same way as we have already. There seems to be no other sensible way of doing it. I am going to try to use the summaries wherever possible. I think there may be a couple of occasions where I need to refer to an individual note within the file itself but I am hoping we can use the chronologies.

Patient~A, Code A We have been through the history more than once, depression and the other problems that there were in this case, and I am going to move, if I may, to page 9 of the chronology, please, which takes us to 4 January, the review by Code A setting out the

A situation there, chronic resistant depression, et cetera, and we can see towards the bottom of that same page the last box on the left in correspondence Code A saying:

> "Has recovered from recent chest infection, but is completely dependent with Barthel of 0. Eating very little, but will drink moderate amounts with encouragement. Overall, prognosis poor. Happy to arrange transfer ...",

B et cetera. Well, "overall prognosis poor" - one never knows, of course, but is an indication that in the view of Code A this patient was unlikely to get better and unlikely to live for any significant period of time.
A And I think any geriatrician looking at this from the information would fully agree with that.

Q Then on the admission on the 5th on page 10 of the same document, one can see what
C the situation was in relation to that general position, "Poor physical condition", say the transfer details and so on, Code A description of the situation when she clerked that patient in, as it were.

Over the page, page 11, I would like to ask you about the drugs the patient was receiving prior to transfer.

D I think, sir, what happened in one of these cases, and it may be this one, is that we had a replacement page but to avoid my having to write out a whole series of notes I kept the same document, but I think at the top of page 11 in red it says "Drugs patient was receiving..."?
A Yes.

Q "Sertraline, lithium, diazepam, and thyroxine". Sertraline --- ?
E A --- is an antidepressant. It is a mood stabiliser usually used in depression with mood swings.

Q Diazepam we have covered already; thyroxine we have covered already.
A Yes.

Q What would be the effect in general terms, if you can give an opinion about it, if those
F drugs were withdrawn from a patient like this, because there was an antipsychotic element?
A There are two issues. If we start with sertraline. If you withdraw most of the antidepressants, there is a risk of a withdrawal syndrome. So general recommendations now, which I think were not so much in place at this time, are to withdraw gradually and to halve the dose for a period and then stop. So you can get agitation and you can also get obviously a recurrence of depressive symptoms, but we know this man is already depressed on an antidepressant.

G

Q I am envisaging an immediate stop. The result would be a risk of increased agitation.
A There is a potential risk of that and also with lithium, if it stabilised his mood and one stops it, there clearly is a risk, if that was having a useful effect, that mood swings could be worse as well.

Q Then the next drug down on that same page on 8 January is where Code A
H prescribed Arthrotec, a painkiller which you said was perfectly appropriate to prescribe.

A Again, the withdrawal of that, just treating it in the abstract for the moment, means a likely increase in pain, does it not?
A If it improved his symptoms to begin with, and I am not sure we are clear whether it did or not. I comment that the issue of stopping drugs in people who are frail and deteriorating is actually quite good practice to see if they are having a useful effect, because you may only be getting adverse effects from these drugs as well. Lithium in itself can produce problems if it is at toxic levels and antidepressants can certainly suppress appetite
B and produce other problems, including agitation. So the decision to stop these I think was entirely reasonable and appropriate.

Q We have the note which was added to the original version, on 9 January, when he was reviewed by Code A the painful right hand and so on:

"Try arthrotec. Also increasing anxiety and agitation ? sufficient diazepam ? needs
C opiates."

So the doctor is considering whether his condition may require the administration of opiates, a perfectly sensible consideration to have in mind. Do you agree?
A Yes. I think I commented that one would first perhaps want to try codeine if he has not had that, or an opioid at the middle of the analgesic ladder.

D Q Then 9 January, "Generalised pain". Do you see that?
A Yes.

Q Would you go to the entry with regard to 10 January, "Reviewed by Code A", where she says, "For TLC".
A Yes.

E Q As you described it yourself, having considered this situation in your evidence, you said anyone who saw him – we are talking about 10 January – would realise this man was near the ending of his life.
A Yes.

Q Would you just help us with that? Code A is saying what she found:

F "Will eat and drink. For TLC
Telephone call with wife – agrees in view of very poor quality for TLC."

