GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 17 June 2009

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

Chairman:

Panel Members: Code A

Legal Assessor:

CASE OF:

Code A

(DAY EIGHT)

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

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: Code A)

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Code A Good morning everybody, and welcome back. Code A the Panel have taken the opportunity to read the file on Patient I, and to refresh our memories of your opening. In the latter regard one of our Panel members noted what would appear to be a transcription error of some significance. It is Day 2 page 6, just above letter F.

Code A I am afraid that re-reading my opening was a joy I denied myself.

Code A It may be one that would not have spotted. I think this requires a medical mind to pick up, perhaps, or a scientific one at any rate. It is Day 2/6F, the sentence that deals with the increase of Oramorph from – and it is recorded as "10 ml four times a day to 20 ml four times a day", and of course it should be "10 mg four times a day to 20 mg four times a day".

Code A Thank you. Would you just give me a moment, please. (Short pause) I am grateful. I am sure that is right – and the chronology is right, I think.

Code A It is just the unit of measurement, as I understand it.

Code A In my opening, yes.

Code A Finally, Code A I should say that we have received bundle I and we are marking it exhibit C10.

Code A In that case we are ready to read to you the statement of Code A made a police statement dated 17 March 2004, and he describes his occupation as a retired Code A He says that he is Code A and he lives with his wife Code A at an address on the Isle of Wight. He says:

STATEMENT OF Code A, read

"I make this statement in relation to Code A who was born on the Code A ... and died on the Code A ... Code A was Code A Code A were from a family of two children. Code A died at the age of 76 from a stroke. My grandparents died at a reasonably young age, my grandfather was 52 but had been involved in a serious accident and my grandmother died at the age of 58, I don't know why.

I am not aware of any family illness or history from that side of my family.

Code A taught at a small private school and later got married at about the age of 26 to Code A Between them they ran a market garden in Code A Hampshire. Code A had no children and sadly Code A died in 1958 from cancer and the effects of mustard gas in World War I. Code A never remarried.

After the death of Code A sold the business and moved to Code A Code A This was to be the house she lived in for the rest of her life.

I would describe Code A as a fit, healthy and active person all her life. She was quite tall and of slim build. I do not recall any health problems she suffered from until she was in the late stages of her life. Code A was still driving a car to the age of 90.

The first time I recall Code A being ill" ---

(Proceedings interrupted by fire alarm sounding)

Code A The fire alarm test sounded at 9.15, and we have been given no indication that there would be a further test, so we must regard this as real. We should, I am afraid, now rise and leave the building.

(The Panel adjourned for a short time)

Code A Welcome back, everyone. It was not a drill, as I said, as I am sure you will all have gathered, but it was happily a false alarm. Code A you were rudely interrupted. Please try and resume.

Code A Yes, I will carry on. We were reading the statement of Code A talking about Code A and we will go on from where I left off.

"The first time I recall Code A being ill was when she suffered from Rymes disease. She was in her late 80s and was admitted to the Queen Alexandra Hospital in Portsmouth. Code A was in hospital for about three weeks. I was told by a doctor that she would never be the same again. However in a very short time she was back walking the dogs and driving her car. She did not seem to suffer from the ill effects having left hospital.

I was one of the people who had most contact with Code A She was always able to hold a conversation and was fully aware of her surroundings. Due to the fact that Code A Code A was such an independent person she did become miserable when she had to give up driving. She would have help around the home but was adamant that she wished to remain there and would not have a live in companion.

In mid March 1999 Code A had an accident, where she fell over outside the Post Office in Stubbington. She was admitted to the Haslar Hospital on the 19th March 1999" –

and she would have been 92 years old at that time –

"where she had an operation on her right hip. I visited her in hospital and although she was in some pain the physio's at the hospital had got her sat up and moving. I was impressed at the level of care that she got at Haslar. Code A seemed ok in herself, she was still lucid when she spoke.

On the 26th March 1999 ... Code A was transferred to the Gosport War Memorial Hospital. I do not know why she was moved, I think it was because of a lack of staff at Haslar. I think Code A was on Dryad Ward, although she had a private room.

A

I fully expected Code A to be discharged from the GWMH and hopefully to return home.

I visited Code A four or five times whilst she was at the GWMH. On my earlier visits she had other friends with her and was speaking with them quite happily. I also spoke with Code A and she seemed fine. She told me that she rarely saw any doctors or physio's. I spoke to the staff and expressed my concerns about this. I was told that

B

Code A was [too] uncomfortable to be moved and had told the staff to go away on several occasions.

Just prior to the Easter weekend in 1999, I don't recall the exact date, but it would have been about the 1st April, I visited Code A with some chocolates. She was again able to hold a conversation and I recall saying to her Code A it's time to get you out of [here]'. Code A replied 'If the old horse doesn't get out of the stable she never

C

will'.

Code A did not seem to be getting anywhere and told me again that she was not seeing any doctors or getting any physio.

I phoned the hospital and spoke to a member of staff, I don't know who but it was a woman."

D

Can I just pause for a moment – I appreciate you have recently read the notes, and these may be fresh in your mind, but you will find two relevant notes. One is at page 132, and the bottom entry, if I may just remind you, is dated 6 April 1999 and reads:

"Seen by Code A MST increased" –

E

that is morphine slow release tablets increased –

"to 20 mgs. Code A has visited, if necessary once Code A is discharged home (as she is adamant about not going to a nursing home) he will employ someone to live in. Code A has been incontinent of urine a few times over the weekend. I have spoken to her about a catheter and she is going to think about it or using pad & pants."

F

He says:

"I phoned the hospital and spoke to a member of staff, I don't know who but it was a woman. This phone call would have been on the 10th or 11th April 1999 ..., I said 'She is an old lady please make her as comfortable as you can'. The lady said words to the effect that she would."

G

Can I take you to the note at page 134, which is just below the middle of the page, 11 April 1999:

"p.m. Code A telephoned at 19.10, as Code A's condition has deteriorated during this afternoon. She is very drowsy – unrousable at times. Refusing food and drink and asking to be left alone. Site round wound in right hip looks red and inflamed and feels hot. Asked about her pain, Code A denies pain when left alone, but complaining

H

when moved at all. Syringe driver possibility discussed with Code A who is anxious

A that Code A be kept as comfortable as possible. He will telephone ward later this evening.

Seen by Code A To commence syringe driver."

I will read on:

B "On the 12th April 1999 ... I visited Code A in hospital, she was quite unconscious and I was unable to rouse her. I stayed for 2 or 3 hours and asked to see a doctor. When I saw him he told me there is nothing wrong with Code A she is on too high a dose of morphine. I believe the name of this doctor to be Code A

If we look at the following page, 136, we see this note on 12 April:

C "Seen by Code A. Diamorphine to be reduced to 40 mgs over 24 hours. If pain reoccurs the dose cam be gradually increased as and when necessary. Code A has been spoken to and is aware of the situation."

Then the statement carries on:

"The doctor told the nurse to reduce Code A diamorphine, he said she would be all
D right. When I left at about 1800 hours Code A was still heavily sedated.

I got home at about 2200 hours Code A received a phone call from the GWMH saying Code A was conscious. Obviously we took this to be good news. We were told Code A had been given sips of water.

At around 0130 hours on 13th April 1999 ... I had another phone call to say that Code A
E Code A had died. Given the nature of the previous call this came as a shock.

The cause of death was shown as Cerebrovascular accident and signed by Code A was later cremated at Portchester."

We can see again in the notes on the page where we were, Code A "Died peacefully", and you have the death certificate at the back of the bundle behind the last tab,
F which indeed shows "Cause of Death: - I (a) Cerebrovascular accident".

That deals with all of the evidence that we are going to call in relation to Code A There is an Code A who is on your list. He is not available at the moment, and we are making efforts. I think he is going to be one of those that we will have to call on 30 June as our sort of sweep-up day, before we get to the expert.

G So can we put those notes for Patient I, Code A away for the moment. We are now moving on to Code A who is our Patient J, and we are just about to hand out the Patient J notes to you. We have three witnesses, none of whom I think will be very long, but you may wish to acquaint yourselves with the notes before you hear from them.

Code A we will receive the Patient J bundle as exhibit C11.

H Code A Thank you very much. (Handed)

Code A Do you have a sense of the amount of material involved, as to whether we will ---

Code A It is not a huge amount of material again, but realistically it is bound to be 45 minutes to an hour, I think, to work through this and cross-reference it with the chronology.

Code A I think what we will do then, is say an hour, and we will try to incorporate a short break for the Panel into that as well.

Code A Very well. So we will aim to come back at 12.10, but obviously if you need more time ---

Code A We will let you know.

(The Panel adjourned for a short time)

Code A Welcome back, everyone. Code A the Panel have reviewed the Patient J bundle and have also re-acquainted themselves with your opening in respect of Patient J. I have been asked to mention a small typo. I think it is no more than that. It is Day 2, page 9, just above letter H. As rendered, it does not make much sense: "There was never Panel order...". We suspect that that probably can be remedied by deleting the "P" and the "el": "There was never an order..." is most likely to be what it is. Whilst we are on the subject – it is very minor – just above it on G: "... and he has been transferred or recuperation". That clearly should have been "for recuperation".

We are now ready for our next witness, Code A May I just mention that I have introduced myself to her outside. She is quite elderly and slightly deaf, so I may shout a little bit. She does have a hearing aid, and she can hear. Code A please.

Code A Sworn

(Following introductions by Code A

Examined by Code A

Q I think it is Code A – is that right?
A Code A yes.

Q And I am going to ask you about Code A His full name was Code A Code A
A Yes.

Q And you knew him as 'Code A and most people called him Code A – is that right?
A Yes.

Q Even though you are nodding at me, and I know what you mean ---
A I have to ---

Q That lady there is going to have to make a note of it, so can you just make sure you do say yes or no, depending on your answer. I think Code A was born in Derbyshire. Is that right?
A Yes.

Q I am going to lead you on the background. I think he was born on Code A He had Code A Are they all still alive?
A Yes.

Q And I think his father died from a stroke and his mum was in her eighties when she died?
A That is correct.

Q And you describe his side of the family as all well built?
A Yes, they were.

Q Does that mean they like their food?
A They did, yes.

Q And so far as Code A was concerned, I think he worked in local government in Derbyshire. You married him in 1956. Is that right?
A That is correct, yes.

Q He got a job in London at Zurich Insurance. You Code A Code A
A Yes.

Q We are going to be hearing, I think, from Code A a bit later. Did there come a time when Code A was involved in the nautical training school?
A Yes, he was quite keen on it.

Q And where was that?
A That was in Emsworth.

Q And where were you living at that time?
A In Emsworth.

Q And Emsworth is where?
A It is between Portsmouth and Chichester on the south coast.

Q And so this was after he had worked for Zurich Insurance, was it? Had you moved down to the south coast?
A That is right, yes.

Q He was quite keen, I think, on the nautical training side of life, but did there come a day when he was away on camp and he twisted his knee?
A Yes, he did

Q And as a result of that unfortunately he became less mobile?
A That is right, yes.

Q In 1983 I think he left the company where he had been working and he became a taxi driver?
A Yes, indeed. He was weary of the insurance world and wanted something a little less arduous.

Q One of the consequences of that, I think, was he began to put on weight?
A Yes.

Q I suppose that is a danger for taxi drivers, but he became quite heavy?
A Yes, he was heavy. Yes.

Q Then, when he was about 57 did he retire?
A Yes. I think it was around there. I am not actually sure.

Q Just to help you, I am taking this from a statement that you made to the police about three years ago, so that is where I getting my information from. For the moment, I am going to assume it to be correct. Just tell us about the period after he retired. What happened to his weight and, in particular, his legs?
A His weight continually increased and his legs were very swollen and they used to weep, and we had the nurse in to dress the legs two or three times a week.

Q When we say he was putting on weight, do you know what sort of weight he reached?
A He reached about 23 stone.

Q So he was a very, very big man indeed?
A He was a big man, yes.

Q How tall was he?
A About five nine.

Q And did there come a stage where he could not really walk properly, and even within the house he would have to lean on things to get himself around.
A He could walk if he held onto things, yes.

Q I think part of his problem that you mentioned in your statement was that he was not a great drinker of alcohol, as it were?
A No.

Q But he liked fizzy sweet drinks?
A He liked to drink anything but alcohol really.

Q Was he a complainer?
A Never, never. No.

Q Did he have pain?
A Not that I knew of, no.

Q In 1999 – I am not going to dwell on your own illness but do you mind talking about it or not?

A A No.

Q I think you were diagnosed with [redacted] and you underwent treatment for it, but that meant that in August you had to be admitted to the Queen Alexandra Hospital for [redacted] Is that right?
A That is correct, yes.

B Q On 5 August you were doing to be admitted that night, presumably for the operation the following day?
A Yes.

Q Can you just help us with Code A s position? Did he come to the hospital with you or not?
A Oh no. He never came to the hospital with me. No. I was preparing to go to the C hospital and he was in the bathroom. I asked him if he was coming out, and he said he would be out shortly. He never did come out, and I had to get a move on because I had to be there for eight o'clock in the morning, so I went in and had a shower and left him in the bathroom, and went to the hospital.

Q All right. Would he have been on his own in the house when you left?
A I think he was because I think my daughter was working at that time.
D

Q I think the following day, did you have your operation?
A I had it the day I went in, and then I came out the following day.

Q I see. I think you were collected from the Queen Alexandra by Code A and did she then tell you that Code A had been admitted to the same hospital?
A That is right, yes.
E

Q And he had come in by ambulance?
A Yes.

Q Without going into the details of it, I think he had got stuck in the bathroom essentially?
A I think he had, yes. Mind you, I did ask him, and he said he had not but I thought he F had really.

Q He was treated in the Queen Alexandra Hospital. Just tell us, please, a little bit about his treatment and how his condition progressed?
A We thought he had improved quite a lot because I looked at his legs as he was in there, and they had dried. I think they had given him some injections into his stomach – I am not... These obviously helped. We thought he was looking a lot better.
G

Q And what was his state of mind, as it were? Obviously when he first went in there, presumably he was not very happy to be in hospital?
A No.

Q But tell us, did his condition and his mental state improve at any stage?
A His mental state never altered. He was just the same.
H

A Q And what was his mental state?
A He was always making jokes and trying to make people laugh.

Q Obviously he was not particularly old at this stage. Mentally, was everything there, as it were?
A Mentally?

B Q Yes.
A Oh, yes. Yes.

Q It was just physically that he found it difficult to move around?
A Yes.

Q And physically you say he seemed to improve at the Queen Alexandra?
C A He did, because his legs improved. I think that would have made a big difference, although I never actually saw him out of bed.

Q When he was in the Queen Alexandra did he ever complain of being in pain?
A No.

Q Did his legs cause him pain, so far as you were concerned?
D A As far as I am aware, he never complained of pain.

Q We know that Code A was transferred from that hospital, from the Queen Alexandra Hospital, and he was admitted to the Gosport War Memorial Hospital?
A That is right.

Q And we know that that happened on 23 August 1999?
E A Yes.

Q What was your understanding of why he was transferred?
A We understood that he was going for a rest and rehabilitation, and would be coming back home.

Q And at this stage of his life, did you have any cause to think that he would never come
F home?
A No.

Q Did you go and see him when he was in the Gosport War Memorial Hospital?
A Yes, I went every day up to the time when I went in hospital.

Q And can you remember meeting a doctor at any stage?
G A I met Code A when she told me that he was going to die.

Q Can you remember how long after his admission into hospital that was?
A I cannot remember exactly.

Q All right. I am going to ask you to stop for a moment, just to help the Panel find a note. You are very welcome to turn it up if you wish to. Have you ever looked at his
H medical notes?

A I have, yes. Some of them, not all of them.

Q I am going to invite the Panel to turn up page 63, please. If you take up the bundle to your left, which is marked "J", and open it about 20 pages in, you will find a page which is marked with two lines either side of it, 63, and next to it on the left, rather confusingly, there is a big 62.

A Yes.

B

Q At the bottom we can see this note, "1900 hours, on 26 August", so this is three days after his admission:

"Code A here for Oramorph 4-hourly. Code A seen by Code A explained Code A 's condition and medication used."

C Could you tell us a bit more about that meeting with Code A Where were you when you first saw her? When you first noticed Code A, can you remember where you were in the hospital?

A I can only remember seeing Code A when she told me he was going to die.

Q Where were you?

A I was by Code A 's bedside.

D

Q Did she tell you that in front of Code A ?

A No, she asked me to go out.

Q I want to start, when you are in Code A 's room the doctor appears – and do you remember what she said to you?

A I think she said, "Which of you is Code A ?" and I said I was, and she said she E would like a word with me.

Q Tell us where you went?

A I do not know where we went. We went to a very small office.

Q Into a room?

A Yes, into a room.

F

Q Can you remember, as close as possible, what she actually said to you?

A I think – let me think – she said that all his organs were not working properly and he was going to die and I could take care of myself, I had got to take care of myself and she liked my coat.

G Q Was that the first indication that you had, or had you had any previous indication, that your husband was going to die?

A No, I never thought about it, no.

Q Can you remember any other part of the conversation?

A I think that was it.

H Q What was your reaction to that?

A I was a bit – well, I was shattered really, because I did not quite know what to say when I went back to Code A because I thought perhaps he would – he did – he asked me, "What did she say to you?", which put me in a difficult position. I just said, "She said what the treatment was going to be for you and she liked my coat".

Q Obviously you did not relay to him the prognosis?
A Well no, you would not do that, would you?

B

Q Tell us how things progressed. First, at that time on the 26th when you went to see him, did you know what drugs he was on?
A No, not really.

Q At that time, he is now at the Gosport War Memorial Hospital, did he complain of pain to you?
C A No.

Q Was he a man who previously had taken pain killers? Would he take pain-killers?
A No.

Q Did he have any particular attitude to pain-killers or not?
A I never saw him take them.

D

Q Tell us how things progressed. Did you continue to go and see Code A in hospital?
A Yes, he just seemed to get weaker and he did not converse as easily. We would feed him grapes and drinks with a straw and then eventually he was completely out of it until when I left him, the last time I saw him, he was not moving at all.

Q Did you know that he had been started on a drug called Oramorph?
E A No, I did not know that until this year.

Q Until this year – 2009?
A Yes.

Q When did you hear that?
A When we got all the reports.

F

Q Did you go along to the coroner's inquiry?
A Yes.

Q But I do not think you gave evidence there?
A No, I did not, no.

G Q Did you know at any stage that Code A had been put on a syringe driver?
A I think we did because we were aware that there was something at the back of him.

Q That something?
A Something at the back of him.

Q Did you speak to any of the staff about the syringe driver?
H A No.

Q Did anybody explain to you about him being put on a syringe driver or why he was being put on a syringe driver?
A No.

Q Did you see Code A again after that meeting in that small room?
A No.

Q Did you understand why Code A was getting quieter and quieter?
A Not really, I do not suppose. I think I had a lot on my mind at the time.

Q Because you had your own difficulties to contend with?
A Well, yes. I really did not go into it a lot.

Q I think you saw him for the last time, so far as you were concerned, on 1 September, because the following day you had to go back into hospital again?
A Yes.

Q When you went to see him on 1 September, what sort of state was he in?
A He was not able to talk, he did not move, he just lay there.

Q As far as you could tell, was he conscious or unconscious?
A Unconscious.

Q You had to go into hospital on Code A Did you hear about Code A death the following day, on the Code A
A Yes, I did. We had a curate at the church and she would – I think she visited him but she rang me and told me.

Q I have asked you about Oramorph and about a syringe driver. Can you remember any discussion about diamorphine with a nurse or anybody else?
A No, I cannot.

Code A Would you wait there please.

Cross-examined by Code A

Q I think you say in your statement that your recollection of that time is vague because of your own concerns about your health problems?
A Some of it is vague, some of it is quite clear.

Q You saw Code A on a daily basis when he was at the War Memorial Hospital?
A Yes, I would.

Q Would you have had a fair bit of contact with the nursing staff?
A No, we did not.

Q Did you speak to the nurses?
A No.

A Q If you had wanted to, could you have done so?
A Yes, I presume we could, but I have just felt that they were knew what they were doing.

Q Is it not right that you had some conversations with nursing staff about your husband's condition?
A I do not think so.

B

Q You do not think so?
A No.

Q The Panel have been asked to look at page 63. There is a note referring to Code A Code A's condition at lunch time on 26 August, just over halfway down the page:

C "Fairly good morning, no further vomiting."

Someone has written "Not for resuscitation".

"Unwell at lunch time – colour poor, complaining of feeling unwell, seen by Code A this afternoon."

D You were not there for that. There is then a reference to a further deterioration.

"Complaining of ? indigestion – pain in throat, vomited again this evening, verbal order from Code A Diamorphine 10 mgs – stat."

Meaning same given:

E "Code A informed and will visit this evening."

I do not know if you are able to recall that you were informed of Code A 's deterioration that he was unwell, something pretty dramatic?
A We had a phone call that he had had a heart attack.

Q Were you told that he had got worse after what was suspected to be a heart attack?
F A No, I cannot remember that, no.

Q Did you go in, having had the phone call?
A Yes, we did.

Q That was when you saw Code A ?
A Yes, I think so, I do not know exactly the day.
G

Q Would it be right that he was in a bad way when you saw him that evening?
A Well, he said he had not had a heart attack, and I am afraid we believed him because he because he said it was indigestion and he had lived on indigestion tablets for years.

Q Another possibility was a massive internal bleed?
A Yes, but we did not know about the bleed until this year.
H

Q You had a conversation with Code A and you have told us about it. She told you to look after yourself?
A Yes.

Q I think the nursing staff were aware about your own medical problems?
A Yes, probably.

Q Had you told people there may be days when you could not come in?
A No.

Q Can I suggest it was known that you had your own medical problems and that you were getting treatment for a serious condition and that Code A knew about that as well?
A Probably. I believe they knew about it at QA, but I do not know how because I never told anybody.

Q Do you think Code A might have done?
A I think Code A might have.

Q It was clear from her conversation with you that Code A was telling you that you did need to worry about your own health?
A Yes.

Q And she was telling you as well that your husband was in a very bad way?
A Yes.

Code A Thank you very much.

Code A We now move to that stage where members of the Panel, if they have any questions of you, are able to ask them. I am going to turn, first, to Code A who is a medical member of the Panel.

Questioned by THE PANEL

Code A When Code A was in the QA, do you remember that there was what we call an order put on him not to resuscitate him?
A No.

Q You did not know that?
A No.

Q No one discussed that with you at all?
A No.

Q Just one other very brief question. When you spoke to Code A in that small room, how would you describe her attitude towards you, her tone as she spoke to you?
A I thought it was a bit factual rather than caring in a way.