Why would the realisation be that this man was nearing the ending of his life? Could you just explain that?
A Because he has had a significant deterioration in the previous weeks and it is in the context of a long history of difficult, disabling depression. Now he is losing weight, he is
G becoming increasingly frail, he has less function. Functional decline is one of the biggest factors predicting death in an older population. And he has pressure sores. So the picture is very clearly pointing to a continuing path of deterioration.

Q As you have indicated, it was reasonable for him to be prescribed Oramorph and commenced.
A Yes.
H

Q So you have no difficulty there with the administration of that opiate.
A No.

Q If we go on in relation to the drug charts, still relating to 10 January, the Arthrotec is discontinued on that day. Yes?
A Yes.

Q We have dealt with the question of the effect of that. Then comes the point where Code A prescribes anticipatorily diamorphine, hyoscine and midazolam. You indicated with the dose range of diamorphine here, if the starting dose was appropriate – if the starting dose was appropriate – then that range is not something one would take exception to, 40 to 80. Assuming 40 was the right starting dose, you indicated it would not be a problem in terms of the range of the dose.
A I did. I think the concern I had was with the starting dose in the context of the morphine dose prescribed.

Q I appreciate that, but I just wanted to make sure that was right.
A There is a range; a two-fold range gives an appropriate leeway for the nursing staff to adjust.

Q In terms of issues between us, no problem. Just that limited issue.
A Yes.

Q You have dealt in your evidence with the normal subcutaneous conversion and you indicated you were criticising that. I think you indicated it should have been, say, 15 if he could not swallow and then a two or three-fold increase to give leeway, getting to, say, 20 to 30 at the top level. If the prescription had been 30 mg, you would not quibble with that.
A Well, 30 mg would be 90 mg of oral morphine equivalent. Let us take the half conversion as referred to in the Wessex protocol. 30 mg over a 24 hour infusion is 60 mg. So if he had been receiving prior to starting the infusion half of that, say 30 mg of oral morphine, that would be an appropriate range, but I think it was a large increase compared to the morphine he was receiving.

Q I am just trying to see what the difference is. If you are allowing for the fact that because his symptoms are not being controlled by the Oramorph, therefore when you start off the subcutaneous analgesia, you are aiming to take care of that by an increase.
A Yes.

Q You are also allowing for the fact that the sertraline and the lithium and the Arthrotec have stopped. What figure are you saying ----
A He was on 30 mg a day. I think I have covered this in my report. 30 mg of oral morphine. If we take the half conversion, 15 mg of subcutaneous morphine, and if one allows for some increase in that – and here, is it 50 per cent we are taking, is it – I indicated that the appropriate lower end if one were converting would be 10 or 15 over 24 hours.

Q But supposing Code A had prescribed, say, 30 mg, you would not quibble with that?
A If he was not having adverse effects at the time, no. But I think this prescription was instituted of course before – we do not have the date – but my understanding is that that was instituted before he had received the doses of morphine.

Q This is an anticipatory prescription. The first time it is administered is on the 15th. This is on the 10th. The first time the diamorphine is administered, and it is administered at a higher level still, is on the 15th. So five days later. To anticipatorily prescribed diamorphine like that, had it been 30, say 30 to 60, you would not be saying that was unreasonable?
A Well, it is too high. It does not allow an appropriate starting dose.

Q Too high by only a very small margin.
A An anticipatory prescription is being made. At the time, one is yet to see his response to oral morphine. So you need to have a lower band of that which would reflect the fact he might receive the lower dose that he has been written up for, which was, looking back to those prescriptions, 5 mg and 10 mg doses. So you would want to have the lower dose of that prescription for anticipatory prescribing to cover the situation to give the appropriate lower dose.

Q The logic is this, is it not? Here is a patient on such and such a dosage of Oramorph. I am concerned that the situation may be reached where his pain and distress may be such that he will need a subcutaneous analgesia administration at some time in the future.
A Yes. He may have problems swallowing , so one needs to move from the oral route to the subcutaneous route.

Q Assuming there is a reason of course for the switch, the odds are, it is very likely that if the switch takes place or when it takes place, the Oramorph will no longer be working at that same level, that he will have reached a higher pain level. Does that make sense?
A Possibly, but not necessarily. The main indication to switch is the inability to swallow, not lack of pain control, because one can deal with that through increasing the oral dose, as we have discussed earlier.

Q Let us go to 11 January. Would you look at that as a starting point? I think it may be page 14. Do you see there where Code A has prescribed 80 for the diamorphine?
A Yes.