Q When she said to you that you should look to your own problems, in what way did she convey that? Was that in a caring way to you?

A That was, yes. I thought she was thinking about me, yes, but I thought Code A was, perhaps the death – the death was not ... I cannot think of the word, but I felt it was just a factual thing and perhaps ... I have been on odd occasions when people have been told they are going to die and people are usually, perhaps, a bit more caring on that.

Code A Thank you.

B Code A Any questions, Code A arising from that question?

Code A: I should have put one more matter and I wonder if I might be allowed to do so?

Code A Yes.

C Further cross-examined by Code A

Q The note we have on page 63 right at the bottom, suggests, and I want your comment, that Code A told you about Code A s condition and the medication that had been used. Do you remember that?
A I do not remember about the medication, no.

D Code A

Code A No, thank you.

Code A thank you very much. That concludes your testimony. We are most grateful for you coming to assist us today and I apologise if you have had to wait until you come before us, but we appreciate greatly evidence from parties such as
E yourself. You are now free to go.

(The witness withdrew)

Code A The next witness is Code A It is probably slightly shorter, but I do not know if the Panel is prepared to carry on now or whether you need a break. It has been a rather disjointed morning.
F

Code A I think given that the two parties are related, and I imagine the last witness will not be able to go until Code A is completed, if it is going to be a shorter matter we should press on.

Code A Could I call on Code A

G Code A Affirmed
Examined by Code A

(Following introductions by Code A

Q Is it Code A
A Yes.
H

Q I think you are the Code A
A Yes.

Q But everybody used to call him Code A
A Yes.

Q But you presumably used to call him Code A
A Yes.

Q We have heard a bit about his background so I do not need to ask you about that, but into the 1990s I think you can confirm that he had got pretty big?
A Yes.

Q We have heard from Code A that he did not drink alcohol – or not much alcohol – but he drank a lot of fizzy drinks?
A Yes.

Q We can take it that he did not exercise a huge amount?
A No, not a lot.

Q As a result he had got very big. Did his legs and feet get extremely swollen?
A Yes.

Q And he had this problem that they would weep a bit?
A Yes, he had an oedema.

Q Right. Then in 1999 unfortunately Code A was also ill.
A Yes.

Q She was diagnosed with having [redacted] and so she had to go to the Queen Alexandra Hospital.
A Yes.

Q Were you living at home at this time?
A Yes.

Q I think on 6 August you went off to work, and when you got back Code A was in the bathroom?
A Yes.

Q He was saying that he was all right ---
A Yes.

Q --- but as it transpired ---
A He was not.

Q --- he was not?
A Yes.

Q The district nurse I think came, because she was visiting regularly to change his dressings.
A Bandages, yes.

Q Eventually she managed to get into the bathroom and she asked for an ambulance?
A Yes.

Q Did they have to get two ambulances?
A Yes, the first one, because the size of the bathroom was so small, they did not have the full leverage to get him up and out.

Q So they had to get him ---
A A second one.

Q --- out. And they got him off to the Queen Alexandra Hospital?
A Yes.

Q That was where Code A in fact had been?
A Yes, I was going down to pick her up.

Q Right. So presumably instead of doing that you also went to see Code A?
A Went to A&E first, and then went up to get Code A told her that she did not have far to walk.

Q We have heard a little bit, obviously, about his progression in the Queen Alexandra Hospital, because he was there for a little while before he was moved to the Gosport War Memorial Hospital. How would you describe the progress of his health?
A When he first got there he was in quite a sorry state for himself, but they put him on a course of antibiotics to relieve the inflammation in his legs – the cellulitis, is it?

Q Yes.
A And his legs were drying up. He seemed to perk up a lot and seemed quite chipper.

Q I was just going to say what was his mood like – but you say chipper?
A When he got there he was very sorry for himself, like where Code A had gone in as well, I suppose he did not really want to panic her, so he did feel a bit sorry for himself. He was there for about two and a half weeks, but as he got towards being moved he was quite chipper, quite happy – good progress.

Q Did the problem with his legs improve at all?
A That improved dramatically. They dried up. I do not know whether it was because he was off his feet, or what, but they had improved dramatically.

Q You say obviously you did not want to worry Code A, because she had her own problems ---
A She certainly had.

Q --- but did he ever complain to you of being in pain?
A No. He never did, even before all this happened, he never complained of any pain, even with his knee.

Q Did he show any sign of being in pain?
A No.

Q You say "even with his knee". What was the problem with his knee?
A He twisted his knee years ago, late '70s, and had a problem with it ever since, and his weight did not help that.

Q No; all right. Then he was transferred to the Gosport War Memorial Hospital. We know that he was admitted there on 23 August 1999.
A Yes.

Q Did you go and visit him when he was there|?
A Yes.

Q Can you remember how often you would go and see him?
A Code A would go probably every day, and if I was not working I would go, you know, as often as possible.

Q Tell us how he progressed in the Gosport War Memorial Hospital.
A When he first got there he was really sort of cheerful, happy – he wanted to come home, really. He had a room on his own, and he seemed really chipper. He looked the best I had seen him for a long time.

Q Sorry, say that again.
A He looked the best I had seen him for a long time.

Q Had the transfer affected him badly in any way?
A No. If anything he benefited from it.

Q How did his position change?
A He was fine for the first three days, something like that. We received a phone call saying that he had had a heart attack, Code A went down that evening, and – Code A always suffered with indigestion, always had done, and he just looked at Code A and went "I've had a bad case of indigestion". Two days after that, he just was away with the fairies.

Q First of all, it is important that you tell us not what Code A told you but what you actually saw.
A Yes. Because I did not go down the day that we got the phone call, but when I did go down there it was a big change.

Q About how long was that after his admission to the Gosport War Memorial Hospital?
A I would say about four days, five days.

Q Just tell us what the big change was.
A He was just drowsy, he could not feed himself, he could not drink for himself. We had to feed him grapes. He was drinking from a straw, a cup that we were holding for him, but he just could not hold it. He just was not sort of with it.

Q How would you describe the change?

A A Quite shocking, from what he was a couple of days earlier.

Q Did things change at all after that?
A Yes, they went downhill. That was probably the last time we could actually speak to him. As to whether he was making any sense of us – but after that he just went into a comatose state and did not know – no facial recognition that we were there.

B Q Can you remember if you went to see him on 1 September and the following day?
A Yes. 1 September he was not even conscious, he did not stir.

Q Can you remember about what time visiting time would have been? Were you still working at this stage?
A At that stage I had stopped working, because the day after I had to take Code A into hospital for an operation.

C Q Do you know you visited him on the 1st?
A I would think half twelve, one o'clock.

Q Sorry, half twelve?
A I would say round about half twelve, one o'clock – early afternoon.

D Q You say at that stage he was not moving?
A No, he did not even know we were there.

Q And the following day?
A The following day I dropped Code A off to Queen Alexandra for her operation, I have gone back home, then went over to Gosport to see Code A. I sat there for about four hours. He did not know I was there, he never stirred, nobody came in, never saw anybody.

E Q Did you speak to any nurses ---
A No, never saw any of them.

Q --- about what was going on? It may sound obvious, but did you try talking to him?
A Yes, yes.

F Q Did you try to rouse him?
A Yes, just had, like, you know, a natter to him, most of the time that I was there, but he was not – well, he was not capable of knowing anybody was there or not, I do not know. But for four hours for somebody not to stir, or, you know, be vaguely awake ...

Q At any stage when he was in the Gosport War Memorial did you see him get out of bed at any time?
G A No.

Q How did you hear about his death on Code A ?
A I was at work at the time. When I come home about 10 o'clock there was a note through the door to say that I had to ring Code A 's hospital, and, like, a neighbour had already written on the note what had happened, so I phoned Code A , make sure she was all right, and she explained what had gone on.

H

Code A: Thank you very much. Would you wait there.

Cross-examined by Code A

Q What you have said in your statement – and just tell me if this is right – is that Code A never really spoke to you about his health problems.
A He never did. It is just the way he always was.

Q So he did not talk about it, and you did not ask him?
A No.

Q Was that the same in hospital?
A Quite possibly. You know, he was just somebody that was very stubborn and would not talk about it anyway.

Q We know that Code A had some pressure sores.
A Yes.

Q Certainly when he was at the Gosport War Memorial Hospital.
A Yes.

Q What did you know about those?
A I did not really know much about them, to be honest.

Q He had pressure sores on his bottom the shape of a loo seat.
A Yes. We did not know about those. We knew that he had them on his heels.

Q And he was getting treatment for those?
A Yes.

Q What did you know about the treatment he was getting?
A Only what I read in the medical notes.

Q All right. You did not talk to him about it?
A No.

Q While you were there? And he did not volunteer any information about it?
A No.

Code A: Thank you.

Code A: Now it is time for the Panel, if any of them have questions for you. Code A is a medical member of the Panel.

Questioned by THE PANEL

Code A: Just one question. When Code A was in the QA and Code A was having her problems, were you aware that at some point in the QA the doctors had decided that if anything happened to him, he should not be resuscitated?
A We were not aware of that until we got the medical notes.

Code A That is fine. Thank you very much.

Code A any questions arising out of that question?

Code A No.

Code A ?

Code A No.

Code A Very well.
(To the witness) I am pleased to be able to tell you that that completes your testimony. Thank you very much indeed for coming to assist us today; I am sorry if you have had to wait for some time.
A No, that is fine.

Code A Thank you, and you are free to go.

(The witness withdrew)

Code A Sir, we have one witness for the afternoon. She certainly will not take up the whole of the afternoon. We deliberately did not overload today because we do not want any spill-over, because we are not sitting tomorrow, but there is one witness left to go.

Code A We will break now and return at two o'clock, please.

(The luncheon adjournment)

Code A Welcome back, everyone. Code A ?

Code A Sir, might I please call Code A

Code A Affirmed
Examined by Code A

(Following introductions by the Chairman)

Q It is Code A is that right?
A Yes.

Q You are currently a Code A working at the Bristol Royal Infirmary?
A Yes.

Q I think you qualified from the Code A and after that you went on to your rotation, which I think you started at Portsmouth, is that right?
A Yes.

Q In August 1999 did you take up a job as a Code A working at the Queen Alexandra Hospital?

A

A Yes.

Q Was that part of your rotation?
A Yes, it was.

Q Was that the end part of it?
A It was the middle. I started ---

B

Q You have to keep your voice up.
A Code A
Code A

Q Your rotation would have involved spending how long in each post?
A There were two six-month blocks and then the rest were four-month blocks.

C

Q So how long would you have been working as the Code A
Code A
A I did six months in 1998 and then four months in 1999.

Q Right. I think you would have been working, obviously under a registrar immediately, and then you would have had a consultant supervising your work?

D

A Yes.

Q I want to ask a little about a operation at that hospital called Code A Is it fair to say that you have little or no recollection of him as a patient?
A No recollection at all.

Q Could I ask you to take up the bundle to your left, and then turn, please, to page 45.

E

When I give you a page number you will see lots of different page numbers on these pages, I am afraid, but you will see a particular page number with two lines either side of it. If you turn to page 45, it has a big 44 actually to the left of it. Do you have that?
A Yes.

Q Just to acquaint yourself with these notes, if you keep your finger where you are but turn two pages on, do you see your writing at the very bottom of the page?

F

A Yes.

Q I think this is a record, as we look at it, page 45, of the examination of this patient on the day that he was admitted to the hospital. Is that right?
A Yes, it looks like it.

Q I am not going to take you through the entirety of page 45, but I wonder if you could

G

help us. This is not your note, first of all, is it?
A No.

Q We know that you went on a ward round on the same day, but later that afternoon, at 17.30. Can we take it that you would not have been on this ward round?
A No. I would have worked on a different ward, so we would have covered our own wards during the day, and then the on-call person in the evening would cover all the wards on

H

that floor.

A

Q I see. So that is how you would have come into it later on?
A Yes.

Q Just glancing first, please, at page 45, we can see that you were dealing with an obese patient with poor mobility. There is a downward arrow next to the word "mobility". Does that tend to indicate ---
B A Decreased mobility, yes.

Q We can see about a third or a quarter of the way down the page, underneath the word "Obesity":

"- Bilateral lower leg oedema" –

C Is it plus, or up? There is an arrow up, I think –

"Swelling legs over past" –

And does that mean "six months"?
A "Increased swelling legs over past six months.

D Q Then "Dopplers", is it?
A "Dopplers one week ago – results not known".

Q A Doppler is a method of checking the flow of blood in the veins?
A Yes.

Q And is it "Results not known"?
E A Yes. I think that is what it says.

Q "Ulcers on legs for" – is it a month?
A I would have said a month. Left calf, right calf, a small ulcer.

Q Then is it "↑ area" and is it erythema?
A Yes.
F

Q What is that?
A It is an area of redness on the skin.

Q "... in groin for" and it looks like three weeks?
A Umm.

G Q Is that right?
A I would have thought so.

Q "Now discomfort and in groin" or "discomfort + in groin"?
A Umm.

Q Then: "[One week ago]" or "[One week] ↑" – I am afraid I cannot read the next
H word. I do not know if you can interpret it for us?

A

A No. I cannot.

Q "Now unable to mobilise".
A Yes.

Q I am going to ask you to go on, please, to the sheet where you made a note and that is page 47. At 17:30, can you tell us what was happening at 17:30. Who would have been
B making a note, and why?
A It says "[Review] Reg", so that would have been the registrar on call for elderly care that night, and it was usual, from what I remember, for the SHO on call, which would have been me that night, to go round with the registrar to review the new admissions that had not been seen on the ward that day.

Q The first note we see is, I think, "No results". Is it "CAR"?
C A I think it is probably chest X-ray – CXr.

Q Thank you. And "Old notes ...", I think it is ---
A "... available yet."

Q Presumably meaning "Old notes not available yet."
A So, no results, no chest X-ray, no old notes.

D

Q Then underneath that at 17:30: "Problems: Cellulitis [left] leg". We have all heard of cellulitis but what in fact is it, if you can help us?
A It is an area of infection of the skin.

Q Then "Chronic leg oedema", is it?
A Yes.

E

Q Does that mean very swollen legs?
A "Chronic" would be long-standing, and oedema is fluid retention in the legs.

Q "Poor mobility. Morbid obesity." What does morbid add to obesity?
A I cannot remember the exact definitions of obesity, but morbid obesity would be at the top end of the large range.

F

Q "Blood pressure [up]". Then there is a "? [Query] AF". Can you help us with that?
A "? [Query] AF" would be "Query, atrial fibrillation," which is an irregular heart rate.

Q I am sorry to ask you to read somebody else's note. Can you help us with what is written below?
A The "P" with the circle round it stands for "plan", and I think what he has written
G there is "As above", and he would mean by that, the plan that was written on the previous page, underneath the clerking.

Q Can you go to the previous page? If we look in the bottom quarter we see again that "P" with a circle around it?
A Which means "plan".

H

A Q And again, I am afraid I am going to ask you to interpret as much as you can. If you cannot read, it is no fault of yours.
A The first bit is "Urinalysis/MSU", which would mean looking at the urine. Then it is "FBC", which stands for "full blood count"; "U&E" is another blood test. "Glucose" and then there is "ESR & CRP" which are blood tests for inflammatory markers, and then "Blood Cultures". So they are all blood tests.

B Q All the blood tests?
A Yes. Then "[Chest] X-ray." Then "ECG".

Q For the heart?
A Yes.

Q Then "Swabs from groin ---"?
C A "... and ulcers".

Q And ulcers.
A "Tilt bed – so can sit him up." Then "IV" is intravenous antibiotics and that is "↑ diuretics". So to increase his diuretics. Then it looks like "Change to frusemide", so that would be changing to a different diuretic. Then up in the right it says "ECG – AF 85/something".
D

Q Oh, yes.
A So that was a comment on the tracing of the heart, to say it was a rate of 85 beats per minute and irregular, or what they thought was irregular.

Q And the purpose of the diuretic would be to reduce his fluid retention?
A Yes.
E

Q So that was the plan. We come back now to page 47; "[Plan] as above".
A So he is saying to continue with all that has been set out there.

Q Then can you take us through the rest of this note?
A I think that says, "IV fluclox/pen G", which are types of antibiotics.

F Q So is that "intravenous ---"?
A Yes. "[Flucloxacillin"].

Q "Fluclox [Flucloxacillin]".
A I think, but I am not sure, if that is "pen G" or shorthand for something else.

Q Okay?
G A "Elevate legs."

Q Sorry. Would pen G be a penicillin?
A Yes, I think so.

Q Below that?
A "Elevate legs."
H

A Q Is it "Clexane"?
A "Clexane as DVT prophylaxis".

Q Just pause for a moment, because this could be significant. Who was making the decision to use Clexane?
A This is the registrar.

B Q And the reason, whether he was right or wrong, that he was suing Clexane was because he was worried that if the patient remained in bed, you might have a vein thrombosis?
A Yes.

Q And prophylaxis means, obviously, to prevent that happening?
A Yes.

C Q Is it "Needs repeat..."?
A "Needs repeat ECG/rhythm strip". A rhythm strip is another tracing of the heart. It is just a long tracing, which would confirm atrial fibrillation. Then he has put "If AF → " – I think that says "anticoag", which would be short for anticoagulate.

Q Just pause for a moment. I appreciate, and I do not mean to be rude, but you are not a
D physician, but you trained as a doctor. To put "→ anticoagulate", Clexane – is that an anticoagulant?
A It is, but it depends on the dose, whether you would use it to prevent clots in the legs or whether you would use it as an actual treatment dose of anticoagulant.

Q "Needs..."?
A "Needs [chest X-ray] ± echo". An echo is an echocardiogram. It is an ultrasound
E examination of the heart. And he has put "? [query] LV dysfunction", so he is querying if the patient had a left ventricle that was not working as it should be.

Q Then: "Consider stop ..."?
A "Felodipine", which is a blood pressure drug.

Q Right?
F A "/doxazosin" which is another blood pressure drug, "since [this] could be exacerbating oedema." And he has put "? [query] change to ACE I". ACE I stands for ACE inhibitor, which is another blood pressure medication.

Q "If AF", so if ---?
A Atrial fibrillation.

G Q "[Atrial fibrillation] and LV [left ventricular] good consider" – is it "Stabilise"?
A I think it is probably sotalol.

Q Sorry.
A It is a drug.

Q Sotalol?
H

A A Yes. It is a beta-blocker type drug. So he is saying, if there is atrial fibrillation and the left ventricle is good, that would be a treatment option to consider.

Q And then: "Watch diuretics don't ..."?
A "... → [cause or lead to] dehydration."

Q And what is the significance of that?
B A If a patient has lots and lots of diuretics because they have fluid in the wrong place, although it will help with the fluid in the legs, it would also cause the patient to become very dry and that could ultimately disturb their renal function.

Q So you have to ensure that although they are on diuretics, they do not at the same time get dehydrated?
A Yes.
C

Q Then "Consider" – is it "empirical"?
A "... empirical warfarin", I think that says, "since high risk of DVT" – so deep vein thrombosis – "/PE", which is pulmonary emboli.

Q Warfarin, again forgive my ignorance, but is that a blood thinner?
A Yes.
D

Q And "empirical" means what in these circumstances?
A I am not sure what he would have meant there.

Q Then he signed that?
A Yes.

E Q And his name was?
A I cannot remember. It says "Code A here. I thought it was something double-barrelled.

Q I think you thought at the time you made a statement that it was Code A ?
A Yes.

F Q Does that ring a bell?
A Yes.

Q Then can you help us, please, with the note that you have made on the left, and why you made it?
A I cannot recall this at all, but ---

G Q Tell us what it says first of all, if you could?
A It says: "In view of premorbid state + [and] multiple medical problems not for CPR", which stands for cardiopulmonary resuscitation, "in event of arrest", and that Code A is my signature, and I would normally write my bleep number underneath it.

Q Can you remember the circumstances in which that came to be written?
A No.
H

A Q In what circumstances would you normally write that? Do you recall ever having written that before?
A Yes. I would have written it – normally or often the SHO was the person who was the scribe on the ward round, and as the registrar has done here, you would write the notes down and the plan. And then, if a decision had been made that they were not for cardiopulmonary resuscitation, then you would write it at the bottom of the notes, and highlight it so it would be seen in an emergency.

B Q What were you intending to signify by writing that note? First of all, was it an indication that you or your senior colleague was expected the patient to die?
A No, not necessarily.

Q So why would you write that?
A It would have been written if the patient was felt to have multiple medical problems
C and if they did have a cardio-respiratory arrest, the chances of resuscitating them would be very, very slim.

Q Was this in any way an indication that the patient should not receive active treatment ---?
A No.

D Q --- for the medical problems he had?
A Not at all, no.

Q Apart from the registrar, would you have consulted with anybody else before writing that?
A Not necessarily, no.

E Q And whose decision would it be? I appreciate you took the pen in your hand and made that note. Would that be your decision to make the note?
A No.

Q Or would that be somebody else telling you?
A It would have been the registrar's decision as it was his ward round.

F Q Can I ask you to turn up, please, page 51 first of all. This is seven days on. It is 13 August. I do not think this is your note, is it?
A No.

Q And your name does not appear on the note?
A No.

G Q I just want to ask you this. It is 13 August. Do you see right at the bottom "Transfer to Dryad ward on 16/8/99"?
A Yes.

Q And then, below that "Not for 555". What does "Not for 555" mean at this hospital?
A I think back then "555" was the emergency call.

H Q The crash call?

A A The crash call.

Q And so if we see "Not for 555" on a patient's note, is that the equivalent of your note?
A "Not for resuscitation in event of arrest" – yes.

Q Could you go, please, finally to page 106. This is going back to 6 August and it is a document called the "Patient Profile". Do you see that?
B A Yes.

Q When would this be filled in?
A From the notes, looking like on the day of the patient's admission.

Q Does your writing appear on this page?
A No.
C

Q If we look at the bottom right-hand corner, we can see a note of resuscitation status. The first date is a little difficult to read, but under "resuscitation status", in the box for "Status", it says "No". Again, can you help us, please, with what these signify?
A My understanding is that this was the admission sheet when the patient was admitted to the ward, and so that it could be again found in an emergency, the resuscitation status would be recorded on the sheet, and it has been recorded twice, and the first time was – it
D looks like 6 August, which would have been when I had signed that order in the notes.

Q Then it is repeated again on the 11th?
A Yes.

Q Finally I want to ask you this. It may be different now, but at this time, ten or so years ago would you have consulted with the patient before you made a decision that that
E patient was not for resuscitation in the event of a cardiac arrest?
A From what I can remember, sometimes we did, but not always, no.

Q Or the patient's relatives?
A Sometimes not, from what I remember.

Q Is that different now?
F A I have not worked on a medical ward for a long time, but my understanding is that yes, things have changed recently.

Code A Thank you. Do wait there, please.

Cross-examined by Code A

G Q I am sorry if it seems like an exam has been sprung on you, and you have been asked a lot of questions. Can I just stay with that point. If you had discussed it with the patient, would you have made a note of that?
A I would like to say so, but I do not know.

Q What about if you discussed it with the relative? We know the relative from page 106 is Code A
H A Yes, most likely. Discussions with relatives were usually written in the notes.

Q If we do not see a note of that discussion, can you tell us whether it was discussed with her or not?
A No, because it might have been discussed and not written down.

Q Why is it that the registrar or doctors would have been taking a decision that a patient was not for resuscitation? You have told us that it does not mean that the patient was expected to arrest or expected to die, but in what circumstances in your experience was anyone making that decision?
A If patients have multiple medical problems and it was felt that if their heart stopped because of these multiple medical problems it would possibly not start again, then that decision would be made and when I say "start again", despite all treatments.

Q I understand. By "multiple medical problems" do you mean serious problems? If I went into hospital with a sore finger and earache, people would not have been making a decision at that point "not for resuscitation"?
A No, they would not. Not seeing your history, and presuming that you are relatively young and fit ---

Q I am not actually talking about me! I am just ---?
A No, but I am just using you as an example. Sorry.

Q People may wish I should not be for resuscitation, but let us take someone whose medical history was simply that – that they had an earache and a sore finger. People would not be making that decision?
A No.

Q Is it an indicator, then, that there were serious problems?
A Yes.

Code A I am grateful. Thank you.

Code A I am tempted to re-examine, but I will not.

Code A You are very wise, **Code A**. I am now going to ask if any members of the Panel have any questions for you. **Code A** is a medical member of the Panel.

Questioned by THE PANEL

Code A These are supplementary questions. This patient, **Code A** was 67. He is morbidly obese, he had fallen, he had ulcers. I cannot tell the Panel what I think, so I need you to say what the doctor would think. If you add in atrial fibrillation to that, is atrial fibrillation a serious problem in itself?
A It depends on whether – on its own not necessarily, but it can be an indicator of something more serious, yes.

Q Is it a rare problem?
A No, it is common.

Q It is a common problem?

A A Yes.

Q We have heard your explanation as to what a crash call, 555 DNR, means. If you put yourself back in 1999 in QA as an SHO, and this patient had a massive GI bleed, what would you do?
A If I was crash called to the patient?

B Q Yes, for a massive GI bleed?
A We would always start resuscitating until somebody had looked at the notes.

Q Can you explain what you mean by resuscitation?
A You run to where the patient is and for resuscitation there is, we call it, an ABC, so you check their airway, check their breathing, check their circulation.

C Q If he was unconscious, you would start some resuscitation while somebody checked his status, his resuscitation?
A Yes.

Q But he is not unconscious, he is not very well but he has had massive PR bleeding – no, he has had PR bleeding and he is not very well from it?
A So his airway and his breathing are okay?

D Q Yes.
A I would move on to his circulation and you would want to give him fluid resuscitation.

Q You would not say to the nurses, "This man is not for resuscitation, leave him alone"?
A No, because he has not had a cardiac arrest.

E Q To simplify matters, would you treat him in exactly the same way you would treat any other patient with a GI bleed?
A Yes.

Code A: Thank you.

F Code A, is there anything arising out of those questions?

Code A: No, thank you.

Code A, anything arising out of those questions?

G Code A: No, thank you.

Code A: Thank you, Doctor, that concludes your testimony. Thank you for coming to assist us today. I am sorry if you have been kept waiting, but it is important we have live evidence from as many live witnesses as possible. We are most grateful to you for your assistance. You are free to go.

(The witness withdrew)

H

Code A: That is all the evidence we have for you this afternoon. I am tempted to say, again, we are making good progress. Whether we will slow down with the nurses when we start them, that obviously may happen. On Friday we have two statements that are going to be read to you and we will be discussing that with the defence. After we have dealt with the case of the last patient, Code A we are moving on to the first substantial nurse witness who is Code A whose name you have heard on a number of occasions. He, we expect, will be a lengthy witness. We may finish him on Friday, we may not. In light of that, we wondered whether you would like – rather than waiting until Friday morning – at least to have the Patient L bundle so we can start as close to 9.30 on Friday as possible.

Code A I would not wish to ask the Panel to be reading it today, given that we are not going to be here tomorrow. I think, however, we could receive it today and, perhaps, given the likely length of Friday, if the Panel would feel able to start a little earlier for the purposes of reading, if we were to start at 9am, would that work for everybody? (Agreement) We will receive now and the Panel will start at 9 o'clock on Friday and we would anticipate seeing you at 10am. That will give us an opportunity to review what you have previously said and look at the notes and then be ready to hear those witnesses.

Code A This bundle, which is about to be handed out to you, will be C13 because we already have K at C12. This is the last patient bundle. I hope you have all the others by now.

Code A We will mark that Patient L bundle as exhibit C13. We do not have a C bundle.

Code A Bundle C is still being perfected, if I can put it that way. We have already given it a number.

Code A We did indeed give it a number, but as we have not heard any evidence on it, it was not necessary ---

Code A There is no live evidence to give on that patient until we come to the expert, otherwise that is all we have for today.

Code A We will rise now. The Panel will come in on Friday at 9 o'clock and we will open formally for business at 10 am.

(The Panel adjourned until 9 am on Friday 17 June 2009
and the parties were released until 10 am)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 19 June 2009

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

Chairman:

Panel Members:

Legal Assessor:

Code A

CASE OF:

Code A

(DAY NINE)

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 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: Code A)

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Code A Good morning, everybody. Code A, the Panel have taken the opportunity to read through Patient L's bundle and also to reacquaint ourselves with your opening in respect of Patient L.

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

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

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

Code A: Sir, may I just confirm what Code A has said.

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

Code A Thank you. The first statement is that of Code A He says:

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

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

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

A

"I live at the address known to the Police. I am the Code A who died on Code A ... at the Gosport War Memorial Hospital, Bury Road, Gosport. I have been asked to provide some background information about Code A.

Code A ... in Gosport, Hampshire. Her parents were Code A She was one of five children, all girls. Two of
B her sisters died in their teens due to someting like diphtheria or TB and her other sisters, Code A died around the age of 70 year and 80 years.

Code A died around the age of 79 .... and Code A died around the age of 69....

Code A worked throughout her life as a shop assistant or canteen assistant.

C We had Code A Code A were straightforward with no complications.

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

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

"She was experiencing a lot of pain and discomfort.

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

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

As a result of this Code A was in constant pain and was prescribed pain killers.

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

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

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

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

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

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

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

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

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

During the evening of Wednesday 19th May 1999.... Code A was visited by Code A Code A I had spent the day with Code A as usual and Code A had come in after she had finished work.

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

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

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

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

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

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

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

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

On Friday 21st May 1999,....at some point during the afternoon, I was approached by a man called Code A He was a Code A on the ward. He said to me something along the lines of "Code A is in a lot of pain, can we have your

permission to double her morphine?'

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

He told me that he would phone Code A for her permission to increase the dose.

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

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

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

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

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

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

Her death certificate was signed by Code A."

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

Code A is buried at Ann Hill Cemetery, Gosport.

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

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

"I am the daughter of Code A"

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

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

Code A says:

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

I am Code A of Code A Code A is till alive and Code A died at the
Gosport War Memorial Hospital on Code A

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

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

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

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

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

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

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

G Around 6 p.m.... on Friday 21st May 1999... I visited Code A was there as always.

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

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

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

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

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

I was taken home by Code A and had only been indoors for a few minutes when the hospital ran to say that Code A had died.

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

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

D That deals with her statement and I do not propose to read the statement of Code A unless I am invited to do so. He is Code A

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

E Code A, may I ask if the Code A referred to in both of the statements just read is the Code A that we are to see?

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

F Code A Thank you.

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

May I now call, please, Code A?

G Code A Sworn
Examined by Code A

(Following introductions by Code A)

Q Is it Code A
A Yes.

H Q Can you tell us your qualifications, please?

A A Code A

Q When did you qualify?
A 1984.

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

B

Code A

A What year did you say?

Q 1998.
C A That is correct, yes.

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

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

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

E

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

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

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

H

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

Q So end of life?
A Yes.

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

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

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

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

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

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

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

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

Q Were they connected in any way?
A No.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q Did you yourself liaise either regularly or irregularly with **Code A**?
A I liaised regularly with **Code A**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q Were you there on occasion when Code A performed an assessment?
C A Yes.

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

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

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

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

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

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

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

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

H

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

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

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

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

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

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

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

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

Q And you would not do that?
A No.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q If we go down to paragraph 5:

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

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

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

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

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

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

Q Look at 7, please:

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

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

Q I am sorry:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q You do not think so?
A No.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H

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

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

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

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

Q In the office?
A In the office.

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

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

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

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

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

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

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

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

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

(The Panel adjourned for a short time)

Code A Welcome back, everyone. Yes, Code A?

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

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

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

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

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

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

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

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

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

A That is an oral analgesic, yes.

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

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

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

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

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

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

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

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

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

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

H

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

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

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

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

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

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

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

Q It reveals:

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

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

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

Meaning the skin is not broken.
A Yes.

Q Then:

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

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

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

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

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

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

Q And getting her walking?
A Yes.

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

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

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

Q Let us have a look at Code A 's note:

"Transferred to Daedalus Ward ..."

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

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

Past medical history – hysterectomy @ 55

A

External operations
Deaf
Alzheimer's

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

B

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

Q "Usually continent"?
A Yes.

C

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

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

D

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

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

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

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

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

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

H

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

Q So it would be written for some patients, but not all?
A Yes. I think that would depend on Code A 's medical assessment of the patient.

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

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

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

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

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

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

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

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

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

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

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

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

A A Yes.

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

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

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

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

Q You would have seen it?
A Yes.

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

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

Q Would you make a note of that?
A Yes.

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

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

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

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

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

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

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

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

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

Q "Remove dentures. Call bell at hand."

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

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

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

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

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

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

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

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

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

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

"Admitted from E6 Ward Royal Hospital, Haslar."

A Yes.

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

A Neck of femur.

Q I beg your pardon:

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

A Yes.

Q Code A She wishes to be informed day or night of any deterioration in Code A s condition."

A Yes.

Q "Swabs taken for MRSA screening. Code A does not want Code A to return to Glen Heathers."

A Yes.

Code A After that there is something of a blank.

Code A It is completely blank.

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

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

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

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

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

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

A

Code A Back to the drugs chart, please, page 63.

Code A Could I look at the original document?

Code A Could Code A be given the original document? (Same handed)

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

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

C

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

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

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

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

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

Q Yes.
A The first one you identified.

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

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

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

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

H

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

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

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

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

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

Q Haloperidol.
A Yes.

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

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

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

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

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

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

G Code A PRN.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A A Yes.

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

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

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

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

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

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

Then is it 19.30?
A Yes.

Q "Pain right hip internally rotated. Code A contacted. Advised X-ray."
E

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Then there is a note:

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

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

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

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

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

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

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

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

"13.05 In pain and distress ..... Code A reports surgeon to say Code A must not be left in pain if dislocation occurs again. Code A contacted and has ordered an X-ray."
F

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

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

A Yes.
G

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

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

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

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

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

Q Code A 's note, and it is not timed obviously although it is dated, is –

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

Plan: continue haloperidol."
A Yes.

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

Q Then "See Code A again"?
A Yes.

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

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

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

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

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

Q On four occasions?
A Yes.

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

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

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

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

Q It may not matter the exact timing but she has plainly been given I think it is at 0.1230, so in other words in the early hours of the morning is the idea, and then also at 4.30 in the morning she is being provided with two doses of 5 ml each. Yes?
A Yes.
D
Q And that would be the equivalent of what 20 mg?
A Yes.

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

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

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

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

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

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

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

Q And it is initiated by you?
A Yes.

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

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

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

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

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

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

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

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

Q Who do you say you spoke to?
A I spoke to one of the Code A.

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

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

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

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

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

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

Q Quite a lot.
A Yes.

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

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

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

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

Q Who?
A Code A

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

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

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

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

A I cannot remember this patient, no.

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

A Yes.

Q We can see I think your initials.

A Yes.

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

A Yes.

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

A 20-200.

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

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

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

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

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

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

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

A Yes.

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

A I would not be able to remember that.

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

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

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

Q Your name appears simply as manager.
A Yes.

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

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

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

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

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

E Code A I am grateful.

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

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

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

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

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

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

B

Q Could you just take us through those?

A Yes.

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

Then at 1945:

D

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

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

A Yes.

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

A Yes.

Q Is that right?

A Yes, that is correct.

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

A Yes.

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

A That is mg.

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

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

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

A Yes.

H

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

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

Q So the total being 5 mgs?
B A Yes.

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

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

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

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

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

Q And 20 mgs of midazolam?
A Yes.
E

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

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

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

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

A

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

B

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

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

C

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

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

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

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

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

E

"Condition has deteriorated. Very bubbly."

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

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

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

Q Is that why hyoscine was prescribed?
G A Yes.

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

H

Q Would there be any other reason for giving it?

A A No.

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

Code A By all means. We will rise now and return at two o'clock.

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

Code A: Sir, we are happy to provide the original notes. Somebody will have to remain with Code A whilst that is done.

C

Code A Yes, we understood that.

Code A If the Panel is content for us to do that we will speak to him purely administratively for that to happen.

Code A Yes, we are perfectly content with that.

D

(Luncheon adjournment)

Code A Welcome back, everyone. Code A, I hope you managed to get some lunch whilst doing your homework?
A Yes.

E Code A Excellent. I will pass you back to Code A and remind you that you remain on oath.

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

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

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

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

H

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

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

Q Then you say:

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

Q You said also:

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

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

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

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

Code A Thank you very much indeed; would you wait there.

Cross-examined by Code A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q I would like us to take a moment, with your assistance, to look again at volume 1. You were looking at this earlier today so it is going back to the same document. I just want to draw everybody's attention, through you, to certain things at tab 4 in that file. The document itself makes it clear that these are guidelines to assist relevant staff in relation to clinical management. I think, following common sense but we are able just to get it confirmed by you, from time to time a guideline might not be followed because there was a reason?
A Yes, that would be correct.

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

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

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

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

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

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

A A Yes.

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

B A Yes.

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

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

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

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

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

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

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

A Yes. I guess that could happen.

E

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

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

F in the UK."

A Yes.

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

G

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

Yes?

A Yes.

H Q And the next bullet point down but one:

A

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

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

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

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

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

Again, you are aware of that?
A Yes.
D

Q Moving a little further down:

"Diagnoses

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

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

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

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

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

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

A A Yes, it could.

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

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

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

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

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

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

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

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

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

Q It goes on:

"If pain is difficult to control, remember:

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

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

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

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

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

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

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

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

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

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

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

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

A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q Maybe screaming in pain.
A Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q Her pain was being controlled.
A Yes.

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

A A Yes.

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

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

B

Do you see that?
A Yes.

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

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

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

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

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

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

Q "Plan X-ray."

Then Code A raising the query:

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

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

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

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

Q Over the page, page 31, still the same day, Code A 's note, as it were, to Code A saying:
H

A "Further to our telephone conversation ..."

Obviously she has been on the phone to him:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q The reason?
A Yes.

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

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

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

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

"Reviewed by Code A for pain control via syringe driver. Treatment discussed
H with Code A ."

A Yes.

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

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

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

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

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

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

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

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

Code A arrived in early hours of the morning. He would like to discuss Code A s condition with someone – either Code A later today."

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

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

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

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

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

"Condition has generally deteriorated over the weekend."

That is your handwriting?
A It is, yes.

Q At 7.45 in the evening:

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

A Yes.

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

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

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

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

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

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

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

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

Q We can see the next entry, which is four days later, Code A

"Condition deteriorating during morning. Code A visited and
B stayed. Patient comfortable and pain free...."

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

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

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

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

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

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

A Yes.
F

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

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

Q Involving clearly the use of the syringe driver and the use of diamorphine and midazolam?
A Yes.

H

A Q Again this is not said by way of criticism at all but did you find that some relatives were much better at understanding what you were talking about when you explained what it was you were using and why than others?
A Yes. People are all individual and some would have a greater degree of understanding and obviously a relative's level of anxiety and distress might have a bearing on their understanding of things.

B Q Then it goes on, after she had been informed, "Message left for Code A ' and I cannot read the name, at a particular holiday camp for her to contact the hospital.
A Yes.

Q So informing it seems all relevant relatives.
A Yes.

C Q Then at 19.45 the syringe driver was commenced with that dosage of diamorphine and midazolam in 24 hours?
A Yes.

Q I am not going to go through all the totting up of the Oramorph again but what you were endeavouring to do in this particular case was to work out a direct equivalent?
A Yes.

D

Q To see whether that would control the pain?
A Yes.

Q How did you see it? Code A , perhaps I can just ask you this. Was it your view, and say if you do not agree or you do not think you are qualified to answer, that the administration of subcutaneous diamorphine and midazolam, assuming it was given for
E proper reasons, might play any part in the decline of a patient in these sorts of circumstances because of their effect?
A Yes, they are both mediations which have a depressive effect on the respiratory centre, respiration, so they can affect the patient's decline as a side-effect of their use to control pain.

Q Again, can I ask you this generally? When Code A in this particular
F case made the point he did not want her life shortened, was that something you always had in mind yourself in terms of the administration of the drugs? Obviously you are following the doctor's prescriptions but, in general terms, was that something you were conscious of, not as it were deliberately shortening the patient's life?
A Yes, we would have to be aware of the medication's side-effects, especially strong medication such as opiates and hypnotics, so you would be aware of that when you prescribed them and the overall effect on the patient.

G

Q Bearing in mind your experience and the gathering experience you got in the course of 1998 and 1999, from what you had learned, either by talking to people or your experience on the ward, if you had ever felt the doses that were being administered of diamorphine and midazolam were too high, can we take it you would have said something about it?
A Yes, we would have said something and we would not have administered a dose which we felt to be incorrect because that is part of the procedure for checking and
H administering medication, any medication.

Code A: Sir, I think, and never trust a barrister when he says this, that is just about all I have to ask Code A. If the Panel was going to take a break at some stage, I wonder if I might just use that time to see if there is anything else I needed to ask him. The alternative, depending on the Panel's wishes, is that Code A re-examines and we then adjourn but I do not want to find myself having to come back with something else to provoke Code A into some further re-examination. It might not; I do not know.

Code A: It might assist us if were possible to have an indication from Code A at this stage about how long he would expect to be in re-examination.

Code A: I have got a bit, I would have thought about 10 minutes, but I am also conscious that the witness has been in the witness box for about an hour and a half.

Code A: Yes, indeed, and what is also attracting my attention is the large number of yellow post-its that are appearing on the panellists' papers, which indicates to me that there will be a fair amount of additional questioning from the Panel. As on the last occasion when faced with that situation, we find it very helpful to spend some time in private working out which questions will be asked and by whom so that we do not have duplication.

Code A: I am in the Panel's hands. I certainly could re-examine now but it is a matter for the witness, and witnesses are not always very forthcoming in saying that they are tired.

Code A: I agree. I think the witness in any event should have a beak now. Whilst he does so, the Panel may spend two or three minutes first of all just getting a sense of how much we will have. What I am leading up to is whether we are realistically going to be able to complete today or whether it would be better for us to finish with the questions from the Bar, as it were, and then resume with Panel questions on Monday. I know that would be very inconvenient to the witness but it might be the only way to go until we have had a chance to discuss amongst ourselves. I cannot be sure how much we may have.

Code A: I know that Code A was only warned for one day. Perhaps it could be checked with him through you, sir, whether he has further availability.

Code A: If it were necessary for you to return on Monday, Code A I would anticipate it would only be for the answering of questions from the Panel and any questions from the barristers that might arise out of the questions from the Panel. In other words, I would have thought it would be half a morning at most. Would that be something that would be possible for you?

A I had anticipated that possibility and I could, if required, do that, yes.

Code A: That is most helpful. Thank you. What we will do now is rise for 15 minutes, give you a chance in any event to have a break. The Panel will use part of that time to consider amongst ourselves where we think we are likely to be. Thank you.

(The Panel adjourned for a short time)

Code A: Welcome back, everyone. Code A you had reserved your position.

Code A Thank you for the opportunity. I have nothing further to ask at this stage.

Code A: Thank you very much. Code A?

Re-examined by Code A

Q Just going back again, please, to the file of Code A file E, you were asked some questions by Code A about how patients would sometimes arrive and the previous hospital would suggest they were in a better state than you found them to be. With Code A Code A we have a note from Code A at page 30, "Transfers with hoist".
A Yes.

Q Can you just explain what that actually means?
A It means we were using a ceiling-mounted hoist and sling to transfer Code A from a bed to a chair or bed to commode or vice versa.

Q This patient I think was certainly meant to be, according to the notes at page 210, in a straight knee splint. Would that affect how she had to be transferred? In other words, would that affect how much help she needed to get out of bed?
A I do not remember Code A being in a straight knee splint when she arrived on Daedalus.

Q Dealing with 17 August – that is what page 210 is dealing with – do you see "Treatment recommendations on discharge: to remain in straight knee splint for four weeks"?
A Yes. I can see that, but I do not remember there being one and I cannot think why you would be in a straight knee splint for hip surgery. It does not quite tally, I am afraid.

Q Is it possible that a patient who requires a hoist to transfer, to get out of bed, would nevertheless then, once she is out of bed, be able to bear her own weight on a zimmer with assistance?
A It might be possible, yes.

Q Page 188 was the better copy of the note that you had from the Hasler dated 10 August which indicated to you that she was admitted to E6 ward and:

> "She had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a zimmer frame."

I just want to have your evidence clear, as it were. Are you saying that you distrust that note, or are you saying that you accept the accuracy of that note at the time that she left the Hasler and came to you?
A I would accept that at Hasler, if that is what the staff say was happening, it was happening, but in our experience we would have to re-assess patients' mobility as appropriate and we often found it to be the case that patients' mobility had deteriorated during that period of transfer and it may be that it would take us a day or two to get them back to the point they were pre-transfer and that would have been the case with Code A.

Q Does the transfer time make a difference? If somebody is transferring from the Queen Alexandra, that is a rather longer journey, is it not?

A A It probably does, but I think even a short transfer can be quite traumatic for elderly patients with complex pathology.

Q Did you have a zimmer available for Code A ?
A Yes, we would have done.

Q And two nurses to help her get out of bed to use it?
B A Yes, we would have done.

Q Did that ever happen?
A That would have been part of the assessment when she was admitted to the ward before we determined that we needed at that point to be using the hoist.