Q So it has gone up. Code A was indicating that the fact of the anticipatory prescribing, although she said she would not have started that high, was a reasonable thing to do in a functioning unit where you trust the nursing staff.
A My concern is not the anticipatory prescribing. In this instance, it is the dose, the starting dose. I do not criticise. It is reasonable, if you are establishing a patient on regular morphine, to have a strategy to be able to convert them to subcutaneous infusion should they need it.

Q You indicated in your evidence by way of general proposition that this man is dying, but your concern was that the levels were too high.
A Yes.

Q You said there is a note that he has anxiety and agitation, so a good indication for those drugs, but difficult to separate out the cause of his anxiety and agitation. Yes?
A Yes. So my conclusion was an appropriate starting dose would have been at 15 to 20 mg or 30 mg if he was showing signs of still being in pain.

Q If we can move on, please, to the 15th, when 80 mg of diamorphine was administered and midazolam 60 mg. You indicated that you could not find any clear indication in the notes for going on to the syringe driver. I think that is right in this case. Yes?
A Yes. There is no information that said why there was a need to change from oral morphine to subcutaneous infusion. That could have been recorded in either the medical or, more likely, the nursing notes, since the nurses were initiating the prescription.

Q You can see the note underneath that in relation to 15 January:

"Now unresponsive. Unable to take fluids and diet."

A Yes. My comment was more, we were not clear about what his status was before he started. He may well have not been able to swallow, but the notes do not give a description of that.

Q I accept that. You can only go on what is in the notes. "Pulse strong and regular". That is an indication that he is not suffering from over-sedation or respiratory depression.
A No, I would not accept that. You can have respiratory depression without impairment of circulation and you can have sedation without impairment of the circulation.

Q Of course, just trying to analyse the situation, if he had started on 20 to 30 mg diamorphine and, say, 10 midazolam, just to give a basis, and he had ended up two days later on 80 mg of diamorphine and 60 mg of midazolam, there would not be any complaint about the course, would there?
A If he had restlessness, we know he is in pain and he starts at those lower doses and that was described and there are continuing observations which indicated he had continuing symptoms and there were appropriate increases that were reasonably consistent with the guidelines or showed that they were still needed, of course one would have no questions whatsoever.

Q So it is not the level that eventually he reached, it is the progression which is your concern?
A It is the starting point and the problem of the lack of documentation which justifies the dosage used at any time in general. I am making a generalisation here. The problem is the lack of documentation, which leads one to be secure that there was an appropriate response in terms of the way drugs were initiated and then increased.

Q Code A I accept that entirely. It is a similar comment that can be made in later cases. That is the problem that is there. It is the product of a failure to keep adequate records of the reasons and so on. We can just note, however, that on 16 January at 2000 hours, eight o'clock in the evening:

"Condition remains very poor. Some agitation was noticed when being attended to. [Seen by] Code A "

That is when the haloperidol is added.
A Yes.

Q I just want to make sure I understood your evidence. You are not objecting to the addition of the haloperidol. I think you were indicating that you thought it was high in the circumstances. Is that correct by way of summary or not?
A My concern was the use in the context that he is already on a high dose of midazolam. It is unclear whether there has been any response to that. The haloperidol is certainly an appropriate response if he has agitation. That is not recorded in the medical notes. We have this one entry which I am not sure is before or after, but presumably relates – one can interpret that the nursing staff had reported agitation and then Code A had prescribed the haloperidol as a response to the reports of agitation. So I do not think I was overly critical of the dose – I do not think I was critical of the dose of haloperidol that was given; it was in the context of the other drugs.

Q If we go on to the 17th, we can see the increase to 120 for the diamorphine.
A Yes.

Q Then on that same day, the note underneath the section setting out the drugs, against the name "Douglas", one of the nurses:

> "09.00. [Seen by] Code A medication increased 08.25 as patient remains tense and agitated, chest very bubbly."

The significance of that? Is that something indicating ---
A At this point, he is clearly having problems with secretions and it would be appropriate to give hyoscine. We again have some evidence that he is agitated and so it was reasonable to treat that symptom.

Q He is remaining tense and agitated having been on 80mg of diamorphine for two days; something for a doctor to consider in terms of increasing the analgesia, to do something about that?
A Well, the difficulty is that the opiates could be indeed contributing to the agitation, or it could be he has got uncontrolled pain. It is very difficult to be certain what is the cause of the agitation, but obviously one of the issues is the opiates could be in part contributing, or it could be his underlying problems of depression and the agitation from that, and you have alluded to the problem that the withdrawal at this point of his antidepressant drug could be a factor, and I would acknowledge that, so there is a number of different causes, and the response to treat that with antipsychotic drugs I am not critical of.

Q No. Can we move on, please, because what the picture was, this man, whatever he was suffering from, if he was, from any kind of respiratory depression, or any kind of over-sedation, remained in the situation that he was for a number of days. Indeed, it was not until 24 January that he died. We have to bear in mind, of course, that Code A saw him at a certain stage. If we move on to 20 January---
A I am not sure he saw him. I think he was contacted about him.

Q Well, I think a verbal order on that evening and then he saw him the next day, I think.
A Oh, okay, my apologies.

Q I think that is right. I may have misremembered it.
A No, there is an entry, he did see him, you are quite right.

Q What happens is the nurses are concerned about his state, his agitation; they contact Code A, who is on call, and he does, which I think is something which everybody accepts is totally sensible, he says, "Well, take away the haloperidol and increase the Nozinan".
A Yes, and I thought that was appropriate because of the undesirability of prescribing two antipsychotics at the same time.

Q He gave his reasons for doing just that. So he says that over the telephone, and there is a note, which does not appear on the chronology, immediately above 21 January, if we move to 21 January, and it says there, in a note, which is one of the notes in terms of the collection shown by nursing care plan:

"Now unable to cope with dietary or fluid intake".

That is what is set out in the nursing care plan:

"Please give regular mouth care."

A Sorry, I---

Q It is not on the chronology. I am just pointing it out to you as a little bit of history. Then we move to 21 January. Code A, who does make a visit:

"Much more settled. Quiet breathing. Rate 6/min. Not distressed. Continue."

He told the Panel that although that is obviously a slow breathing rate, he did not form the view that he was respiratorily depressed, as he said he would have made a note of it if it was, and he was content that the treatment that was being given was appropriate.
A I find it difficult to accept with a respiratory rate of 6 per minute that any doctor would claim he has not got respiratory depression. I am not saying he did not need at this point necessarily the drugs to achieve symptom control, but he has respiratory depression.

Q What he said was, "I checked his respiratory state. I did not conclude he has respiratory" – I cannot quote his exact words – "or that he was over-sedated", and in his view, obviously by his note, the treatment should continue.
A The treatment may well need to continue, but he has got respiratory depression if his respiratory rate is 6 a minute. It is not normal.

Q Well, all we can do is go on the evidence of Code A as to what he did or did not do and why. May I just pause, Code A because I think that may be all I need to ask you about this patient, and I want to just check. (After a pause) That is all on Patient A. I move on, if I may, to Patient B.

THE CHAIRMAN: I am getting non-verbal signals, Code A from the Panel. I think we will take a break at this point and then come back to the next patient, if we may. So fifteen minutes, please, ladies and gentlemen. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Code A

A Code A Patient B, Code A Again, I will try to use the chronology at the front of the file if possible. This is the lady who fell down the stairs at her home address. On the very first page of the chronology there is an indication of X-rays being conducted initially on arrival at Haslar. I am simply going to mention this to you, I think probably if only to discard it, but there is a note, and I will give the page reference, I am not asking people to turn it up, but in A&E there is a note, the reference is actually page 130, where whoever examined her in A&E has put "Cx spine" and ticked it, which indicates on
B the face of it no problem with the cervical cord, or spine, on the face of it.
A Sorry, X-ray cervical spine or cervical spine?

Q You had better look at it because you will know what it is.
A I think I did look at it. 130?

Q I am not suggesting it is necessarily of any significance at all. 130.
C A I now have it. I agree, what that refers to, I think they have clinically checked the cervical spine, I think that refers to, not that they have ordered a cervical spine X-ray.

Q No.
A I mean, I still think this lady most likely had, and I know other experts think, a neck injury – if not fracture, contusion to the cord.

D Q I appreciate that. I just wanted to establish with you your view. That is of no particular significance because it is somebody in A&E carrying out a pretty basic check.
A Yes.