Q I understand that, but you have looked through the notes. Did it actually ever happen
C that she was got out of bed and walked?
A That would have been tried on admission.

Q Is there a note to that effect?
A I could not find one when I looked through the notes.

Q Page 41 is the Barthel score.
D A Yes. That would have included assessing mobility and transfers.

Q How would mobility have been assessed?
A Given that the transfer letter said that the patient could transfer with two and zimmer frame, we would have attempted that the first time the patient required a transfer to see how we got on with it.

E Q Apart from this Barthel index, would anybody have made a note of that event?
A It would not appear to have been done in the case of Code A , other than the Barthel record.

Q Dealing with the notes, I think you have accepted that the documentation was poor.
A Yes.

F Q And you have accepted that there was no note of this patient's pain, justifying the Oromorph.
A Yes.

Q You were asked by Code A what would happen if you had found that diamorphine was being used to keep a patient quiet.
A Yes.
G

Q I think you said, but I might not have heard you properly, "We would have reported that person." Did you say that or did I misunderstand you?
A Well, it never occurred, so it is a hypothetical question, but if I had felt that was the case, then that would have been dealt with. I would have discussed that with a senior nurse manager so that it could be dealt with appropriately.

H Q You also told Code A that there was good handover between teams.

A A Yes.

Q Could I just ask you about the note making and the importance of note making? Is the reading of notes part of the transfer of a patient between teams?
A Notes could be used for reference when handing over between teams, yes.

Q Would they be an irrelevance, as it were, or would they be an important part of such a
B transfer?
A Yes. They would be useful in handing over and useful for looking back at the care that the patient received.

Q You say useful for looking back at the care the patient has received, so that you can keep an idea, as it were, in your mind as to whether the patient is improving or deteriorating.
A Yes.
C
Q So it is not only important for the handover between teams, but so that you know where the patient is in terms of their recuperation.
A Yes.

Q This is going back a little bit, but could you just go back to page 36? This is jolly difficult to read, I am afraid, but it is a note made on 11 August. Where would this note be
D made? Is this a Gosport War Memorial Hospital note?
A Yes. This is part of Code A 's nursing notes at the War Memorial.

Q In the fifth line down, it says:

"She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a zimmer frame."
E
Is that simply a reflection of what was in the transfer letter, or is this something that happened?
A Given that we know Code A to be hoisting and that that does not tally with the Barthel, I think that looks to me to be a transcript of what was written in the transfer letter.

Q You told us I think that if you felt it was appropriate, you would yourself challenge a
F prescription.
A Yes.

Q May I ask you this? In the time that you were there on Daedalus Ward, during the period that we are talking about, did you challenge any of Code A 's opiate prescriptions?
A No.

G Q You also told us that the pharmacist would challenge any prescription that she felt was wrong. To your knowledge, did the pharmacist ever challenge an opiate prescription by Dr Barton?
A I cannot remember that ever happening.

Q Did you ever think that a dose should be reduced of opiates that Code A had started?
H A I cannot remember that happening.

Q You were asked about the Palliative Care Guidelines and you quite rightly pointed out that they were guidelines only.
A Yes.

Q Could you help us with this? To what extent would you be attempting to follow them?
A Guidelines would help in guiding care, but you also have to take into account patients' individual specific needs and make sure that the patient is receiving the right care. If the right care does not coincide with the guidelines, you have to weigh up the needs of the patient against the guidelines and make professional decisions as to what is appropriate.

Q That is exactly what I was going to go on to ask. If you are going to go outside the guidelines, do you have to take any particular care?
A Oh, absolutely, yes.

Q Because the sort of drugs that were being administered, the opiates that were being administered, could actually kill a patient, could they not?
A In high doses, yes.

Q You were also asked about the importance of keeping a patient pain-free, but monitoring the level of consciousness.
A Yes.

Q Would it be important to keep a careful note of the level of consciousness once a syringe driver had been initiated?
A Yes, it would.

Q Did you to your recollection ever decrease the level of diamorphine as being too high because a patient had become unrousable?
A I cannot recall having done that.

Q You told Code A that Code A was very easy to talk to and that she demonstrated sensible, professional judgment and that she found time to talk to relatives.
A Yes.

Q Can I just ask you this? Is that something that relatives had to request? We have heard, as you will appreciate, from a number of patients' relatives, some of whom never saw Code A in the entire time that their relative was there. Is that something that a relative would have to request – "Could I have a meeting with Code A ?"
A It could happen in a number of ways. It might be a request from a relative or it might be a member of nursing staff saying, "It would be helpful if you saw this patient", or it might be Code A saying, "It would be helpful if I saw the relatives." So it could be in any of those three ways.

Q If a patient is near death, would that necessarily trigger a meeting with a relative, or not?
A Not necessarily.

Q In relation to Code A you have told us now on a number of occasions that it was obvious to you that she was in pain.
A Yes.

Q Otherwise, you would not have started Oramorph.
A Yes.

Q Given that Code A 's assessment when she saw the patient was that there was no obvious pain and that the Hasler noted that she was weight-bearing and there was no note there of pain, did you consider that anything might have gone wrong with this patient's operation?
A That would be something that would be considered when assessing the patient's pain, yes.

Q If the patient is effectively pain-free when she arrives at your hospital, or appears to be, and then you think she is in significant enough pain to prescribe opiates to her, would you want to have examined what had gone wrong, or if anything had gone wrong?
A Yes. That would be part of the assessment of what sort of pain is the patient in and where is the pain.

Q How did you perform that assessment in this case? Other than prescribing Oramorph, what did you do?
A Looking at where the pain is, what the nature of the pain is and in particular looking at the site of the surgery to see whether anything looked abnormal there.

Q What did you conclude?
A That there was nothing abnormal with the hip at that time.

Q Did you record that?
A I cannot find it in the notes that you showed me.

Q But you remember that now, do you?
A Yes.

Q Are there any circumstances where an injection into the thigh directly might have helped? I appreciate you say you did not do it, but I just want to know.
A That could be a route of administering analgesia medication and could be prescribed that way, yes.

Q Directly into the joint?
A Not into the joint. You would give an intramuscular injection into the upper/outer quadrant of the thigh.

Q And that might be an effective way of relieving pain?
A Yes.

Code A Thank you very much.

Code A Thank you, Code A The Panel took the opportunity in the break to compare notes, as it were, and to see how much work we felt we had to do together before we

would be in a position to put our questions. The view is that we would be keeping you here fairly late if we were to embark on that process now. So what we are proposing is this.

We will rise now. Individually we will be considering the issues that we wish to raise over the weekend. The Panel will come in earlier on Monday morning and we will have our own private discussions before we all sit formally. The normal starting time is 9.30. We think if we come in at nine o'clock, we will need a little longer than 9.30, so out of an abundance of caution, we are going to say a 9.45 start on Monday morning. That should cause the least disruption possible to the schedule whilst at the same time ensuring that the Panel have had adequate time to reflect on what their questions should be. So on that basis, unless there is any other business?

Code A I think this is the first occasion we have had a witness go not only overnight, but over a weekend.

Code A Code A I should remind you that you are on oath now and you will be on oath when you return, so you are effectively in the middle of your evidence and it is absolutely essential that you talk to nobody about any aspect of this case, the evidence that you have given, the questions that you have been asked or what is likely to happen. You can have perfectly normal conversations with people otherwise, but please draw a line about this.

Code A: I understand.

Code A Very well; thank you very much indeed. We will see you back again, please, ready to start at 9.45 on Monday.

(The Panel adjourned until Monday 22 June 2009 at 9.45 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 22 June 2009

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

Chairman: Code A

Panel Members: Code A

Legal Assessor: Code A

CASE OF:

Code A

(DAY TEN)

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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Code A Welcome back, everyone. Code A the Panel are now in a position to ask their questions if that is convenient to yourself. Very well.

Code A Continued

Code A, I remind you that you are still on oath. We do not require you to take the oath each day. It just continues.

As you know, we are now going to the stage where members of the Panel have the opportunity to ask questions of you and, as you had anticipated, there will be a certain amount of that. We are going to begin with questions from Code A who is a lay member of the Panel.

Questioned by THE PANEL

Code A My microphone does not seem to be working.

Code A I am very sorry, ladies and gentlemen. We have a technical problem. That is a learning point for us: we shall see that every new day we will do a quick check of all the microphones before we call you back. In the circumstances we are going to have to break until IT can come in and fix the problem.

Would you like to return to your various rooms. As soon as we are able to start, we shall let you know. I am very sorry, Code A.

(The hearing was adjourned for a short time)

Code A Welcome back, everyone. I am very sorry for that delay. Everything, I think, is now fixed. Code A I remind you that you remain on oath. We were just turning to Code A who I mentioned is a lay member. We will see if everything works now.
Code A

Code A Good morning to you.
A Good morning.

Q I have a few questions. First of all, may I ask if this was your first management role?
A It was my first post as a ward manager, but my previous roles had had large management-type components to them.

Q Right.
A Do you want me to elaborate on that?

Q Not too much. Was it your first management role at this hospital?
A At this hospital, yes.

Q And had you transferred from outside of the area?

Code A

Q I remember you telling us that, but this was your first managerial role in this particular hospital?
A It was, yes.

Q You tell us that you had some previous experience working with elderly people, and you had some training before you took up your actual post. During that experience had you experienced the types of prescriptions that Code A was prescribing, with this range of 20-200?
A No, I had not seen drugs with that wide a prescription range previously.

Q You never queried those? You told me that you had never queried those?
A No, I did not query those specifically. We had the pharmacist who looked at them and I was happy, understanding that that range meant that you started at or near the bottom of the range.

Q That was your understanding but not a direct instruction, for instance?
A No. I would realise. It is fairly self-evident.

Q Did you ever hear of anyone else who perhaps queried the types of prescriptions that were being made? Any of your staff?
A Certainly I can recall one of our staff who joined from another hospital commented on it, and it was part of the sort of discussion that nurses would have as part of induction and development. We came to the conclusion – I just said that. Okay, although it was a range of dose, you were actually looking at the bottom end of the range if a patient needed to start on that medication.

Q You had not previously seen this type of prescription and you had had one member of staff who had queried it?
A Yes.

Q Who had come from outside of the area?
A Yes.

Q Who was not part and parcel of the Gosport War Memorial Hospitals psyche?
A That is correct, yes.

Q I want to explore with you the ward. You gave us a breakdown of the ward that you were on, and you said there were so many beds allocated. There were 24 beds. Eight beds were for ---?
A Eight beds were what we termed "slow-stream/rehabilitation".

Q Rehabilitation?
A So people who had had very dense strokes. Initially in 1998 we had 16 beds which were titled "Elderly continuing care".

Q Which meant what?
A Which were elderly patients who had complex, multiple pathologies and were going to need a long time in hospital to make any sort of recovery.

Q But no beds that were purely for palliative care then?

A A No.

Q Of those beds, let me ask you about the eight for the stroke and rehabilitation.
A Yes.

Q Were the eight beds in two confined areas? The hospital near us has four beds in little rooms. I do not know if your hospital is the same. Were the eight beds in two of those little
B rooms?
A No. That was just how the beds were allocated numerically. We had four four-bedded bays, and the rest of the beds in single rooms, but patients could go in any of those beds. There was not a division for patients in different categories.

Q You would not walk into an area and know that all these patients are here for rehabilitation?
C A No.

Q It could be the individual bed throughout the ward?
A Yes.

Q There is something else I want to touch on, but before I go on from that. I am trying to build up a structure of how I see the ward. How would a nurse know, coming on on shift
D perhaps on afternoons, what that particular patient was?
A I think we used different colours on our ward state boards to denote whether a patient was a stroke patient or a continuing care patient. But also it was in the hand-over that went from shift to shift of why a patient was with us, what was wrong with them and what care they have received and what care they needed to receive. Our ward hand-overs at change of each shift were quite comprehensive.

E Q It would be in the patients' notes?
A It should be in the patients' notes as well.

Q Should be?
A Yes, yes.

Q You talked to us with regards to the amount of people on the ward, the nursing cover?
F A Yes.

Q And you always tried to get two nurses per shift covering?
A Two qualified nurses.

Q Two qualified nurses. Were there times when you were not successful in that?
A Yes, there were a lot of times, quite often at weekends or at the end of a late shift in
G the evening, when we would only have one qualified nurse on duty.

Q How would the distribution of controlled drugs be done there?
A The policy within the hospital was that if only one trained nurse was on duty, that qualified (sic) drugs could be checked by a support worker. However, what I would add is that if it was someone just starting on a controlled drug, we would actually ask a qualified nurse from another ward to come across and actually check that medication with us so that it
H

A was two nurses checking the drug. So whenever possible, we aimed for two nurses, but there was a provision for a nurse and a support worker to check.

You also said that if you could, to make up the nursing contingent that you wished for, you would use bank nurses?
A Yes.

B Q Would there be occasions then when you would have two bank nurses on one shift?
A As qualified nurses? As far as I can recall, certainly on the day shifts we always managed to have our own staff on. There were occasions on night duty when we would have a qualified bank nurse on duty.

Q So there could be occasions when there would be just one nurse, and that nurse could be a bank nurse?
C A At night, there could be. I cannot remember that happening on Daedalus during the day time, although I could not say that it did not ever happen. Usually we would swap shifts or juggle round, or someone would work a double shift to make sure that we had someone. You appreciate it makes a big difference knowing the ward and knowing the patients from bringing someone in from outside who does not know the patients.

Q Yes. I think that has answered those questions. Bear with me for a second please.
D (After a short pause) You talked about the notes accompanying a patient. I think you said that the notes would always accompany the patients – say they came from the Haslar or the other one.
A Queen Alexandra Hospital.

Q The notes would accompany the patients?
A Yes. They should come with the patient on transfer.
E

Q And I think you also said that they were there within 24 hours even if there they did not?
A If they did not accompany the patient, which sometimes happened, we would phone the ward and explain we needed them, and asked them to forward them as quickly as possible, and that would mean they would get to us some time the following morning.

F Q Who would see those notes?
A They would be looked at by the nurse admitting the patient and by the doctor clerking the patient and also by the consultant on the first ward round after the patient had been admitted.

Q I think this is a question for yourself. If you have a patient who comes in, the nursing notes accompany them from the other hospital. Then you have a prescription that allows the
G range from between 20 to 200. What was the effect if someone was opiate naïve and they gave them 200 mg straight away of diamorphine?
A That would have a seriously adverse effect on the patient.

Q And if they give them 80?
A I could not answer that in precise terms.

H Q Sorry, not of diamorphine, but if they did it with midazolam?

A A With midazolam?

Q Yes.
A If you started someone right at the top of a dose range, then I would expect that to have an adverse effect to the patient.

Q Can I ask you questions with regards to Patient E. You did say that you had ---
B A Patient E, did you say?

Q Yes. You did say that you had some memory of this particular patient?
A Yes, yes.

Q Page 188. That letter would have accompanied that patient?
A That is correct, yes.
C

Q I think you made some comments, some references, to other hospitals and what they perceived the patient's situation to be. Can you just remind me what you said?
A Yes. Very often would have reached a certain stage of recovery and rehabilitation prior to transfer. However, when the patient has arrived with us, we would often find that they were not at that level. I think part of that may well have been the actual act of transfer, which we know is traumatic and unsettling for patients. We would need to re-assess the
D patient, to find out what they were able to do and what their needs were.

Q Can I just stop you for a moment? You are actually saying it was the transfer of the patient, as opposed to the high expectations of the previous hospital?
A That would be the only thing. If the transferring hospital had stated the patient was doing something, such as mobilising with a zimmer frame, then I think it would be hard to think why they were not doing that now other than the transfer, because that is the only factor
E that has changed.

Q We had this patient's Code A give evidence. She said that she was there when Code A Code A arrived at your hospital, and she was brought in in a wheelchair. This lady was, I think, 42 years as a nurse, made matron, specialised in working with older people, worked at nursing homes and she said that her assessment of Code A was the same as when she had seen her at the Haslar – what this accompanying letter more or less says, and how she
F found her. She was actually at the hospital before Code A got there and so had come into the hospital, saw the mobility that she had, and she was more or less, I think – I would have to check the actual transcript – but she was more or less in agreement with what they had said. Now, after that, Code A assessed her, wrote out prescriptions immediately for Oramorph. Are you telling me that the deterioration would have been the transfer? The only thing that is wrong is the high expectation of the other hospital or the transfer?
A That is the only factor that I could see which would account for a deterioration in the
G patient's ability, yes.

Q You told us that morphine is only given to relieve pain?
A The management of pain, yes.

Q We have heard about the step situation where you start on step one, and move up to step ---?
H A Yes.

Q I want to suggest – is co-codamol step one?
A Yes.

Q And Oramorph would be step two?
A Yes.

Q So we have moved straight to step two on the entry to your hospital?
A Yes.

Q That is possibly caused by the transfer?
A Well, yes. A transfer is obviously has had an adverse effect on the patient.

Q You did say on Friday that on the ward there is the BNF?
A Yes.

Q There is a copy of that on it?
A Yes.

Q I do not know if you have this in front of you, but it is called C1. Is there one down there?
A No, I do not have it.

Code A That is Panel bundle number 1. If it is not with you, we will get it to you.

THE WITNESS: I do have it, thank you.

Code A May I ask you to turn to it. Can you help me with this because, as the Code A said to you, I am a lay member so I am trying to find out the process. Can I ask you to turn to tab 3? I think you will see the front cover is a photostat of the BNF.
A Yes.

Q If you turn to page 22 – let us see if we are both singing off the same hymn sheet – can you see if there is a conversion table from Oromorph ---?
A There is, yes.

Q Code A started this patient on 11 August 1998 on 10 mg. Is that the dose? Looking at this chart, are these doses for adult patients?
A As far as I can see they are, yes.

Q Would you just turn to page 24. Perhaps you can help me with this. It says "Guidelines":

"First always question whether a drug is indicated at all."

A Yes.

Q That is not necessarily a question for you – there is a question there but not for you. This is prescribing for the elderly – you can see at the top?

A A Yes.

Q "Reduce Dose: Dosage should generally be substantially lower than for younger patients and it is common to start with about 50% of the adult dose."

Would that be 50 per cent of the adult dose to start with, for someone who has been on co-
B codamol the day before?
A No. That would not be 50 per cent of the dose.

Q And no one every questioned these doses?
A The doses we felt were being used were compatible with the level of the pain that the patient was experiencing, so when a drug is being administered you have to look at whether it is the right drug, the right patient, the right time and the right dose, so you would always look
C at the dose and in terms of who it was being used for and for what purpose.

Q For a layman it seems as though somebody has come in with co-codamol and they are straight on to 10 mgs of Oramorph and this is telling me that you should be starting at least 50 per cent and that is saying to me that that is quite high. In fact on the same day, on 11th, there is also a prescription for diamorphine with a dose range of 20 to 200 and midazolam of 20 mgs to 80 mgs and you never questioned this.
D A I did not question the range of the dose because my understanding was that we were starting at the bottom of that range.

Q But these dosages are for normal adults similar to ourselves and not elderly patients. Can you tell me how long it takes before Oramorph starts to have an effect?
A That is not something I could answer off the top of my head at the moment, I am afraid.
E

Q Could be variable for different patients?
A Yes, it would be.

Q Would that be the same before it is through the patient's system?
A Oramorph is usually given four-hourly so its effect you would expect to wear off by four hours, but it would depend on how much pain the patient is in and various other factors.
F

Q One final question. I think you were asked about the statement "confirm death" that Dr Barton had occasions to write?
A Yes.

Q You did explain it and probably adequately and I may have missed it, but did you say that that was just an issue of custom and practice?
G A Yes. The hospital was a community hospital so the patients were looked after by a team – nurses, doctors and therapists – but the people who were there round the clock were the nurses and out of hours there was limited access to medical staff. Because on occasions a patient's condition did change and deteriorate quite rapidly and the fact that a situation could change it was practice that was written in the notes of some patients. That then spared both the patients and the relatives the anguish of us having to call in a locum doctor, say over a weekend or in the early hours of the morning to see a patient they did not know when the
H patient had clearly deteriorated and the patient had died. The death still had to be certified by

a doctor when they came on duty but I understand that it is common practice within community settings for nurses to be able to confirm that death has taken place and just acknowledge that in the notes. But it did not necessarily mean at the time it was written that there was an expectation that the patient was going to die; it was just a possible outcome.

Q How would a bank nurse on nights on her own know that?
A I would not expect a bank nurse on nights to know that. If we had a bank nurse on nights the handover they would have had would have been extremely clear; there was always an F grade senior staff nurse on night duty for the hospital who would have come across routinely to check how the bank nurse was and deal with any problems and overview things, and could have been called at any time should the bank nurse needs support and guidance. So it is not something a bank nurse would probably even come across or had to deal with.

Code A Thank you very much for your help.

Code A The next member of the Panel is Code A, who is also a lay member.

Code A Good morning Code A Can I go back to Code A and some of the questions he was asking as well? You have talked about when you had a patient transferred to you that there was probably more of an optimistic note within the notes about the patient's condition; there was an assumption made that probably it was the transfer that had actually contributed to that. What was the dialogue or communication that was held with that hospital to indicate that there had been this change?
A As in feedback from us to them?

Q To them; or to try to clarify because here you have a patient's condition that does not seem the same – so not making assumptions. So how do you establish what was the dialogue with the other hospital?
A Usually once the patient was transferred to us we would take over care so if we had any particular queries about a patient then we would make contact with the ward to clarify things; but we were quite used to patients being transferred to us and not being at the same level that they had been at prior to coming to us. So it was more our practice to accept that as part of the transfer and work with the patient and their relative to try and settle the patient in and then bringing them back to the level they were at, rather than enter into a dialogue with a ward who had transferred and you would probably find that the nurse who had seen them last was probably off duty by the time they had come to us. But we could contact them if we had very specific queries, which we would do from time to time.

Q Did that not make it quite difficult for you, though, to just base it on assumptions that it is the transfer that had contributed to the deterioration?
A As well as the fact of that feeling that the transfer ... There were other things that you could see with patients and relatives settling in and getting to know staff and orientating us to who they could call and what was happening. Often patients arrived and relatives arrived with us in varying degrees of anxiety and so you could actually observe the effect that the transfer had. You are used to looking after patients and picking up various clues as to both their mental and physical state. I do not think it was just an assumption, it was actually an observation based on nursing experience as to what was happening with the patient at that point in time.

Q So with Code A do we understand that there was no time with Code A that actually she was able to walk with a Zimmer frame and aided by two nurses?
A I was not involved in actually admitting Code A to the ward. But the handover from the staff, from what I recall, is that either she could not or her transfer with the Zimmer frame at that time is what I would term "unsafe" in that it placed both her and the nurses at risk. So initially we were hoisting and that was quite common for patients to be hoisted initially until we could get our physio to assess and look at how best to help the patient to become mobile again.