Q Right.
A I mean, I think, just to expand on that point, that was good practice by the A&E doctor. At that point it was not clear she had any problems with her hands and arms, so they
E would have checked her cervical spine in somebody who had had a significant fall, so a very good assessment.

Q Then moving on to page 3 of the chronology, just to take notice of the fact that really throughout her stay at Haslar she has got problems with pain.
A Yes.

F Q Halfway down that page, in the box last but one, last two lines:

"Regular analgesia given with poor effect."

Over the page, page 4, it is a continuing picture with regard to the pain, just in general terms?
A I do not think it was really sorted out at this part of her stay the cause of the pain, and it might have been neuralgic pain rather than musculo-skeletal. We just do not know.
G

Q Then on page 5, looking at the date of 16 February when Code A saw her, she concluded:

"Most likely" – that is the way she put it – "problem is brain stem stroke leading to fall."

H

A We know from the documentation that she apparently was told by the patient she had had her neck X-rayed, so she, Code A, assumed it was normal, just to cover the picture.
A I did not know that.

Q That is on one of the letters we looked at, it is page 935, and saying in that letter "not sure we will get her home but will try" is a comment she made.
A Yes.

B

Q The Panel have already heard about that. You have indicated in your view you thought a stroke unlikely, symptoms were not typical, more likely a fracture of the spinal cord, a cord injury of some sort. Then we can go on to page 6, where she is seen by the physiotherapist and so on, and the other problems are set out. We can go on to page 7 of the chronology, and may we just look at the admission to Daedalus under Code A, "Reviewed by Code A". You have indicated already, and I do not need to take it up with you any further, C that that was a reasonable assessment and you would not expect Code A in the circumstances to challenge the brain stem finding.
A No.

Q For obvious reasons. Now, in relation to that, just in general, looking at not only the previous descriptions of the condition of this patient, but also the summary by Code A, she has obviously got co-morbidities, correct?
D A Yes. She has got diabetes, and she is---

Q AF, atrial fibrillation, which appears earlier on, I think.
A Yes.

Q The blindness, and so on.
A Due to cataracts, yes.

E

Q It is clear, when she is Barthel 2, she is obviously pretty dependent. In general terms, chances of recovery small?
A Well, I am not sure I would agree with that. The reason is she was managing independently at home, limited mobility around, she has had an acute event. This is where the whole issue of what the diagnosis is becomes important, but let us accept that the working diagnosis, probably wrong, is that this lady had a brain stem stroke, it is really too early; she F has not got a major deficit at this point, but you would say this patient has rehabilitation potential. I mean reasonable: she was obviously precarious at home beforehand.

Q Yes. All right.
A Sorry, I am trying to paint my view of it. It is certainly a completely different picture from the last patient. I mean, this is somebody who has potential.

G Q I am not suggesting it is the same.
A Yes.

Q We can see that Code A is obviously allowing for the possibility of her improving:

"Assess general mobility ? suitable for rest home if home found for cat."

H So it is there as a consideration.

A A Yes.

Q Then we move on, and there is no problem with what was prescribed by Code A She does not go, as it were, straight to Oramorph.
A Yes, very reasonable.

Q Dihydrocodeine. There is no issue between us. 24 February, page 8, the pain is not
B controlled properly, and then there is the progression to MST, all right?
A Yes.

Q You said you do not usually convert to MST from DF118, but I do not think that is going to be an issue which is going to---
A No, it is not optimal, but I am not going to ...

C Q I think in the Wessex guidelines it looks as if you can, but you are not saying it is not usually---
A I would not be particularly critical of it. It is just you do not know what pain control this lady needs at this point.

Q You are making the point that the MST is slowly absorbed---
A It will take a while, yes.
D

Q ---and so on and so forth, but once she is on the MST, as it were, no problem about that. We can see that it still does not achieve the effect of controlling pain, correct?
A I think at this point, this is where I think there should have been an evaluation when you are failing to get pain control in somebody who has had a fall, it is attributed to musculo-skeletal injury, and that was one of the aspects I was critical of.

E Q Yes. In a lady born in Code A so she is Code A who has had a pretty massive crashing fall, you might well still expect pain from that, might you not?
A You should not be expecting it to be worsening at this point. You should be expecting some recovery if it is general musculo skeletal injury, you know, bruising and the like.

Q I see. Anyway, the pain is not controlled. She is seen by Code A. I am not going
F over every entry, but on page 10, 26 February:

> "Not so well over [weekend]. Family seen and well aware of prognosis and treatment plan. Bottom very sore ..... Institute [subcutaneous] analgesia if necessary."

The nursing notes record that she was seen by Code A, the same way.

G > "Son and wife seen by Code A - prognosis discussed. Son is happy for us to just make Code A comfortable and pain-free. Syringe driver explained".

Then the prescription is written up for the diamorphine, over the page on page 11, anticipatory, right, and you say starting dose there too high?
A I do.

H

A Q I am not going to go over the calculations, but you are saying if you calculate in the way you would have thought appropriate it is too high. Can I just check in relation to that whether there is a particular point I need to put to you. Would it be sensible to bear in mind that this is a case where transfer of somebody who had a pre-existing illness, with a significant event in terms of the major fall, followed by transfer, might well have a very serious deleterious effect on her condition, that series of events, in any event?

A My reading of the information we have got in the notes was that this lady had not B deteriorated. She was very dependent prior to transfer and she was at a similar level of dependence at transfer, unless I have misinterpreted the information. So the process of transfer did not appear to have resulted in a deterioration in this lady. At the point when Code A and the nurses assessed her on arrival at the ward, she seemed, as far as one can tell, very much like she was the day before she left the ward.

Q Going on the notes that we have got.

C A Yes.

Q All right.

A If she had a cervical cord injury, and was, you know, taken on a long ambulance journey – I do not know how long this journey was – that might well have worsened the pain she was getting.

D Q Then on page 12, 1 March 1996, we have to remember, and I do not think there has been any alteration to the document, but the Panel have been reminded that on 29 February, so the day before that, Code A was contacted because the nursing staff had raised an issue about her blood sugar level. Does that---

A I am not sure I covered that in my report, but---

Q I do not think you did, and this is not a criticism. Can we just look, please, to register E the fact, at page 1022 in the file itself. We can see that on that page 1022, about two-thirds of the way down, can you pick up the date 29 February?

A Yes.

Q "Blood sugar at midday 20mmls. Code A contacted. Ordered 10 units", is that?

A "actrapid stat", and that was an appropriate response.

F Q So there the nursing staff still keeping a check on things.

A Yes.

Q Code A is contacted, sensible response in relation to that particular condition.

A Yes.

Q Then the pain goes on, as we know, and you have already said. Then on page 13, if G you would, of the chronology, the date 5 March, the note by Code A "has deteriorated over the last few days", the note did contain and should reflect in this chronology but it is not there, "not eating or drinking".

A That is in my report. I did notice that, yes.

Q I am sure it is. It is just a reminder that the entry was:

H

"Has deteriorated over the last few days. Not eating or drinking. In some pain. Therefore start subcutaneous analgesia. Let family know".

Bearing in mind you say, well, I think there should have been an examination, further consideration as to what was causing the pain, that response in terms of subcutaneous analgesia, bearing in mind your reservation, of itself is not something you would criticise?
A If the indication for opiate was appropriate, and that would depend on the nature of what was being treated.

Q Yes.
A But if the opiate was helping control her symptoms - I mean my criticism of the case is the lack of evaluation of either the pain or the cause of the pain, and she is not eating and drinking, and I comment that may have been an adverse effect in part from the opiates; to convert to an equivalent subcutaneous dose to achieve pain releases an appropriate action.

Q It may be that the deterioration was because of her general slow process ---
A It may be.

Q --- towards terminal decline.
A Well, it may be, but this is a lady who has not got a progressive illness. The natural history from stroke is to recover unless you get a complication, which was what the working diagnosis was here. I fully accept she is elderly and frail and it may have been a general deterioration, but there should have been some thinking about that.