Q I will leave that one at that point then. Can I move on then? We have already talked about "happy to confirm death" and that is on page 30 in the notes here.
A Yes.

Q What was the influence on the staff of that sort of note being there?
A I think because we were used to it being there it was not something which – it would be wrong to say we took no notice of it, but we regarded it as it being there and that being part and parcel of the nurses' documentation, but it just signified to us that if a patient's condition changed at some point in the future we would not necessarily have to call in a locum doctor or a doctor who did not know the patient. I certainly did not regard it as an indication that the patient was likely to die at that point and I do not believe my colleagues did either.

Q To a lay person looking at this, we have a patient who is coming in for rehabilitation and at the very first point we are talking about happy for staff to confirm death.
A Yes.

Q That seems very incongruent.
A Yes; I can understand how that would appear to a lay person and of course I was viewing it through a professional's eyes but when you point that out to me I can see that a lay person looking at that may read that – in fact quite possibly would read that in a different way to the way I had read it as a professional; and there is certainly – possibly a lesson to be learnt in terms of how we write professional notes.

Q Because what would you perceive as some of the risks that may have been associated with that, that were there at the beginning?
A Sorry?

Q What would you perceive as some of the potential risks that could be there for you and your staff?
A With that statement? I would not have viewed it in that way because I understood the context in which it had been written. I suppose potentially – I was asked the question about if we had bank staff; but, as I said, bank staff usually would not have had cause to refer to the patient medical notes because all the information they would have needed would have been in the handover, and bank staff who did not know the patients in the wards, we would have made strenuous efforts to make sure that they were supported by regular staff who did know the ward and the hospital.

Q But I did understand you to say that there could be occasions when a bank staff member may be on the ward alone at night.

A A Yes, but they would have got a very thorough handover and briefing from the nurse they were taking over from, and there would be a senior staff nurse who would have overall responsibility for all three wards and would come and support that nurse during the shift. So although they would be in charge of the ward and the patients there would be someone senior supporting them and giving them any help and guidance that they needed.

Q So it is your view then that there were sufficient safeguards in place?
B A I feel so, yes. I can understand how that statement can appear but I did not feel at that time that it actually placed patients at risk in any way because it was written in a particular context and providing that that context was understood – and to my knowledge it was understood by all the nursing staff on the ward – then it did not create a risk; and it had a very specific meaning to it anyway.

Q That you felt was there and everybody understood that?
C A Yes.

Q Let me move on. Can you tell us what you understand is the purpose of the medical notes, the purpose of the clinical notes, etcetera, because there is a range of different notes. So what is the purpose of those?
A Of the medical notes? Because they were pertinent to that patient they would contain everything that happened to them medically, not only during that admission but in previous
D admissions and illnesses and outpatient consultations; also, old nursing notes and drug charts. So they were a point of reference for the problems that patients had had, the care that they had received and so on; and they would also contain medical information as to what needed to happen with the patient during their stay on the ward.

Q And the nursing notes?
A The nursing notes would have been kept in a separate file. In fact – I am trying to
E think at that time – how we kept nursing notes changed over time, but they would certainly be in a file of nursing notes for the patient and a care plan either within that file or by the patient's bed; and they would be an assessment of the patient, their nursing problems, their needs – things like their Barthel and possibly their mental test score – and they would include care plans which would indicate the care that that patient needed, and a contact record where we would summarise the ongoing care that the patient was receiving on a shift by shift basis.

F Q So in a nutshell the overall purpose of all those notes was to make sure that everyone was fully on board for the care plan and the treatment plan for that patient.
A Yes.

Q I have to say that I have looked through these notes with which we have been provided, and I cannot find the decision that was made that this patient was moving to palliative care. I understand from yourself, what you said previously is that palliative care
G was the end of life.
A Yes.

Q But I cannot find in here when that assessment and that decision was actually made to move to palliative care. So are you aware of it being in the notes or could you help me to understand how that decision was actually made and communicated?
A I was asked to look through the notes on Friday and I would agree that there things
H there that I would expect to be in the notes that I was not able to find. I can clearly remember

A Code A seeing the patient and discussing with myself and with family what care the patient was to receive. The only thing I can say is that I think at that point in time we focused an awful lot of our attention on patient care and communicating with relatives and where we had limited time we compromised on patients' note keeping and that is something which, in retrospect, we should have paid far more attention to our note keeping, say.

Q But it is also how was a decision communicated to you? On what basis was a B decision communicated to you that the assessment is now made and we are moving to palliative care? Because that meant nothing else got attended to – the haematoma or anything like that did not get addressed because we are no longer curing, keeping him until death.
A Yes.

Q So that is a big decision to be made.
A Yes. C

Q I am not certain I am clear as to how that decision was actually made. I am clear as to how that was carried through with you but now how you knew that that decision was made.
A Without it being in the notes I can only remember from the verbal recollections that the patient had been seen by two of the out of hours doctors and then by Dr Barton as well as X-ray. So there would have been discussion on the ward as to what the plan was for the patient. D

Q You take me back to what safeguards were actually in place to prevent too speedier moving to that position of care, because you have told me that your safeguards were your notes. So I am not certain at that point then what the safeguards were to prevent you moving to palliative care. You probably cannot answer that.
A I cannot answer that now, I am afraid; I am sorry.

E Q There is just a quickie that I would like to take up, following on from Code A as well. When we actually look at the use of the Oramorph, what is the effect on a patient when it says in Code A 's notes "but very sensitive to Oramorph". Again, what are the implications of that for you?
A That Oramorph in this particular patient can have side effects, or the side effects would perhaps be a little bit more pronounced than in some patients.

F Q Sorry, the side effects?
A The side effects could be more pronounced than in some patients.

Q What can some of those side effects be?
A Oramorph can cause – the pain, side effects can be nausea, vomiting, drowsiness, confusion are some of the key ones.

G Q So it is quite a big step to go from co-proxamol, whatever it was, when this lady came in to actually moving on to the Oramorph?
A Yes, it is an increase in analgesia.

Q We are told about the deterioration in these patients from one hospital to another hospital. What contribution could the Oramorph have had on that?
A I think with a patient, if that deterioration was noted before the Oramorph was given H and the patient was in pain, hence they were given Oramorph, yes, it is possible that if the

dose was too strong, that could also have contributed towards the patient being more confused or nauseous or vomiting or more drowsy.

Code A Thank you. I think I will leave it there.

Code A Before we move on, this is for our visitors today. It is important that those who are here to observe the proceedings restrict themselves to just that. Although there have been no spoken words coming from the back of the room today, there have been clear visual comments made in body language, shaking of heads and so on. That is really not appropriate. It does not assist anybody and it is distracting for Panel members who will not take any other notice of it. If I can ask please that that stops now and does not continue.

We turn to Code A who is also a lay member of the Panel.

Code A My question is about how you assess the amount of pain a patient is in and we have heard that there is a lot of communication with relatives as regards decisions to be made about a patient's treatment and care.

A Yes.

Q I have not actually heard what role, if any, relatives play in terms of the assessment of pain, particularly patients who are unable to communicate or are unconscious. Could you elaborate on that?

A A relative's involvement in assessing pain?

Q Yes.

A As well as the things we would assess, we would want to know from relatives what is normal for that patient and whether they perceive them to be in pain and what they perceive that level to be. I think we would take into account the fact that the relatives probably, in some ways, know the patients better than we do as nursing staff.

Q Sorry if I can interject, does that happen all the time, at each stage you are assessing the amount of pain a patient may be in?

A I would expect it to if the relative was present and available, yes.

Q If the relative is not present and the patient is unable to communicate?

A If a relative is not available and a patient is unable to communicate and the patient is clearly in pain, then the normal thing to do would be to want to do something to relieve that pain.

Q When you say the patient is clearly in pain; would that be based on your assessment?

A On a nursing assessment of the patient, yes.

Q I think you did mention it. Perhaps you could reiterate, if a patient cannot communicate with you, how you are making that assessment.

A There would be a range of non-verbal clues. A patient who cannot speak may still make verbal noises, but also facial expression, agitation, body posture and that may change with nursing care to the patient. So actually moving a patient may have an effect on those things as well.

Q Would you, having made an assessment, then consult relatives further down the line?

A Yes, certainly if a patient was needing regular analgesia or we were starting them on a stronger analgesic, it would be appropriate to bring that to the attention of the relatives at the earliest opportunity and if it was found that that was because of a change in the patient's condition, it would be normal to make contact with the relatives and maybe talk to them on the phone or even ask them to come into the hospital so they were aware of what was happening with the patient so they could be involved in the decision making and just put their minds at ease that things were being observed and dealt with appropriately.

B

Q What form would that communication take? If I were a relative, what would you be expecting from me?
A I would expect to talk to you about what I observed and what the plan was, and then allow you the opportunity to ask questions and discuss it and together come to a consensus on what is an appropriate course of action or treatment to deal with the problems.

C

Q So it would be a consensual arrangement?
A Yes.

Q If you felt my relative was in pain and I felt that she was not, how would you be able to resolve that? Would you be able to come to a resolution? How would you deal with that?
A I would hope so. I would want to have the relatives on board and yes, we would come to an agreement. I would be very reluctant to move forward with a course of action with
D which a relative was particularly unhappy about or not in agreement with.

Q What happens in those circumstances?
A I cannot think of a specific example of it happening, but I would aim to come to some sort of compromise that we would maybe review things or ask someone else to look at the situation, or try to find a course of treatment we could agree on and then review things at a later time.

E

Q Would a note be made of that discussion?
A I would expect to make a note, yes.

Q Of the nature of the discussion or the conclusion?
A The nature of the discussion and the conclusion.

F

Q So it would be noted that there was disagreement between you?
A Yes.

Q Has that appeared, or have you found when looking in the notes any examples of that?
A The notes we are looking at here, which I was asked to look at on Friday, I could not find that. I can think of other patients where I know that I have recorded things where we have not agreed, and in fact some of these cases were a learning experience for me.

G

Q Is it something you would expect to see in the notes?
A I would, yes.

Q In terms of priority, because I know you have said that sometimes you are busy and care needs to take priority.
A Yes.

H

Q Would that be something you may not do immediately, but would aim to do as soon as possible? Would it be a high priority?
A Yes, it should be something that is done and I think in 1998 I can see now looking at the notes that that was not always the case, but yes it should be a high priority and should be done.

Q Slightly moving on but still related to that, you mentioned that relatives sometimes have unrealistic expectations. Would that mean that part of your role would involve or did it involve managing their expectations?
A Yes. Regularly patients would have arrived on Daedalus Ward with relatives thinking, or having the idea as far as we could establish that two or three weeks on Daedalus Ward and patients would be returning home. Quite clearly, even without the deterioration, without the defective transfer, the patient was going to need a longer period of rehab than that and it would be quite complicated. So part of the assessment and discussion with relatives would be around how long rehabilitation might take, what some of the problems might be and how we might deal with them, and often we found we were having to help patients and relatives come to terms with the fact that their stay on the ward was likely to be more complicated than they had envisaged from the information they had at the transferring hospital.

Q How did they take that information generally speaking?
A I think it really varied, but if someone has an expectation of three weeks in a community hospital and they will be well enough for home, and then someone is telling them it might not be that, I think most people would be disappointed and might find that difficult to take on board. That would temper how you actually gave that information because you would not just say, "Actually it is going to be eight weeks" and so on. You need to be gentle with people and helpful and supportive with them.

Q Did any of them complain about the difference in the information they had received?
A Sometimes they were not surprised at all, particularly with relatives of elderly patients who they knew had been having problems for some time, perhaps, but some were very surprised and were not happy that they were being told something different from what they either had been told or thought they had been told by the transferring hospital.

Q Again, is that something that would appear in the notes, the conversation regarding the expectations?
A Again, yes it should. Whether it always did I do not know and I am sure there are notes where that conversation or a good recording of that conversation probably was not there. It should be there, but I think there are probably cases where that conversation was not there.

Code A: Thank you very much.

Code A Good morning. Just some general points first. **Code A** was the doctor who came pretty much every day, and you saw her, went round with her, I think you said, once or twice a week because of shift patterns.
A Yes.

Q Then other nurses would go around with her in the same frequency.
A Yes.

Q How well did you know each other?
A Myself and Code A ?

Q Yes.
A I knew Code A relatively well as the doctor managing the ward. Our relationship was limited to Code A and doctor, so I did not know Code A outside that.

Q In a professional capacity?
A In a professional capacity I felt I knew her very well.

Q Would that be the same with the rest of the staff? That is to say, would the whole relationship be very much a team?
A Yes. I mean, many of the staff had been working on the ward for a much longer period than myself and knew Code A very well, so I think we all felt we knew her professionally very well.

Q Would you say there was a mutual understanding of each other's points of view?
A Yes, I would.

Q The ward itself, we have heard before a description and Code A took you into that. I just want to go a little e bit further into that because even though I am a doctor, I sometimes find some of the titles difficult to understand. I think I can understand "Slow stream/rehabilitation" – very disabled people you are trying to get into some kind of a state, not necessarily up and walking but some kind of a state.
A Yes.

Q What is "continuing care"? Can you try and help us with that?
A Yes. Continuing care in Gosport, Portsmouth was the title given for the care of elderly patients who had complex needs and were going to take a long time to make recovery and that recovery was expected to be limited. Probably in that category the patient may never be well enough to return home so they may need ongoing hospital, nursing home or rest home treatment, more likely nursing home. Or if they were to return home, they would probably need a very complex care package and these would be patients who were dependent with very restricted mobility and a range of other problems as well.

Q This was in 1996. I cannot really remember, but you were there, you were working in it. At that time were some of those patients permanently in hospital, would not go home?
A At the time I arrived on the ward in 1998, there were a small number of patients who had been on the ward for I believe 12 months or more. We were working towards getting them home or discharged, but it was not looking terribly hopeful for them because of the length and extent of their illness.

Q Nevertheless, the ethos of the ward was to do what you could for patients and then move them on to the most appropriate place.
A Yes.

Q In such a ward – again it has been gone over but I want to look at it from a slightly different angle – how was patient prognosis communicated? Who would decide what the prognosis is first?

A A Patients arriving with us would be for active treatment to improve them, but if things changed then that prognosis would be dealt with by either Code A as our medical assistant doctor on the ward or by a consultant at the ward round. So it would be conveyed to nursing staff on duty who would then convey it to the rest of the team.

Q So you have given us one flavour for active treatment. What other kinds of labels might be used?

B A I think if a patient's condition was deteriorating and they needed palliative care, then that would be conveyed from medical staff to nursing staff, and then to other members of the team.

Q What kinds of words would be used? What kind of technical professional words would be used?

A I am struggling to think, actually.

C

Q Might you say, "End of life"?

A "End of life" might be used, but also sometimes if a patient's condition was deteriorating, that they were to be kept comfortable and had to receive sufficient pain relief.

Q It is passed on by word of mouth?

A I would expect it to be in the notes, but also communicated verbally as well, yes.

D

Q It should be in the notes?

A Yes.

Q We have heard and we have seen three statements. Code A 's statement, "I am happy for nurses to confirm death", written early or immediately on admission. Another one was, "keep comfortable", and another one was, "For TLC". Were all these three there as a

E matter of custom and practice?

A I believe they were, yes.

Q Code A said that a lay person might read it as something quite different. You said, "No, as a professional I take it to mean what we generally felt it to mean". I am a doctor, and I find it difficult to take a different view to Code A . As a doctor I am fairly worried by a statement that a patient who has just come in, said to be mobile with a zimmer

F frame and two nurses, can have their deaths confirmed. Can you explain what it is, the feeling in the team, that makes you comfortable with that statement, with the statement that Code A has written in the notes?

A At that point in time it was something that we would have been used to, so our understanding of it was as I explained, that it was something that was there and we understood it to mean that if things changed and the situation deteriorated. So yes.

G Q Had you ever seen it before in another hospital?

A I had not worked in a community hospital before so that was not something I was familiar with.

Q It could be misunderstood, could it not?

A I would agree that it could be misunderstood, yes.

H Q By a bank nurse at night.

A A It could have but I would not anticipate a bank nurse to be referring to the medical notes to direct them in patient care, and I come back to the fact that the bank nurses were well supported by a senior staff nurse as well as their handover from the nurse passing the shift on to them.

Q If a patient was in pain at night and the bank nurse referred to the admission note where the prognosis is written?
B A I would expect them to refer to the senior staff nurse if they wanted to, if they were concerned about the patient.

Q These three statements are not a code that you all understood?
A No.

Q They are not a code?
C A No.

Q For "We are not going to do anything more for this patient"?
A No.

Q You were pretty dogmatic that opiates were never given except to control pain?
A Yes.
D

Q You also said – and I think more than once – that once a syringe driver had started, the dose was never reduced?
A Yes.

Q Yes?
A Yes.
E

Q This rendered patients unconscious. At least in many of the patients that we are looking at this rendered these patients unconscious?
A Yes.

Q One of those patients rendered unconscious had pain from a haematoma in the hip. Would you agree that a haematoma in the hip is not a terminal condition?
F A Yes, I do.

Q What is the objective of the syringe driver?
A The patient was not just in pain from the haematoma, but the patient's overall condition had deteriorated significantly as well as the fact they were in pain.

Q So it is not for pain?
G A Pain was one of the symptoms that the patient was demonstrating, but there was also an overall deterioration in their condition.

Q Why not reduce the dose and see if the pain has gone away?
A I think the feeling at that time was that actually reducing the dose would cause the patient to be in pain when the dose was reduced.

H Q Is that a reasonable professional view?

A That was certainly the view held amongst myself and my colleagues at that time.

Q That suggests, does it not, if you have a bad pain you are going to become unconscious and you are not going to come out of that. That could be suggested, could it not?
A I think it needs to be viewed in the context of the patient's overall condition, not just the pain they were in.

B

Q So a frail old lady gets severe pain – you are not going to reduce the dose and see if the pain has gone away?
A At that time with syringe drivers, it was considered that the dose would be continued and the patients monitored. In fact, in this case Code A was continuing to be in pain when we were delivering nursing care to her. That was the factor that was deciding whether that analgesic was finished. So when she was being turned or washed, even though she was
C unconscious, there were indicators that she was still in pain at that time.

Q And midazolam was added – a further sedative – and that was not reduced either?
A No.

Q And no hydration was given?
A No.

D

Q This is terminal care?
A Yes. I think the decision had been made at that point that the care Mrs Richards was received was palliative care.

Q And hyoscine – what does hyoscine do?
A Reduces secretions.

E

Q So if hyoscine is prescribed, if you like before the terminal state, before the very end, is that not anticipating that it is going to happen?
A Yes.

Q That death is near?
A Yes.

F

Q You said to Code A that when a syringe driver was started you asked permission, and you elaborated on that that it was a consensual thing. You discussed and it was consensual?
A Yes.

Q Did you ask the relative's permission in an explicit way or was it always implicit?
G A As far as I am aware it was always explicit.

Q She would say, "So is that all right" – having described what you are going to do, what might happen?
A Yes.

Q "Is that all right"?
H A Yes.

Q Once the syringe driver was started the dose was never reduced?
A Yes.

Q So what would you do if a relative said, "But this is going to hasten his death/her death"? What would you say to that?
A I felt that the use of a syringe driver was keeping the patient comfortable. It was not my opinion that it was hastening death, but it was keeping the patient comfortable at a time when their death was anticipated. If they had that concern, I would have talked to them about it and the effects of the syringe driver. If there were real concerns, I did have the option of asking a more senior member of staff to come and review the situation and discuss things with relatives.

Q And the relative, Code A says, "I do not want Code A to have something that will hasten her death". What do you say to that?
A That would be a cause for me, having talked to the relative, if we did not have consensus, it would be to ask the senior nurse to come and review and look at the situation.

Q But we know either that Code A was mistaken and never asked that, or that if he was not mistaken ---
A Sorry?

Q --- the senior nurse was not involved.
A You are talking about a particular ---

Q Maybe it was not a patient you were involved with.
A Right.

Q But in Code A case Code A says that she asked for the dose to be reduced so that she could speak to Code A and have some last words, so she could make some arrangements.
A I have no recollection of that being asked of me by Code A

Q I may be mistaken in the specific, but in the general if somebody asked that what would your reaction be?
A I would be concerned about the patient being in pain if the dose was reduced, but I would be quite happy to discuss that with the relative and, as we discussed with starting analgesia, to look at the dose that the patient is on. If I was not happy, then I would actually ask a more senior nurse to come and look at the situation with me.

Q And that would be a normal situation?
A I have no recollection of any relative ever asking.

Q I apologise. If I have the specific wrong, I apologise.

Code A

A Yes.

Q I do apologise.
A That was not on the ward that I worked on.

Q Nevertheless, to crystallise it, would you resist that, or would you go along with it?
A I certainly would have been. I would be happy to consider that. If that is what a relative was asking, it needs to be looked at very carefully and very properly, to make sure that between myself and the medical staff and the relatives, that we are making the right decision. It is hypothetical because I cannot recall it having been asking of me, but I think if it was asked of me, my view would probably be that I would be in agreement to do that and see what the outcome was because that situation could always be reviewed again and the dose increased if a patient became in pain. So yes, I cannot comment on what someone else has done, but what I do ---

Q I would not ask you to do that.
A --- in that situation would be to reduce the dose.

Q Just one other general point. We have heard that the pharmacist came once a week and the pharmacist would review the controlled drugs register?
A Yes.

Q But some patients might have died in the meantime. Would the pharmacist check over the prescriptions for a patient who had died?
A Probably not, because the patient would be no longer on the ward and the notes would have been sent away. So no, the pharmacist would have looked at the drug only for patients who were actually currently on the ward receiving treatment at that time.

Q Can you remind me, and certainly inform the lay members of the Panel, does the controlled drug register indicate the precise dose given each time?
A Yes, it does. It records the dose, the time it was given and the nurses who checked that prescription.

Q The pharmacist, in looking at the control drug book, would see what dose has been given?
A Yes, yes.

Q Without seeing the notes?
A Yes.

Q That is helpful. Finally, let us just move to Patient E, **Code A** I think you have agreed that on her first admission, when she came – and this is when she came from Haslar walking with a frame plus two in Haslar – she was given what I think you conceded is quite a large dose of Oramorph, 10 mg?
A Yes.

Q And I think you conceded that that should perhaps have been 2.5 mg. You did not say that specifically, but would that be right?
A Sorry. Can I ---

Q Can we go back to the BNF?
A Yes, right.

Q A starter dose would be 5 mg in a so-called adult.
A 5 mg rather than 10 mg.