Q By this stage with a lady in this state what, then, were the options? For her to do what?
A Well, re-examine, re-think why is she having the pain, has a fracture been missed in her shoulder? Is it actually, as I was indicating, neuralgic pain? At this point there should have been a re-think about the working diagnosis because stroke does not, certainly not at this stage in general, present with pain, so it cannot be that. She has had a fall, yes she has injured herself, but, again, we are some weeks on from that so you should not be getting pain from that unless there are complications, so that would be what I would expect in somebody who has not got a progressive malignant disease or other life-threatening problem at this point ---

Q I do not want to cut you short but what actually would you do?
A Oh, sorry. You would examine the patient, you would look for focal tenderness, you would look at their movement, you would examine power to see if there was any neurological deficit, you would consider whether to re-X-ray. I think at some point having gone through that process there would have been a thought, actually, this maybe does not look like a stroke, particularly because of the nature of the symptoms, and then discussion with a consultant or specialist ---

Q Can I move on? Supposing the decision was that she needs an X-ray, and the X-ray revealed some kind of cervical problem.
A Well, I think she would have needed an MRI scan, as I indicated, because an X-ray in itself of the cervical spine would not necessarily tell you what was going on with the cord. Now that would have needed her to be transferred back. I think at this point there was a question what was going on, and you have a choice. You either try to determine the underlying diagnosis because she is not recovering or improving as one would have started to expect, or you could look at the patient and say: There is no prospect of recovery here. I do

not see that that was the case in this lady but I did not see her, I was not there, but I think there should have been a discussion about what was happening in this lady at this point.

Q Yes, and it may be that the product of that discussion would have been: "There really is not any intervention that is sensible --- ".
A It may have been. For example, if it was a neck problem she might have had a collar applied, that might have relieved her symptoms. If it was a nerve entrapment you might have tried carbamazepine or other, a drug approach to controlling symptoms. There were a number of things that might have been done. I mean, she clearly did not seem to be responding very well to opioids.

Q And your point is that the admission of subcutaneous analgesia was at too high levels, assuming it was the right thing to do?
A Yes.

Q We can notice that in that situation the subcutaneous analgesia was commenced on the 5th at about 9.30 in the morning, and there was further deterioration which you say may be the effect of the opiates; on the other hand, it may not, correct?
A Yes.

Q And we can see that the time of death is recorded at 9.28 that following day.

I am going to pause for a moment because I think that may be all I need to question you about in relation to that patient. It is.

Sir, I do not know what time the Panel was thinking of adjourning but I was going to try to deal with Patient C, and it may take up the rest of the time that is available. I am in the hands of the Panel.

THE CHAIRMAN: I think the Panel can still absorb another patient today.

Code A: Good. Code A one more patient for today, Patient C.

Again, trying to use the chronology, we have touched upon this lady already in relation to an earlier issue about something in your report. She is the lady who had a diagnosis on 6 February 1998, "probable carcinoma of the bronchus and depression", and then we need to look, please, because I do not think this has made its way on to any version of the chronology, in the main file, if you would, for Patient C, page 299. It is not a very good photocopy, Code A but looking at 12 February, do we see in that top section in what is the third paragraph down:

> "In view of advanced age: Aim [something] management should be palliative care. Charles Ward is suitable",

I think it says.
A Yes.

Q "Not for CPR", and then the following day, still at the hospital, there is a reference to a discussion with the son, and the last section of that I think is probably all we need to look at:

A

"Discussion with son, explained probable ca bronchus. Agrees not suitable for invasive --

A -- treatment."

Q This is something you touched upon in your evidence when we looked at this?
B A Yes.

Q And then the remainder of it I will not trouble you with. But we need to bear that in mind on 12 and 13 February in relation to this history, and we can move on with regard to general deterioration and so on, please, to page 4 of the chronology which at the top, before she gets into Dryad Ward, has a review by Code A

C "Confused and some agitation. Says she is frightened. Not sure why. Tends to scream at night. Not in pain. Try thioridazine."

Transferred to GWMH on 27 February and the diagnosis is given there on the transfer form from the hospital requiring total assistance and so on.

Would it appear that she is on the palliative care route?
D A I think very much so and everybody agreed. Nobody would disagree this was not appropriate.

Q And then "Reviewed by Code A ?. I do not think we need to go through it all but at the end of it she is saying:

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

and you have described that as entirely reasonable. The rationale was not described but you made no complaint. Use of opiates if she is not showing pain we have covered already because you made the comment in your report that in cases of this kind it might be appropriate. Then on page 5, the drug chart showing the prescription of Oramorph, you are not making a criticism of that, right?
F A Correct.

Q Over the page, page 6, we have the duty doctor calling on 28 February; Oramorph was being given with no relief, and a doctor - I think Code A - sees her. She was asked whether she had pain: "Yes, on movement", the next box down. The Oramorph continues. On to page 7, please, and we can see on page 7 on the night, it appears, of 1 March she had problems:

G "Slept well but calling+ [out]. Shouting from approximately 5.30. Spat out all medication."