Q But for some strange reason elderly patients are not adults any more.
A Right.

Q Which worries me now. That would be reduced?
A Yes.

Q To 2.5. So 10 mg is a pretty big slug?
A Yes.

Q Then she was found on the floor?
A Yes.

Q Is that a surprise?
A In which context?

Q She has just had 10 mg of Oramorph?
A I could think of a number of reasons why she might have ended up on the floor. I do not know that I would necessarily relate that to having the Oramorph, but it could perhaps, I agree, have been a factor.

Q You are an experienced nurse. If I gave you 10 mg of Oramorph now, what do you think you would feel like?
A It certainly would have a degree of sedative effect.

Q Would that be equivalent to a pretty good dose of alcohol?
A Possibly so, yes.

Q Just finally – and this is difficult. This is difficult. If somebody asked me this question, I would find it difficult to answer. I just wondered. I will just clarify if I can, crystallise, that statement that you made that the Wessex ladder is only a guideline. Just take us to that again. Just try and help us understand what you mean by that?
A It was a protocol and we subsequently did have a protocol in the hospital that would specify precisely what steps would be taken, and when, and you would usually adhere very rigidly to the protocol, where as the Wessex guidelines gave you a framework for what you would usually do for any given patient, but there is a degree of scope for operating outside those guidelines within certain situations.

Q What is the general rule if you break a guideline? What do you do?
A I would expect to have some clear documentation as to the reasons why you did not follow the guideline.

Q You would cover your back?
A So that you can refer back to it.

Q You would write it down?
A Yes, yes.

A

Q There are not any notes.
A No. I agree with that.

Q When I was a medical student I was taught if it is on the notes it did not happen. What do you say to that?
A I would agree that our documentation at this time did leave something to be desired in
B certain areas.

Q I am wondering how you defend actions afterwards ---
A Yes.

Q --- in an inquiry as serious as this if there are no notes.
A It makes it very difficult. All I can tell you is what my recollection is of things at that
C time, of decisions we made and why we made them, and things we did and why we did them.

Q You mentioned a protocol and a guideline. Can you take us to the protocol? Is it ---
A No, no. The protocol was introduced later on from 1998.

Q Right. It is this thing – Drug Therapy Guideline? That was later.
A Sorry – which?
D

Q It is in the big folder 1, behind tab 5. It is called the Portsmouth Hospitals Drug Therapy Guideline, 1998. I am just wondering if that is what you are telling us about? 1998 is when Code A was a patient in your care. It is behind tab 4.
A Yes , yes.

Q Is that it?
E A No, no. That is not. Some time, I believe in 1999/2000, there was an analgesic protocol which particularly covered syringe drivers but also for analgesia which was introduced into the Department of Elderly Medicine, which included Daedalus and Dryad ward, but that was post the period we are talking about here. But that protocol was much more structured in the way that syringe drivers particularly were managed.

Q Do you think the Wessex handbook was in place in August 1998?
F A We had the Wessex handbook in August 1998, yes.

Q Was any other protocol in place?
A Not that I was aware of. That protocol that I was talking about was developed specifically because of issues that had been highlighted with the difficulties that had been associated with syringe drivers.

G Q Your only other guideline at that time was the BNF that was current?
A Yes, yes.

Q 1997?
A Yes, and advice from other colleagues that I was working with.

H Code A Thank you very much.

A **Code A** Code A I am conscious of the fact that you have been giving evidence now for more than an hour and a quarter. We are down now to me as the final member of the Panel, but if you feel that you would need and would welcome a break now, I can ask questions of you later. If you prefer just to continue we can do that, but it is in your hands.

THE WITNESS: I am happy to continue, if that is what you would like to do.

B **Code A**: Very well. We will attempt to do just that. I am the last of the lay members, and so you will have to bear with me on occasion, I think. My role really is to try to cover any matters that still remain outstanding, and generally to pull things together. It seems to me that the evidence that you have given to us today and last week is of a ward with staff functioning strongly as a team, trusting each other, having confidence in each other, getting on well with each other and, indeed, knowing each other. One clear area of weakness, you have candidly conceded, has been in paperwork and notes. I think if it was not before, it C is very clear to you now, the importance of good quality notes, not just for those involved in care at the time but for those such as us, coming in and taking a forensic approach to often very elderly notes. I am not going to say anything more about that, but there are a few areas that I might ask you some questions on.

First of all, there is the business of the notes that would have come over to the hospital when somebody was being transferred, for example, from Haslar. You have told us that those notes D would be seen by the admitting nurse, by the doctor clerking and probably by the consultant involved. Would any other nurses routinely see those documents?

A Certainly any member of nursing. They would be accessible to any member of nursing staff and the usual pattern would be for the admitting nurse to go through them and pull out the pertinent and key issues but if you had concerns or issues with the patient, and you needed to refer back, then it would be common practice to get the notes out and refer back to them if it was appropriate.

E

Q Certainly every one of your senior regular nurses would be aware of the fact that those documents were there and would be ale to refer to them as and when they wished?

A Yes.

Q The reason I ask is because we have heard from one such nurse that so far as she was aware, the only document that ever came over was the simple transfer letter, the referral F letter.

A Was this with **Code A**?

Q I am not talking about a specific patient; this was a general answer to a general question. Her response was, "No, all we got was this referral letter and that was why we often were not able to tell more about the patient's previous treatment."

A It was not uncommon for notes not to accompany the patient by mistake; but also in G 1998 Haslar, as a military hospital, was still using its own nursing notes – medical notes. They were subsequently merged into one department. So the practice for Haslar was that the notes came to us; the military notes, the Haslar notes remained until the consultant ward round and a consultant would then summarise the information and they would be returned. Staff at Haslar were not used to the principle that their notes had to accompany the patient when they came to Gosport. So if notes were going to be forgotten or missed for being sent with the patient that was a more common occurrence from Haslar than it was from Queen H Alexandra, which was actually part of the same department within the hospital system. So

A the notes did come but I think possibly with the time lag people are confusing the fact that there were instances where actually notes quite often did not come, it just was a letter and then we had to chase up the notes and get them at a later date.

Q Indeed, that was the evidence that you have given before; that if they did not come then you and your staff were assiduous in chasing them up.
A Yes.

B

Q It may not have any great significance but there would appear to be a difference in experience and understanding on this point as to the availability of notes between yourself as the ward manager and one of your senior nursing staff.
A Yes.

Q It is no more than that; it was just something that stood out. If we can look briefly at
C the transfer of patient E. This was a patient who came in on a low part of the ladder and promptly went on to opiates, and you indicated that in general the reason that this sort of change will usually occur is because of the effect of transfer, and even a short distance in transfer is still capable of having a very major effect on a patient – the confusion that can be involved and the distress of moving from a bed that they know to a bed that they do not and nurses that they do not know, and I am sure we all understand that very clearly.

D However, this specific patient was brought to your attention by Code A I think, because it was an occasion where, on the face of it, that would not appear to be the answer. You will recall she put to you that when the patient left Haslar she appeared to be in good condition and when she arrived Code A was waiting for her and has given evidence that she was in pretty much the same condition on arrival as she had been on departure. Again, this is a case where the clerking doctor, Code A had also on admission noted that the patient was apparently pain free. Your own nursing staff later on also noted that the patient appeared not
E to be in pain.

So the usual reason for going up the ladder – the unfortunate and sometimes almost inevitable effect of transfer – does not appear to have been acting in this case. Is there any other reason that you are aware of from custom and procedure and your experience on that ward as to why that patient or such a patient would be nonetheless started on opiates?
A The only reason normally for starting on opiates would be pain. Why the patient's
F condition deteriorated between admission and the time they were started on the opiates at this point I cannot see what particular reason there would be for that, no.

Q Not only that, but there does not appear, does there, from the record to be any note of deterioration. From what we can see, both from what the daughter told us but also from what the notes tell us, there is a complete absence of any indication that there had been a deterioration before the start on Oramorph. You have no explanation?
G A No, other than that the patient clearly had deteriorated.

Q There is no reason why you should have. What is clear though is that once the Oramorph was started a deterioration did begin to manifest itself and you have conceded that although neither you nor any of your staff ever queried the starting doses the BNF does make very clear that the appropriate starting dose for this patient would have been two and a half milligrams, whereas in fact I think I am right in saying that she started on ten.
H A Yes.

Q So that is four times the appropriate dose. You were asked by Code A what would be the effect starting you on ten – which I take to be the appropriate dose for a person in your health and age – you indicated that there certainly would be an effect.
A Yes.

Q Can I ask you to conjecture what four times that dose would do to you?
A The effect would be possibly increased.

Q Would it make it likely that, among other things, if you were to remain there having been given this dose you might fall off that chair?
A I would suppose it might be a possibility.

Q Would it be a reasonably foreseeable possibility?
A Yes.

Q We have also heard that putting somebody onto a dose of Oramorph may have a number of side effects and you have indicated that one of those might be confusion. Putting a patient on to four times the appropriate starting dose, how would that work for confusion? Would it be likely to result in confusion or not?
A Yes, that might well result in some confusion.

Q Of course, a confused patient is going to generate a reduced Barthel score, is that correct?
A Yes, that would be correct.

Q And a low Barthel score has what consequence within the way that your ward was operating at that time?
A Barthel was just an indicator of the patient's level of dependence or independence and was just used to guide nursing and medical staff and thereby aid staff in planning patients' care.

Q And it would be a useful indicator for those that have to make the unhappy decision to change somebody from continuing care to palliative care; would that be correct?
A No, it would not be used as an indicator for palliative care.

Q It would not be a part of the picture?
A No.

Q It would be irrelevant.
A We had lots of patients with a Barthel of one, two or even zero who I can remember remaining with us and actually being discharged; so no, I would not agree with that.

Q Thank you; that is very helpful. You have talked to us about the consensus on action that you and your colleagues routinely sought in a ward where there were patients' relatives available to consult. You said that you were not comfortable moving forward when a relative was not on board and that you would do what you could to bring a patient on board. As I understand it, that really means making it very clear to them what the true clinical position is.
A Yes.

A Q So in the case of Code A, for example – Patient L, Code A – if I could ask you to look up page 1309, I think this was a patient in whose care you were involved.
A Yes.

Q We have a note on this page that Code A on the patient came and spoke to staff and he agreed to commence syringe driver for pain relief and he was aware of the poor
B outlook but he was anxious that medication should not shorten her life. What actions did you take to give effect to that caveat that had been placed on the permission given by Code A Code A ?
A We had explained, we had talked with the relative about Code A s condition and explained that the use of the syringe driver and the pain relief was principally aimed at controlling pain and keeping Code A comfortable, and that although the expected prognosis was that she would pass away, that the syringe driver was not altering the duration of that
C process but just making it more comfortable for her while it occurred.

Q That was not strictly speaking accurate, was it? Once you put her on that syringe driver with that combination of opiates you were not going to be in a position – because she would be unconscious – to keep her hydrated at that time.
A No.
Q So as a direct consequence of that dehydration her death would be hastened, would it
D not?
A Given her condition, even if she was not on a driver she would not have been receiving hydration at that time, so the hydration and the syringe driver I would regard as separate issues.

Q Let me understand that. If she were not on the syringe driver and was conscious she would not be receiving hydration.
E A Unless she could take fluids orally and from the notes and my recollection this lady was very poorly and was taking either no or very little oral fluids.

Q That is something I am sure we can all look at individually at a later stage. But your recollection is that although conscious prior to going on to the syringe driver she was in effect not being hydrated.
A No.
F

Q You have indicated that you made it clear to the patient's relative that in effect once started on a syringe driver the patient was not going to come out of it.
A Correct.

Q And in your experience, once started on syringe driver in these circumstances with these doses of opiates patients did not come out of that.
G A Not usually, no.

Q I think you told Code A that that was an indication that the decision to move to palliative care had been taken ---
A Yes.

Q ... and indeed it was one of the actions of palliative care. You will have gathered
H form I think every member of the Panel that we have been struggling to understand from the

notes where the decision to move to palliative care was taken and how it was evidenced. You made it very clear to us early in your evidence last week that that is the decision of the doctor and you made it clear that in this case or in the cases before us the doctor concerned would have been Code A
A Yes.

Q We have already discussed the importance of note taking and of recording key decisions. I am sure you have gone through all of these notes with the care that we have and it is right, is it, that there is no indication anywhere in the notes of a decision taken and noted by the doctor herself of "decision made; we now move to palliative care"?
A Is this in Code A notes?

Q This is in Code A case but we could widen it, if you like, to any of the cases on which you have had an opportunity to review notes.
A I think that would probably be a correct statement.

Q Would it also be true that in respect of all of those notes that there is nowhere recorded in terms, using those words, by any member of staff, "Decision taken; see change; we are now moving to palliative care with this patient." It is never expressly said, is it?
A I do not believe it is, no.

Q There was some questioning, particularly from Code A about the significance of certain phrases – phrases that of themselves might not seem particularly significant but which he asked might have significance to your staff as people who were members of the team and familiar with the custom and practice of that particular ward in that particular hospital. I think he asked you whether these were in effect a code. The first collection of words were the ones that appear beginning with the word "happy" – "happy for nursing staff to confirm death", and you were asked if that was a code and you said no because it did not necessarily mean that the patient would die.

We have heard evidence from one of your colleagues already and she was asked whether she could recollect any occasion – any occasion in her entire experience on that ward when a note reading "happy for nursing staff to confirm death", whether any patient had ever recovered and left the ward, and she was not able to recall a single one. Are you able to recall a single occasion when that happened?
A I would not be able to specifically say that I can recall that, but at the same time it would not surprise me to go back through notes of patients who are discharged and find that there because I am fairly confident that it was written on occasions when actually patients make good progress and actually it became an irrelevant comment which probably should no longer have been there in the notes.

Q What about the next phrase "patient to be kept comfortable". In your experience – you have already indicated that that was an indication of an end of life prognosis – once that appeared on a patient's notes were there ever patients who recovered and left the ward well?
A Again, I would have to look through notes to find ones. Yes, I would agree that it could be used to indicate that patients were entering a palliative stage and were to be kept comfortable; but it could also be used for patients who were very poorly and need to be kept comfortable but nevertheless would, once comfortable, stabilise and plateau and if not make a recovery then at least their condition would stabilise.

Q Rather dangerous, is it not, to have on a ward a system where a particular choice of words could mean palliative care, terminal, end of life or it could mean just what it says?
A Yes, I agree that that could be confusing.

Q But other than these key phrases we have not been able to find, as a Panel, any direct reference to palliative care; would it be fair to say that that just did not happen, it was never overtly recorded in records?
A I certainly know it was recorded in records but again I would need to go through notes of various patients to find it, and I would agree that it would be much better if it had been recorded to give us a clear indication of the type of care patients were receiving.

Q The phrase, "TLC" – tender, loving care – is in the same category, is it not? It could be interpreted as meaning just that, or it could be interpreted as meaning "End of life".
A Yes. I think "TLC" is very commonly used as an "End of life" term, not just in Portsmouth but quite widely so. That is a term I had encountered before I came to work in Gosport.

Q **Code A** asked you to tell the Panel how the change to palliative care would be conveyed to staff. In the absence of those phrases I have referred to, we as a Panel are struggling to see where this would have happened. It appears that you were too. In fact, that is the word you used. You said, "I am struggling" – I think the complete sentence was, "I am struggling to think of ways in which that decision was conveyed".
A Right.

Q Yet it was conveyed as a matter of practice routinely, was it not, by definition? A large number of these patients were never going to be leaving alive simply by reason of the conditions they were suffering from.
A Yes.

Q But you were not, when the doctor asked you, able to think of the way in which this would have been conveyed to you.
A It would have been conveyed verbally. My understanding of "conveyed verbally to me", was that it would have to be clear and I would have sought clarification if it was not.

Q What the doctor said was, he put to you an example of a phrase, "End of life", and you accepted that. You said, "Yes, that might be used", although that is a particular phrase that we certainly have not come across, so far as I am aware, in any of the records before us. It was then that he put to you another phrase, "Patient to be kept comfortable", and that was one to which you responded, "Yes". So the only phrases that are appearing repeatedly in these records are phrases that, with the exception of "Happy for nursing staff to confirm death", at the very least you do seem to accept are the sorts of phraseology that would be understood by your staff, routinely but not necessarily always, as meaning the change.
A Yes.

Code A I do not think I have any further questions. There is now the opportunity, I am afraid, for the barristers to come back and ask questions that arise from those asked by the Panel. Before I ask them to come back, you have now been giving evidence for a fair bit – you are coming up to one and three quarter hours – would you welcome a break now or would you wish to continue?
A A break now would be appreciated, thank you.

Code A We will return at quarter past twelve. Of course you need still to consider yourself on oath, in the middle of your evidence, and therefore you must not discuss this case with anyone.

(Short adjournment)

Code A: Welcome back everyone. I hope that was sufficient for you to refresh yourself, Code A We are now going to turn to Code A and ask if he has any questions arising out of the questions asked by the Panel.

Further cross-examined by Code A

Code A, I do have further questions arising out of what you have been asked this morning. I am going to try to avoid going over old ground, but some of it may be repetitious. Dealing with one matter you were asked about in terms of bank staff and the situation where there might be, although you try to avoid it, a lack of staffing resources meant there might be a bank nurse on duty at night alone on Daedalus. Right?

A Yes.

Q You were saying that there was always available a senior member of staff who could be consulted or seen by that nurse if necessary.

A Yes.

Q Is that somebody we think of as in effect a night sister covering the wards?

A It was an F Grade senior staff nurse who would be on duty on one of the other two wards but would also have responsibility for overseeing all three of the elderly care wards. So it would not be sister level but it would be senior staff nurse level and very experienced both in working terms and with working in the hospital.

Q So that is the person who would be available if some drama occurred or something completely out of the ordinary run of things.

A Yes, and not only be available but would routinely visit the two wards she was not covering to make sure that all was well and to anticipate any problems, if you like.

Q You were asked about the question of nursing staff confirming death – I may have to come back to that in a moment – but perhaps we can turn up in File 1, Tab 9, what are the guidelines from the Portsmouth Healthcare Trust with regard to community hospitals. Let us just remind ourselves what it says in the first part of that.

> "It is not the duty or responsibility of the Nurse to confirm a death when a Doctor can reasonably attend to do so, during daytime hours the patient's Doctor should be contacted and asked to certify the death immediately".

Correct?

A Yes.

Q "However in Small Hospitals" – is that what we are talking about in terms of the Gosport?

A That would be Gosport War Memorial Hospital, yes.

Q "...without resident Doctors, where medical staff are on call for emergencies, during the night or at times when Doctors are unable to attend any qualified Nurse who is competent to do so, may verify death".

A Yes.

Q Was that occurrence something which did occur from time to time?
A Yes, because quite often patients would die, either during the night or during the weekend or even early in the evening, so yes, that was a quite regular occurrence.

Q What would the position be if a doctor had not indicated that he or she was happy for nursing staff to confirm death if that happened? A doctor would have to be summoned, would they?
A It would be normal to contact a doctor if a patient's condition was deteriorating so they would see them at that time, but if that had not occurred, then yes, if that had not been indicated by a doctor, we would have called a doctor even if it was out of hours.

Q You have already told us and told the Panel specifically that the fact that Code A had written in the case of Code A "I am happy for nursing staff to confirm death", was not a sort of signal or code to the effect that there was nothing more that could be done for this patient.
A No, it was not.

Q I would like to look back with you, please, in the light of some of the questions that have been asked, at that note made on admission, back to page 30 of the file relating to Patient E. We must remember, of course, that this lady was suffering from dementia.
A Yes.

Q As Code A recorded, "Frail, demented lady". We also have noted, "Not obviously in pain". Right?
A Yes.

Q "Please make comfortable. Transfer with hoist".

May I deal with that first? If this lady on admission, in the hands of the nursing staff, had been capable of moving from the wheelchair to the bed with the aid of a Zimmer frame, would that have been done?
A Yes.

Q What I am trying to get at is, would you have used a hoist unless you had satisfied yourselves that a hoist was necessary?
A We would not have used a hoist unless we felt it was necessary.

Q That indicates, obviously, that she had been, as it were, got into bed by the nursing staff before Code A saw her. Correct?
A I could not say whether she was in bed or in a chair at that time.

Q "Transfer with hoist", what does that signify?

A That a patient either is not able to mobilise with a frame or that mobility is actually unsafe.

Q At what stage would the Barthel Score be established with this patient?
A That would usually have been done on admission.

Q If we look at page 41 in that same file, we see there that the total is, I think, 3. It is not a very good copy.
A It looks like 3, yes.

Q The date at the top is certainly the date of admission although it does not give a time.
A That is right.

Q Normally speaking that test would have been carried out before any medication or drugs were administered.
A Yes.

Q You told the Panel, when you gave evidence about this in answer to questions from Code A the gentleman across from me, that where Code A had written, "Please make comfortable", you said it means what it says: make sure she is not in pain.
A Yes.

Q In the case of this patient, was that carrying any message or signal so far as you were aware, "Well, there is nothing more we can do for this patient", or anything like that?
A No, not with this patient.

Q You told us that in some cases you had known – please correct me if I am wrong – that "Please make comfortable" in relation to some patients in the circumstances in which they were, might be an indication that the palliative care routine was what was going to be done.
A Yes, that is correct.

Q In some patients, but not in the case of this patient.
A That is correct.

Q May we just deal with the administration of Oramorph. I know you have been asked about this more than once, but in the light of certain questions that have been asked I would like you to help us with certain things. We see that Code A had noted, "Not obviously in pain", on the page we have just looked at.
A Yes.

Q If we go to page 63 we can see what she prescribed.
A Yes.

Q She says in the prescription note, which is an "as required" prescription, so it would depend on the judgment of the nursing staff as to whether it should be administered at any particular time, it says, "Oramorph".
A Yes, 10 gms in 5mls.

Q Then the dose underneath that is what?

A A It is 2.5 to 5 mls.

Q We have, for me anyway, this ghastly business of translating millilitres and milligrams, but 2.5 mls would be what?
A That would be 5 mgs.

Q So 2.5 is the lowest dose, 5 mgs. Right?
B A Yes.

Q Up to a maximum of what?
A Up to 10 mgs.

Q Looking at the dose, I want to make sure I am reading it right. The 2.5 --
A It is 2.5 to 5 mls.
C

Q To 5 mls. So turning it into milligrams, would be what?
A It would be 5 to 10 mgs.

Q Thinking about the physical side of it, as it were, the minimum dose, the 2.5 mls is about half a teaspoon, very roughly.
A Yes.
D

Q And obviously that is about the smallest quantity you can sensibly give of Oramorph, is it not?
A We use a syringe or a medicine measuring pot to make sure we were giving the dose as accurately as possible.