Then Code A sees her on what, in fact, is a Monday, Monday 2 March:

H "No improvement on major tranquiliser. I suggest adequate opiates to control fear and pain. Son ... seen",

so there is nothing you criticise about the proposal with regard to opiates?
A No.

Q And obviously over the page, in fact, Code A, as it were, confirms that same view.
A Yes.

Q She approves opiates and it is clear that one is talking about terminal care now?
A Yes.

Q Which, again, you have made clear. The fentanyl is commenced that morning.

"Very distressed this morning. Seen by Code A",

She has an intramuscular diamorphine injection, appropriate.
A Yes.

Q "Seen by Code A - you have already indicated that is alright.
A Yes.

Q You indicated that the fentanyl was appropriate, you could understand the rationale, it was not unreasonable, it was quite a high dose.
A It was a big increase, as best as I could work out. I think I was not entirely sure when certain doses of opiates had been received, although I think that has been clarified now, but it was a big increase so there was a risk it might be more than was required to control her symptoms.

Q But obviously something that had been sanctioned by Code A in terms of that fentanyl patch?
A I cannot remember if the use of the fentanyl patch had been discussed with Code A

Q "Reviewed by Code A Spitting out thioridazine. Quieter on PRN SC diamorphine. Fentanyl patch started today."
A So Code A had seen that and was aware of it.

Q And Code A helpfully reminds me that at page 272, we do not need to turn it up, on the drug chart she signed the fentanyl prescription.
A OK.

Q So, if anybody is making a note of this, page 272 shows that the prescription is written by Code A and signed, but also Code A signature appears there as well, or her initials do. Then Code A writes up a prescription - it is not administered on that day, it is undated I think - for diamorphine, midazolam and so on, and you indicate that the notes do not indicate specifically that she was in pain and the notes do not actually record any terminal restlessness.
A Yes.

Q And you gave us some calculations. You indicated that the fentanyl patch would reach its peak 24 hours after administration?
A Probably at least that but it would certainly take longer than would morphine.

Q You say there is no indication if the patch was removed. If it was removed there would still be some effect, am I understanding that correctly?
A There would be a sustained effect which would be longer than ---

Q You take it ---
A Yes. The BNF which we looked at at the beginning of my evidence said "can take up to 17 hours for it to fall by 50 per cent".

Q And then the administration of the diamorphine at 20, midazolam at 20 on the following day, 3 March. "A rapid deterioration of condition" says Code A. "Neck and left side of body rigid - right side flaccid".
A Yes. Meaning weak and low tone.

Q I know what it means; I was not sure of the pronunciation. What is the indication?
A Well, that may indicate she has had a stroke or, as I said when we discussed this patient she may have had a cerebral metastasis and there had been swelling around that in the brain which produced weakness. Those are the two most likely causes.

Q So if the patient was demonstrating terminal agitation and restlessness, then it would be reasonable to prescribe midazolam?
A It would be reasonable to start prescribing midazolam. Again, we have commented before that guidelines would suggest preferably starting at a lower dose of 10.

Q And here what happened on 3 March might well have happened in any event without the administration of the subcutaneous analgesia?
A Yes.

Q It might have happened in any event without the ---
A This lady was clearly deteriorating, so the deterioration I think I acknowledge might have happened. I say again drugs may contribute and the indication was not well-explained or recorded, but the deterioration - she had a lot of opiates at this point with both the fentanyl and the infusion.

Q Maybe it played a part: maybe it did not.
A Yes. You could not conclude in this lady that her death was clearly ---

Code A: I think we have covered those general issues already and I am not going to repeat them.

Thank you. That is the end for that particular patient. Sir, that is the last patient we deal with today. I am confident that I will be able, without unduly rushing, taking care I hope of the proper issues, to complete my cross-examination about the remaining nine patients before the end of tomorrow.

THE CHAIRMAN: You will be on your own then, Code A!

Code A I am sorry. On Monday.

THE CHAIRMAN: I think you have made excellent progress today. Everybody has. Thank you very much. We will break now and we are returning, Professor, for 9.30 on Monday. Thank you very much indeed, everybody.

(The Panel adjourned until 9.30 a.m. on Monday 13 July 2009)