Q Obviously the 10 mgs would be the equivalent of a teaspoon full, more or less.
E A Yes.

Q You have told the Panel already in your evidence, before you were asked any questions, that although it is not recorded, the patient obviously was in pain otherwise you would not have administered any Oramorph at all.
A That is correct.

F Q And in sufficient pain to justify the administration of that opiate.
A Yes.

Q We can see that that was carried out by you at 2.15 in the afternoon. Right?
A Correct.

Q You were using the higher dose of the range.
G A Yes.

Q Can we take it, although you may not be able to remember, that you did that for a reason?
A Yes, I did.

Q I want to ask you one further matter about Oramorph before I continue with the
H history of it. You were asked about what the effect would be of 10 mgs of Oramorph on you,

A we hope a perfectly fit individual and all the rest of it, if you were asked to take it and what the effect might be. Is that something that is sensible to compare with what the effect would be on an elderly lady in pain, in sufficient pain to justify the administration of Oramorph, which is a rather different situation?
A Yes. It is not a terribly straightforward comparison, particularly given somebody being given a completely effective analgesia when someone is in pain is different to when somebody is not in pain.

B

Q That is what I wanted to ask you. Is this right, in general terms, that the pain of the patient is in a sense absorbing the effect of the opiate.
A Yes, that is correct.

Q Therefore is this right, that there is a greater tolerance?
A Yes, that is correct.

C

Q Is there any other way you would like to put it? I am putting it in layman's terms.
A When patients are in a great deal of pain they can receive quite strong doses of analgesia without it having any significant effect and **Code A** is not a good example, but people with cancer who are on strong doses of morphine still continue to drive cars, for example, quite safely, because it does not have the effect it would have on someone who was not in severe pain. I could not describe the pharmacology of that.

D

Q I am not going to ask you to. I think that will probably assist us with what the basic situation is. In other words, with a patient as this lady was, with dementia and all the rest of it, and in such pain that Oramorph was warranted, it is not the same as an opiate naïve perfectly well person, is it?
A That is correct.

E Q Perhaps I can just deal with one further thing about analgesia because you were asked some questions by the Panel, about the BNF. Perhaps you could go back to File 1, please. The relevant BNF extracts are at Tab 3 and I wonder if you would turn up, please, first of all page 22, which a member of the Panel asked you to look at and speak to. Looking at the equivalences, as they are described at the bottom part of the page, is the heading of that, just above the actual figures and columns,

F

> "Equivalent doses of morphine sulphate by mouth (as oral solution or standard tablets or as modified-release tablets) or of diamorphine hydrochloride by intramuscular inject or by subcutaneous infusion.
>
> These equivalences are approximate only and may need to be adjusted according to response."

G Is that something you were aware of?
A Yes.

Q Then we can see the oral morphine every 4 hours, every 12 hours and the diamorphine being administered either intramuscularly or by subcutaneous infusion, 4 hours and 24 hours. We have looked at the figures more than once. Would you just note, please, on page 19 of the same tab, there is a section half way down the left hand column headed "Pain". All right?
H A Yes.

Q "Analgesics are more effective if started at the earliest stage in the development of pain that if used for the relief of established pain."

A Yes.

Q Is that something you were aware of?
A Yes, it is. Yes.

Q That is the case of Patient E, Code A and still on page 63, the drug chart that we were looking at a moment or two ago, you were asked some questions about the effect of Oramorph in a slightly different sense. I would just like to look through the history of what happened with this lady. First dose of Oramorph, 2.15 is on the afternoon of the 11th?
A Yes.

Q Correct?
A Yes.

Q And although it is not you, the next date we have agreed, I think, should be 23.45?
A Yes.

Q In other words, in the evening, another 10?
A Yes.

Q That is all on the 11th. Then on the 12th at 6.15 in the morning, 10 mg - right?
A Yes.

Q And then no further Oramorph that day.
A Right.

Q And indeed the next administration of Oramorph is on the 13th at ten to nine, 20.50 hours in the evening?
A Yes.

Q You were asked about people falling off chairs and so on, in relation to Oramorph, and I would just like to see what the nursing care plan, and so on, and the history shows us with regard to that. Would you look back, please, to page 46.
A Yes.

Q On 13 August at one o'clock ---
A Yes.

Q It may not have been precisely when it happened but this lady was found on the floor?
A Yes.

Q Having apparently fallen off her chair?
A Yes.

Q If that timing is more or less right, that event took place nearly a day and a half after the last administration of Oramorph?
A Yes, it did.

Q In your view would any Oramorph that she had consumed in the period of time we looked at have had anything at all to do with her falling out of the chair?
A I would have expected the effect of the Oramorph to have worn off within four hours.

Q I think that follow from what you said to us earlier on.
A Yes.

Q We can see, just following that through in the note – we were just looking at it –

"Found on the floor, checked for injury … none apparent at time. Hoisted into safer chair."

Then at 19.30, 7.30 in the evening:

"Pain [right] hip internally rotated."

Then Code A was contacted and he said, in effect, this must be x-rayed but the following morning?
A Yes.

Q And said she should have suitable analgesia during the night?
A Yes.

Q And that is exactly what happened, because we can see back on the drug chart on page 63 – is that right?
A Yes.

Q That night, at 20.50 hours on the 13th, she was given 10 mg?
A Yes.

Q Then on the 14th we can see the times and the other doses. I am not going to go through all that, and the Oramorph progressing when she comes back on the 17th and 18th. I am not going to go through the other records which are there in relation to this period of time in the nursing notes but we have already looked at those. I want to turn to just two more matters, I think, please, Code A You were asked to look at the notes with regard to Patient L, Code A You remember the entry you looked at was in relation to Code A indicating he did not want the opiates that were to be administered to shorten her life?
A Yes.

Q We can go back to it if necessary, but I do not think it will be. Is that an example of you having a discussion with a relative about the situation?
A Yes, it is.

Q And taking into account what the relative was saying?
A Yes, it is.

A Q And obviously having to make a sensible decision in the light of that?
A Yes.

Q I would like to ask you about a situation which you were referred to or you were queried about, where a patient – perfectly properly in your view as a nurse – is having diamorphine and midazolam administered by means of syringe driver, subcutaneously. All right?
B A Yes.

Q And a patient who is plainly, as it were, on the palliative care route?
A Yes.

Q And a relative says – I am not using the precise words but in effect says – "I want this relative of mine taken off the syringe driver so that they can recover consciousness fully
C enough to be able to speak to me." Who, in terms of the nursing or medical staff, would be the appropriate person to make that decision? To take a patient off subcutaneous analgesia in the sort of situation we are talking about in palliative care?
A Really it would need to be a medical decision ---

Q So if it came to it ---
A --- to stop the prescription.
D

Q If it came to it. I appreciate this is not a situation you have had to face.
A Yes.

Q But the proper course for the nurse would be to contact a doctor or, I suppose, a consultant?
A Yes.
E

Q Because it would be a medical decision?
A Yes.

Q As to whether that treatment should be stopped or not?
A As a nurse, the responsibility for giving medication is not only to make sure patients do not receive incorrect medication, but also to make sure that they do receive medication
F that has been prescribed for them, so a nurse, in stopping medication or not giving medication, would have to have very good reason for doing so and it would be appropriate to get medical advice on that as soon as practical.

Q Because the consequence if you do do that is the patient is going to be subjected to a return of pain?
A Yes. That would be the major concern.
G

Q The pain having been sufficient in the first place to justify the subcutaneous analgesia earlier.
A Yes.

Q One further question. I am sorry – I should have asked this slightly earlier. You were asked about the Oramorph dosage that was given to Code A the first time she had it
H administered to her by you on that afternoon, the 11th. She was apparently on transfer, and I

will remind you what the transfer letter says. You do not need to turn it up. She was, leaving aside anything else but in terms of opiates or analgesia, on co-codamol, two co-codamol, as required?
A Yes.

Q In what way would you take that into account in terms of making any kind of assessment and what sort of jump, 2.5 or 5.0 ml of Oramorph would be?
A You need to look at how regularly she had been receiving that, and whether it had been effective in controlling the pain.

Q Because co-codamol is a step one drug?
A Yes.

Q Yes?
A Yes.

Q The transfer letter does not appear to be indicating when she had last had any co-codamol?
A No.

Q And with a demented patient, it may be rather difficult to establish when on admission at Gosport?
A Yes. The only thing, we would have had to refer to the drug chart from the transferring hospital. That would be the only way to establish that.

Q Would that normally comes, or sometimes not come?
A It should come, but it is the factor I discussed earlier, and whether it had arrived with Mrs Richards, I would not be able to say.

Q I am afraid, to be frank, I have forgotten whether we have seen it, but I will not trouble with that. That is a factor you take into account if you were trying to work out a precise conversion?
A Yes.

Code A Thank you, Code A That is all I have to ask.

Code A Thank you, Code A it is now the turn of Code A

Further re-examined by Code A

Q I am probably going to be the last one asking you question, you will be relieved to know, but I cannot promise you. I want to go back to some of the questions that Code A asked you first of all. I want to ask you about verbal handovers because I think you have agreed already that the notes are not quite what they might have been?
A Yes. I agree to that.

Q Is that fair?
A Yes.

Q I just want to ask you about verbal handovers. You have, say, 18 to 20 patients on the ward generally?
A Yes.

Q You have night staff taking over from staff, and day staff taking over from night staff?
A Yes.

Q What does the handover actually do? Do you go and sit in a room and discuss each patient? Do you go round the beds? Do you just discuss the problem patients?
A Handover would take place in the ward office. It would be allocated, as long as it was needed, but typically it would be anywhere from 20 minutes to half an hour. If there was one trained nurse on duty, they would go through all the patients. If there were two, we would probably divide it up and talk about the patients we had had responsibility for for that shift, and we would go through every patient.

Q Right?
A And make sure they were clearly handed over to the next shift.

Q So you have an average of 18 patients from the ward?
A Yes.

Q Is that fair?
A Yes.

Q You would verbally discuss 18 patients, would you?
A Yes. Every patient would be handed over.

Q That is what I am trying to get out of you. When you say "every patient would be handed over"?
A Yes. We would discuss each of them individually and talk about the care that they were in with us, the care they have received, the care they needed to receive, and any specific issues and problems.

Q And would notes be being made or would they be relying on the notes that were already in the patient notes?
A The nursing notes should have been written up prior to the handover and then could be used during the handover, if necessary, to refer to, as well as nurses on shift would carry their own written copy of what they needed to know for that particular shift.

Q You are an experienced manager. You have been at these handovers presumably?
A Yes.

Q And you have had patients handed over to you?
A Yes.

Q Did you ever have any difficulty remembering which one of 18 patients had a particular problem?
A The practice among nurses is usually to keep a written note of all the handovers they get, so you would have the patient's take-over sheet, patient's name and you would jot down the important key things you needed to know to help you with that.

Q And those notes would be kept where?
A That would be my crib sheet for the shift, if you like, so that would be used for that shift, and then a new one on the next shift I came on. It would not be comprehensive. It would just say patient's name, fractured neck of femur and things I needed to know for the next seven to eight hours.

Q If there was any doubt about it, you would go to the nursing notes, would you?
A Yes.

Q And hope that they revealed what you needed to know?
A Yes.

Q You have mentioned bank staff. Code A asked you about bank staff, but I do not really have a sense of how often bank staff were used. Are you able to help us at the relevant time?
A Quite regularly. Typically we would be filling gaps where support workers have gone off sick. Sickness rates amongst support workers were higher than rates amongst qualified staff. I could not tell you quite why. It would probably be not unusual for at least one or two shifts during the 24-hour period to have a bank support worker on. Qualified nurses less frequently – more importantly so on nights when there was only one qualified nurse on. Because it is difficult to get qualified bank nurses it would be more common if we were short of someone qualified. That someone would swap their shift or work a double shift.

Q Right.
A That would often arise if there were two nurses due to be on a shift. One of those nurses would end up swapping a shift, so would end up with only one qualified on when, as I said, two qualified nurses is a much more desirable situation.

Q Yes. I understand that. You might get a qualified nurse with a support worker. Did it ever happen you had a bank nurse and a bank support?
A I cannot remember that happening. If that was likely to happen, you would be more likely to bring a regular member of hospital staff across from another ward who would at least know the hospital, and may have worked on the ward previously. I cannot think of any occasion when none of the staff on the ward were familiar with the ward at all.

Q You might be bringing a nurse of from a different board to come and deal with patients who would be foreign to her, as it were, but she would know the ward at least?
A Yes, yes. I would anticipate that on any given shift, depending on which shift, the majority of staff would be regular staff who knew. We did have bank staff who actually worked regularly enough that actually they knew the ward as well as some of our part-time staff.

Q You were asked by Code A again, I think, what the effect of giving an opiate-naïve patient – an elderly patient – 200 mg of diamorphine, and you used one of those expressions, "You would expect it to have an adverse effect". There are all sorts of adverse effects in life.
A Yes.

Q Are you able to say what you mean by an "adverse effect" in giving 200 mg to an elderly patient who had never had opiates before?

A A I am not sure that I can really answer that question. I know that is the top of the dose range. It is a very high dose. I would expect it to have a severe effect. I have never experienced a patient being given that dose and I do not have the pharmacological knowledge to tell you exactly what effect it would have. It is quite obvious to me that a dose that high would have effects on a patient. Whether it would make them unconscious or semi-conscious or what it would actually do, I am afraid I could no more than hypothesise on that.

B Q You were giving evidence about the stepped process, and Code A put to you, and you accepted I think, that co-codamol would be step one, and then morphine would be step two?
A Yes.

Q Can I just take you to tab 4 of the Panel bundle 1, just to explore that with you for a moment. Would you go to the printed page 5 and it is page 6 of the internal numbering?
C A Yes.

Q We actually have the analgesic ladder set out for us. If you look underneath the ladder, you can see a paragraph starting, "The WHO analgesic ladder has been adopted to emphasize that it is essential to use an analgesic which is appropriate to the severity of the pain;"

D Then, underneath that, do you see the various steps?
A Yes.

Q Is this the same ladder that you were referring to when you were speaking to Code A ?
A No, that would not be because that is indicating co-proxamol and co-co-codamol to be in step two.

E

Q That is why I draw your attention to it. Which ladder are you referring to, which starts off with co-codamol? You have gone past paracetamol or aspirin or anything like that.
A Yes.

Q You have gone straight for the co-codamol, co-proxamol; what is that based on?
A I think I possibly misunderstood the question I was being asked. I thought
F I was answering the question in co-codamol in relation to Oramorph.

Q I entirely understand that; that is why I want to clarify it with you.
I understand that Oramorph comes after co-codamol, but does that make co-codamol step one on the analgesic ladder?
A No. Clearly co-codamol is step two on the analgesic ladder.

G Q And you would start off, if it were appropriate, with aspirin or paracetamol?
A Depending on the level of pain the patient is in, yes.

Q Staying with that bundle, tab 3 – back to the BNFs, please – I want to ask for your assistance in relation to how these drugs actually come. If we go to page 9 – I do not think it really matters which version we use; this is the '97 version of BNF – we can see on the right hand side of the page, two-thirds of the way down, "Oramorph", which is a registered
H trademark, apparently. Do you see that?

A A Yes, I do.

Q It is described as an oral solution of morphine sulphate, ten milligrams in five mls. So what form does that come in? Is it a bottle, a phial?
A It comes in a bottle, usually in a 250 ml bottle.

Q So ten mgs in 5 mls is an indication of the concentration, is it?
B A Yes.

Q Again, this may sound like a silly question but I want to have it absolutely clear. You can give any amount within that range, as it were, underneath 5 mls; so you can give 2.5 mls?
A Yes, you can.

Q You could give 2 mls, I suppose, until it gets to a point where it is almost ---
C A I think one of the Wessex Guidelines suggests not giving odd figure doses ---

Q You are quite right, it does.
A ... to avoid confusion; so it is usually given in regular steps.

Q So are you saying that the lowest you would give of Oramorph of 2.5, or would it be normal to give less than that on occasions?
D A I have never experienced a patient being given less than 2.5 mls.

Q So if you are going to start with Oramorph you are effectively going to be starting with 5 mgs of morphine?
A Yes.

Q You were asked by Code A about the effect of transfer upon patients.
E A Yes.

Q And you said that you were used to patients being transferred and coming to you in a – it is my précis but it is an "iller state", a more poorly state than when they left the previous hospital, and that, you say, is sometimes the effect of the transfer itself.
A Yes.

F Q Did patients who came to you and who had suffered ill effects from the transfer sometimes recover and get back to where they were?
A Yes. The majority of patients, given a few days of recuperation, would recover.

Q So if a patient has suffered an adverse effect, as it were, from a transfer, would you normally give them a period of time to see how they recovered, as it were, or did not recover after the transfer?
G A Yes, we would.

Q If you would just give me a moment because I am going to come on to Code A Code A but I want to make sure that I have dealt with everything else first. (After a slight pause) Code A asked you about the words "keep comfortable", "TLC" and "happy for nursing staff to confirm death".
A Yes.
H

Q You indicated, as I have understood it, that it was not an indication for palliative care for every patient.
A I did not regard it as that, no.

Q But in some cases it might be.
A Certainly the expression TLC is commonly used amongst nursing and medical staff to indicate palliative care.

Q Let us put TLC to one side for the moment. "Keep comfortable", let us concentrate on that; is that sometimes an indication of palliative care or not?
A Yes, sometimes it can be. I did not regard it as being that in this situation.

Q "Happy for nursing staff to confirm death"; is that in a different category or the same category?
A No, that was a different category; that was custom and practice within the ward that we were working on and was used to aid us if a patient's condition deteriorated out of hours. But it did not indicate palliative care.

Q Does that mean that you would expect to see that on every patient's form?
A No, what factors determined whether it was written I would not be able to say, but it certainly would not be on every patient but perhaps those who had multiple pathologies or who were particularly frail might have that written.

Q The decision obviously is not yours but that of, in this case, Code A?
A Yes.

Q Leading on from that, we have also seen in one patient's notes from another hospital "not for resuscitation" or "not for 555"; do you know those expressions?
A I do know those expressions.

Q Let us start with TLC. If you see "for TLC" on a patient's notes and they then suffer a significant event would you read "for TLC" as meaning "not for resuscitation"?
A Yes, I would.

Q Would you read the words "keep comfortable" – if that patient then suffered a significant event would you regard that as being a signal for non-resuscitation?
A Yes, I would.

Q If you saw the words "happy for nursing staff to confirm death" and if that patient suffered a significant event would you regard that as a signal for non-resuscitation?
A Yes.

Q Still sticking to the general questions you told us – I think it was to Code A – that there were no other guidelines of which you were aware at the time. I just want to draw your attention to tab 5 of the same bundle – and I am not going to test you on it, as it were, you will be relieved to know, but I just want to know of your state of knowledge about this document. Just have a look at it and see if it triggers any recollection. It seems to have been printed in 1998 and is entitled *Compendium of Drug Therapy Guidelines*. Did you know of the existence of this document and, if you did not, just please tell us?

A I cannot remember. You will appreciate that an organisation as bit as a Trust had a number of documents referring to all sorts of aspects of practice and whether I was aware of this in 1998 I honestly cannot remember at this point in time.

Q Then please put that away. I want to turn, if I may, to Patient E. Could we go to page 188 first of all? You were asked some questions – and I will not keep trying to record which panellist asked you these questions, although I think it was Code A At page 188 this is the transfer letter?

A Yes.

Q We can see that this patient is described as fully weight bearing and walking with the aid of two nurses and a Zimmer.

A Yes.

Q Can I ask you this in respect of that patient: once that patient is put on to Oramorph – as we know she was – would you make attempts when the patient is under the influence of that amount of Oramorph to walk them with a Zimmer?

A Yes, it would still be practical to try and in fact if a patient had severe pain and that pain was then controlled then it may well be that the patient is more mobile having had Oramorph than having not had Oramorph, but of course it does depend on the individual patient and the cause of the pain and various other factors as well.

Q Below that you will see the words:

> Code A is continent. When she becomes fidgety and agitated it means she wants the toilet."

A Yes.

Q If we go to Code A 's note at page 30 – and I am not going to read all the way through this, we are all getting pretty familiar with it – would you expect a nurse to read Code A Code A 's note?

A Yes.

Q A nurse taking over the care of this patient the following day, say, on 11, 12 or 13, would they necessarily read the transfer letter?

A Probably not because they would have the handover from the nurses on the shift before to give them the information they needed.

Q How would you expect a nurse taking over from the previous shift to know that if Gladys got fidgety and agitated it meant that she wanted the toilet?

A We would include that in the handover.

Q Is that going to be part of the verbal ---

A That part of the verbal handover – that was quite a clear piece of information and that is one of those clear things that I would expect to be handed on from shift to shift as well as being in the nursing notes.

Q So when you hand over your 18 or 20 patients you would say, "This one, if she gets agitated means she needs the loo"?

A A Absolutely; and that is not something that is untypical for a patient with dementia anyway, so it would be something we would expect and anticipate as qualified nurses and our experienced support workers as well.

Q Page 243 is the Haslar drug sheet and we can see that the patient was on I think co-codamol and haloperidol. Can you help us; I am just trying to see when that finished? The co-codamol this sheet certainly finished, I think on 7 August.

B A That looks to be the case here, yes.

Q If a patient had remained on co-codamol what would be the signal to go up a stage to the next analgesic level?

A If the pain was not being managed by that analgesia.

Q Would that be a significant event?

C A It probably would, yes.

Q Would you yourself normally make a note of that?

A Yes.

Q If we go to page 67, Code A pointed out to you that the Oramorph had stopped a good while before the patient had her fall. Is this your administration of the drug – page 67

D of the E file?

A I have just haloperidol.

Q Who was giving that haloperidol; is that your initial?

A I do not think that is my initial.

Q I am sorry, I thought it was. Could you help us, was that given at one o'clock on 13th?

E A It looks like it was given at one o'clock, yes.

Q 30 minutes before the patient is found on the floor; is that right?

A That would be according to the times given, yes.

Q I am not criticising the administration of that drug but does haloperidol sometimes have an effect on the coordination of the muscles?

F A That I do not know, I am afraid.

Q Finally, can I turn to Code A ? I only have one matter about which I want to ask you. Please take up Patient L's file and there are two pages I want you to look at. The first is 1309. I think we were all having a bit of trouble making the conversion there. The second is 1342. Do you have that?

A Yes.

G

Q At 1309 we have Code A saying he does not want her life to be shortened.

A Yes.

Q Then we have this note,

"Agreed to commence syringe driver for pain relief at equivalent dose to oral

H morphine with Midazolam".

A Yes.

Q The oral morphine she was on we can see at 1342. She had 15 mg the day before, on 20th. Is that right?
A Yes.

B Q It is 5 mgs and then somebody changed it to millilitres but the essence is that she had 15 mgs and 5 mgs on the morning of the following day.
A Yes.

Q If we tot all of that up it would be 20 mgs.
A Yes.

C Code A: I am sorry to interrupt but you are talking about the previous 24 hours.

Code A Yes. Have I got it wrong?

Code A I may be wrong, and I am even worse than Code A is on the figures, but when you tot it up for the previous 24 hours to before 6 o'clock on 21st, I think it is 50 mgs in total.

D A I think if I remember rightly there was another page where it was given four-hourly.

Code A Because it was being given not as a PRN.
A Yes. There is page 1342 where it was on the PRN side and to make sure it was given regularly, on 21st, it was given as a regular four-hourly dose.

Q Thank you. And the effect of adding Midazolam to that, are you aware of the effects
E of adding Midazolam?
A Yes.

Q What would the effect be then?
A It is given to calm and relax the patient, but it would also have an additional sedative effect.

F Code A That is all I wish to ask.

Code A I think that really is the end. The Panel are very conscious of the stress and strains that coming before us can give rise to, and you have spent a considerable time answering questions from all of us. We are extremely grateful to you for the measured way in which you have stuck with us. You are now free to go with our thanks.

G (The witness withdrew)

Code A I think we will break now, Code A and return in one hour.

Code A Perhaps I can fill you in after then on the witness arrangements.

Code A We will return at 2.15.

H

(Luncheon adjournment)

Code A: Welcome back everyone. Code A, I have been asked by a Panel member whether there is any possibility of assistance from you in respect of two documents that are difficult to read in Bundle E. It may be that what we have is the best we can get, but if it is possible to improve on pages 41 and 43 that would be greatly appreciated.

Code A: Can I make sure what they are. Bundle E, page 41 is Code A Barthel.

Code A: Page 43 is a lifting/handling risk calculator form.

Code A: Can I ask Code A to have a look at those? While we are looking at that bundle, I did make some copies earlier. If you go to page 64 it should be headed, "For nursing use only. Exceptions to prescribed orders". That is very difficult to read and I do have a better copy of that and was going to pass it round. It is not a document we have concentrated on.

Code A: One never knows when an individual panellist reading alights on a particular page that no one has yet looked at.

Code A: So a new page 64 to replace the old version. (Document handed) We will see if we can do better on the other two documents.

Code A: If you can it will be great. If not, we understand that not all the documents can be improved upon.

Code A: There is not a lot of point in my going through the whole witness schedule, but it may have become apparent rather as we imagine my patterning, once we got to the nurses that we are slipping behind. We will produce for you tomorrow a refreshed version but we are trying to change the order somewhat.

Code A: I have to say that having reached Day 10 without slippage is something of a record anyway and you are to be congratulated for keeping us to it.

Code A: I think it was fairly obvious that we were going to get some slippage at this stage so we are just doing what we can. At the moment there may be a matter that I am going to have to raise in relation to one of the witnesses who wants to be anonymised, but I prefer to do that at the end of the day and get on with the evidence now. So may I please call Lynn Barratt?

Code A Affirmed

Examined by Code A

(Following introductions by Code A

Code A: Is it Code A?

A It is, yes.

Q I think you are a registered nurse.

A I am, yes.

Q Can you tell us a little bit, please, about your background and experience in nursing? When did you qualify?

Code A

Q We have heard of that.
A I worked then on various specialities. I then came back from Plymouth to Gosport and I worked in the private sector in private nursing homes.

Q Can I stop you for a moment? I think in 1980 you were working for a company called the Code A Is that right?
A Yes.

Q How long did you work for them for?
A From 1982 to 1987 I think it was.

Q Then I think you started work at the South East Area Health Authority working in something called the Northcott Annex
A It was the Northcott Annex. It was an annex of the Gosport War Memorial Hospital.

Q Is that still there?
A No, it closed, and I moved over to the Redcliff Annex, which was another annex for elderly patients of the Gosport War Memorial.

Q The Redcliff Annex we know also closed and moved to the main building.
A Yes.

Q Tell us the sort of patients you were dealing with in the Redcliff Annex.
A We dealt mainly with what we called long-term elderly patients, which meant that they came into us and stayed with us for a long time and usually until they passed away. We also had shared care patients, which were patients that were looked after so many weeks at home and then they came into Redcliff to give families a rest.

Q Respite care.
A Yes, like respite care.

Q When you were working at the Redcliff, did Code A begin working there?
A Yes, she did.

Q Were you already there when Code A came in?
A Yes, I believe I was, yes.

Q Can you remember when the Redcliff Annex closed?
A I have got to be honest and say no, I cannot remember what year it closed.

Q By the time we are going to be dealing with, which is 1997-98 onwards, the Redcliff would have closed and the patients would have moved over.
A Yes, I believe it had.

Q When you moved to the Gosport War Memorial Hospital proper, the main building, did you move to a specific ward?
A Yes, I did.

Q Which ward was that?
A Dryad Ward.

Q Help us please with the sort of patients you had on Dryad Ward and how many beds you had?
A We had 20 beds. Initially we had patients again that were long term. They stayed with us for quite some time. We also again had respite care patients. We used to have occasionally patients that were what we would call "Slow stream rehab", but we were basically there to look after just the elderly patients really.

Q Was there much rehabilitation that took place on Dryad ward?
A Not an awful lot, no.

Q What seniority were you when you were on Dryad?
A I was a staff nurse.

Q Staff nurse? Forgive me for not knowing, but is that one below sister?
A No. That is two below sister.

Q That is two below sister?
A Yes.

Q There is a hierarchy in everything.
A Oh yes.

Q Above staff nurse is what?
A Senior staff nurse, and then sister.

Q Are you still working in nursing?
A No, no. I have had to retire because of ill health.

Q I ought to say, I think you have a medical condition. If at any stage you need a break or you need to stop, you only have to ask.
A Thank you.

Q We will allow a break, I am sure.
A Thank you.

Q Tell us a little bit about the staffing on Dryad ward please. Who was the sister in charge when you started?
A On Dryad it was Code A. She was our day sister. Then there was a senior staff nurse. We had two or three senior staff nurses due to people leaving, and things like that.

A Then there were the staff nurses like myself. We also had enrolled nurses and we had healthcare support workers.

Q But the senior manager, as it were, for the nursing staff would have been Code A
Code A
A Code A yes.

B Q How many beds did you have on Dryad ward?
A We had twenty.

Q Was that a mixture of patients?
A Yes.

Q Tell us a little bit about the layout of Dryad ward, please. What did you have there?
C A Let me think. As you went in the main ward door, to the left was a four-bedded unit. To the right were two single beds, two single rooms. Going on further down there was another two single rooms.

Q Is it a mixture of single rooms and four-bed wards?
A We had three four-bedded units and eight single beds.

D Q Apart from the nursing staff, can we just examine for a moment what other staff you had. Did you have any physiotherapists, either on the ward or who used to visit the ward?
A We had a physiotherapist that used to visit the ward but we did not have many physiotherapy hours available to us.

Q What about a pharmacist, because we are going to hear quite a lot about controlled drugs?
E A We had a pharmacist. I am trying to thing of the dates now. It was not until towards the end of my stay on Dryad that we used to get a pharmacist that actually came to the ward to check stocks and see what we needed. The nursing staff would check the cupboards to see what we needed and it would be ordered on a pharmacy form, put into a locked box, and it would be taken to the Queen Alexandra Hospital and then delivered back to us a little bit later on in the week.

F Q Just to give us an idea of timing, when did you finish on Dryad ward? When did you leave?
A I finished on Dryad, I think it was 1984. Sorry! 1994.

Q I think you are decade or more out.
A 1994. No – not 1994 either! What am I talking about?

G Q It is all right. Might it have been 2004?
A I completely finished in 2006 and I left Dryad 2004. Sorry about that.

Q When do you think the pharmacist started to come onto the ward? If you are unsure about dates, just say so.
A I would say a good couple of years.

H Q Before you left?

A A Before I left.

Q You know that part of this case, at least, is examining the use of syringe drivers and diamorphine, and you were spoken to by police back in 2004, I think, so not part of the initial inquiry but the later part of the police inquiry. You made a number of statements to them – is that right?
A Yes.

B

Q And you were being asked questions. You were not being interviewed under caution, but you were being asked questions about the use of syringe drivers?
A Yes.

Q Yes?
A Yes.

C

Q And the extent to which diamorphine was used?
A Yes.

Q And more recently, I think, you gave evidence at the coroner's inquest?
A I did.

D Q You were asked questions there, again about diamorphine and the extent to which syringe drivers were used?
A Yes.

Q Your view, I think, when you were asked questions about whether patients were being administered diamorphine in excess of their needs for pain relief was, in short, that that was rubbish?

E A Yes.

Q Your view is that patients under your care were not being administered excessive amounts of diamorphine. Is that right?
A Yes.

Q Does it follow – I do not know – that you are saying that they were not put on syringe

F drivers unnecessarily?
A Oh, no. Most definitely not. No.

Q And so far as **Code A** is concerned, I think you have described her as being used as a scapegoat?
A Yes, I did.

G Q All right. I understand that. I want to ask you please about the use of diamorphine and syringe drivers?
A Uh-hum.

Q Having made your views clear. We know that syringe drivers were used on both Dryad ward and Daedalus ward?
A Yes.

H

A Q I want to ask you a bit about the authority for their use. All right? Code A, we know, was prescribing variable doses?
A She was, yes.

Q So far as you are concerned, in order to administer a variable dose when it had been written out by Code A what was needed? What more, if anything, was needed before a nurse could set up a syringe driver and insert it into a patient?
B A It had to be written on the drug chart.

Q Right?
A The dosage had to be written so that it was legible and clearly stated what the doctor wanted.

Q Yes. Who then would make the decision to use the syringe driver?
C A It was always done in conjunction with the staff, Code A and the family when possible. It was usually a big sort of conflab between everybody.

Q Could it happen, or did you ever begin a syringe driver on the basis of a prescription but not having discussed it with Code A?
A No. No. It was always a doctor's decision to commence a syringe driver.

D Q In terms of the dosage that was used in that syringe driver, because we know they could be loaded up with various doses, whose decision was it as to the dose that was used?
A Code A, or whoever the doctor was prescribing the syringe driver.

Q Let us just examine that for a moment. We know that Code A wrote out variable doses?
A Uh-hum.
E

Q And there comes a point where there is a conflab, a discussion you say, and a decision is made to use a syringe driver on a particular patient?
A Yes.

Q Whose decision is as to the dose that goes into the syringe driver?
A The doctor.
F

Q If Code A was not present what would be done?
A Another doctor would be called if. Code A was not available then we would call whoever was on call for the ward at the time.

Q In your experience we know that Code A was going along every week day?
A Yes.
G

Q Unless she was on leave or ---
A She used to come in in her own time as well.

Q She used to come in on her own time as well. So how often would she be coming into the ward?
A She came on a regular basis, Monday to Friday, once in the morning. It would then
H depend if we had new admissions coming in, she would come in again later on in the day and

she very often used to pop in on her way home from surgery to see if there was anything that we needed or to check on patients.

Q We have heard that her GP surgery was not very far from the hospital?
A No, it was not. No.

Q Did you find it easy or difficult to get hold of her if you needed her?
A Very easy.

Q Very easy?
A Very accommodating like that.

Q And if you needed her to attend the hospital – let us ignore week-ends and nights for the moment – but if you needed her to attend the hospital, did you ever have any difficulty in getting hold of her?
A No. We just used to ring the surgery and we would have a word with her, and she would tell us what time she was coming in.

Q What about the other GPs of her practice. How often did you use those? How often did you need to use those?
A Whenever Code A was not available.

Q I have understood that.
A I know. It varies. Obviously if Code A was away, then they used to take over her duties, but they did not do the morning rounds like Code A used to do. We only got the doctors in when it was necessary.

Q If Code A was working – so it is a weekday and she is not on holiday?
A Yes.

Q How often would you have used one of the GPs in her practice?
A Only if it was after five o'clock in the evening when Code A finished her duty.

Q Was that common, or a rarity? Can you put any ---?
A It was not rare. It was not every single day. Possibly maybe once or twice a week

Q Let me turn to the issue of increasing the dose after the decision had been made to use a syringe driver. After the decision had been made as to the initial dose, whose decision would it be to increase the dose?
A Code A

Q How would that work if she was not there?
A We would ring her. Whoever was in charge of the ward at the time would ring her at the surgery, say we had some concerns. She would then come in and visit.

Q And would she actually have to come in, or could that be done over the telephone?
A Occasionally, very occasionally, she would give permission to increase it over the telephone but it would have to be done to two nurses and then she would come in personally to sign the drug chart. But it very rarely happened. She nearly always came into the ward.

Q What was your understanding of the rule or the guideline, or whatever you want to call it, as to the degree of increase?
A The dosage could only be increased fifty per cent in 24 hours.

Q And so if a patient is getting, say, just to keep the figures simple, 50 mg on day one --- ?
A Yes.

Q --- you could increase up to 75 on day two?
A Up to, yes.

Q Up to?
A Up to.

Q Did it ever go beyond that?
A No. Not without good reason and permission.

Q Hydrating patients. We have heard some evidence in this case about hydrating evidence once a person has gone onto a syringe driver. Can I just ask you about your experience, please. Once a patient goes on to a syringe driver what is done about hydrating the patient or not hydrating the patient?
A Our normal procedure would be if the patient was unable to swallow, which is one of the big reasons that the syringe driver was usually started, then subcutaneous fluids would be introduced.

Q And how would they be introduced? Where would they be?
A Almost like the syringe driver, just by a little tiny needle under the skin in a fleshy area of the body.

Q What would be going into that?
A Normal saline usually – just to keep the patient hydrated.

Q Hold on. I just want to understand this. Did you ever do this yourself?
A Yes.

Q You did?
A Yes.

Q And you insert the needle where on the body?
A In the abdomen. Wherever there is a fleshy part because it just goes underneath the skin so that the fluid can go in slowly.

Q Was a decision ever taken not to hydrate a patient who is on a syringe driver?
A Not that I can remember, no.

Q So your recollection is, if a patient is put onto a syringe driver that you always hydrate them?
A The ones that I can remember, yes. Yes.

Q Finally this, I think, before I move on to the individual patients: the analgesic ladder – I am not going to call it the Wessex guidelines because some people have heard of the Wessex guidelines and others have not heard of the Wessex guidelines – but have you heard of the analgesic ladder?
A Yes.

Q What is your understanding of how the analgesic ladder works?
A The analgesic ladder is a series of steps of analgesia, starting with the very simple ones, something like paracetamol. The next step up is something with codeine in it and then up to the weak opioids and then up to things like diamorphine, which are the opioids.

Q What would it be that brought about the initiation of opioid analgesia to your mind?
A If the patient was not being settled on anything else that they were being given.

Q What does that mean – the patient not being settled on them?
A When you are nursing a patient in pain, hopefully they are able to tell you if that pain is being settled by the analgesics that they are being given. If they cannot, then as nurses we have to observe what we call "non-verbal indicators". It is just the patient – if the patient is restless or grimacing when they are being moved. Anything out of the ordinary would be made a note of and passed on.

Q Passed on to whom?
A **Code A**, or whoever the doctor was.

Q Were opioid analgesics used in your experience to deal with anything other than pain?
A No. The syringe drivers and opioids that I used were for pain control.

Q So if a patient was agitated but it may have been for a reason other than pain, are you saying you would not use an opioid?
A No, I am not. Yes, I have used an opiate for agitate on doctor's instructions.

Q Right. In what circumstances? What sort of degree of agitation?
A Very severe agitation where there is nothing that we can do that can calm them down and other methods have been unsuccessful.

Q Would you ever initiate a syringe driver in those circumstances?
A Syringe drivers can be used for other things than opiate, other than ---

Q Oh yes, I understand. I am sorry. You are quite right.
A If I had a patient that was very agitated and we could not settle them in any other than a syringe driver with a sedation may be used.

Q You are quite right to pick me, but I meant really would you ever use a syringe driver with opioids?
A Oh, no.

Q To deal with agitation?
A No, not just agitation. No.

Q We are going to look at your dealings with a number of the patients that we have been dealing with. I am going to ask you on each occasion to indicate to us whether you can remember the patient. I think there is one patient you can remember, but not surprisingly perhaps, given the amount of time that has passed ---

A The others....

Q --- you do not remember ---

A No, I do not remember the others.

Q --- much about the others?

A No.

Q Then I am not going to ask you a huge amount about those, but could we start, please, with a patient called Code A. To your left you will find some files. Can you take up the file with an "A" printed on it. Just to help you, and to remind the Panel, this patient had been reviewed by Code A, having been admitted to Mulberry Ward back in December 1995, reviewed by Code A on 4 January 1996 and this patient was suffering from chronic depression and ulceration of his buttock and hip. Yes?

A Yes.

Q And he was admitted to Dryad ward, so your ward?

A Yes.

Q On 5 January 1996 and I think you were asked about this patient in the coroner's inquiry?

A Yes.

Q And you were asked about this patient by the police and is it fair to say you do not recollect the patient?

A No.

Q There is no criticism of you for that. Can I ask you to go to page 209 of his notes? It is really to identify on occasion where you have made an entry. If you want to, you can look at the beginning of these nursing notes, if you go back to page 205 just to orientate yourself. Does the layout of this ring bells for you? Do you recognise this document?

A I recognise the documentation, yes.

Q I do not think you were the named nurse, were you, for this patient? If we look at page 205 is it Code A?

A Yes.

Q And the consultant is shown as Code A

A Yes.

Q If we go to page 208, just to read ourselves back into these notes, the first entry is not made by you, it is made by is it Code A?

A Code A

A Q "Transferred from Mulberry Ward at lunchtime. Appears to have settled well. Code A visited this afternoon. He has a sore on his right buttock which is being treated and similar on his left buttock. The skin on his scrotum is broken."

If we look to the bottom of that page, 15 January, we can see just above that Code A appeared to be distressed apparently and there were problems with the catheter.

B A Mm hmm.

Q Then we can see on 15 January that Code A had commenced the use of a syringe driver.

A Mm hmm.

Q Prior to that we know that the patient had been on Oramorph.

C A Mm hmm.

Q And he was commenced on 15 January with the lowest dose that Code A had prescribed, which was 80 mgs.

A Mm hmm.

Q Can I just ask you this: did you know anything about the conversion rate from oral

D morphine to subcutaneous morphine?

A To be perfectly honest with you, I would have done at the time; but now I cannot remember the ratios.

Q If you ever saw a prescription or a use of a drug that in your view contravened any of the basic guidelines, would you have done anything about that or would you have just administered it?

A Oh no, I would have said something at the time.

E

Q Can you remember ever challenging Code A about her use of opiates?

A I cannot remember ever doing it but I am sure I would have done if I had felt it was necessary.

Q If we go to page 209, so the following page, do we see a note by you?

A Yes.

F

Q Is that on 16 January?

A Yes.

Q Can we just go to 13.00 hours, or is it the whole day?

A 13.00, yes.

G Q So it is half way down page 209. Can you read us your note, please?

A 13.00 hours:

"Previous driver dose discarded. Driver recharged with diamorphine 80 mgs, midazolam 60 mgs, hyoscine 400 micrograms and haloperidol 5 mgs given at a rate of 52 millimoles hourly. Visited by Code A) who is now aware of poorly condition. All nursing care continued. Right ear found to be blistered along

H

A upper edge. Please nurse only on back and left side. Marking very easily. Please turn one and a half to two-hourly."

And it is signed by me.

Q After that it is not your note, I think.
A No.

B

Q But we can see:

"Condition remains poorly. All care continued. Syringe driver running satisfactorily."
A Mm hmm.

C Q I think you previously made one note back on 9 January, which I am not going to bother with at the moment. But just dealing with this scenario here, you have come along to do what for this patient?
A To check the syringe driver and, if necessary, it looks as though I have changed it.

Q What would you be checking about it?
A Normally when a patient is being administered medication via a syringe driver we D check the needle site; we check the driver to make sure that the fluid is actually going in. Just to make sure that everything is comfortable really for the patient. Then obviously if it is time for it to be changed to make sure that it is on time and changed at the time.

Q If the patient had been conscious or saying anything at this stage would you remember it or make a note about it?
A If the patient had spoken to me I would make a note of what was said.

E

Q Are you able to tell from this whether the patient was awake or unconscious?
A Not really. The only thing I can say is it looks as though he is obviously very poorly at this point because he was being turned on a very regular basis. His position was being changed on a very regular basis; so he was obviously unable to do it himself.

Q Can we go over the page, please, to page 210. We can see again at the top not your F writing.
A No.

Q We may come across your writing later on.

"See by Code A Medication increased 09.25 as the patient remains tense and agitated. Chest very 'bubbly'."

G

Is 08.25 a time when you would expect Code A to be coming round?
A Yes, she used to come round very early in the morning.

Q If we just cast our eye further down the page we can see that there is are various entries about further deterioration.
A Mm hmm.

H

Q Little change and poor condition on the night entry.
A Mm hmm.

Q Have you made the next note?
A Yes, it is me.

Q "Poorly condition. Continues to deteriorate. All nursing care given."
A Yes.

Q What does "continues to deteriorate" really mean in these circumstances?
A It means that his poorly condition was continuing to get worse; it was not getting better, it was getting worse.

Q How do you tell?
A The colour of the patient and how much more nursing care they required; how often the position was being changed.

Q The colour of the patient would indicate what to you?
A That the blood supply was not circulating properly.

Q What would you put that down to? If you just see this note what does that actually tell you?
A That the patient was dying – close to death, possibly.

Q Would you know from this note what was causing that?
A Not from reading just that, no.

Q How much of the previous notes would you read?
A Sorry?

Q When you come to perform a particular action, as you did with this patient, which was recharging the syringe driver by way of example, how much of the previous note would you read?
A We would read what had been written by everybody else.

Q Everybody else?
A Whenever you came on duty you would read what had been previously written, as well as having an oral handed over report.

Q I just want to know how much of it you would read. Would you read the last entry, the last couple of entries, all of the notes?
A If I had come on duty at, say, where it says here 14.30 hours, if I came on duty just before there I would read what had been done in the morning and possibly what had been said at night as well. Or maybe go even further back if I had not been on duty the previous day.

Q Would you ever take a decision to decrease the dose or increase the dose on your own?
A No.

A Q We know that there was a change, as we can see at the top of the page, with the medication being increased.
A Mm hmm.

Q On this occasion that is being done by Code A
A Yes.

B Q Should we take it that you would follow the medication that had been provided previously, unless ordered otherwise?
A Yes.

Q The sort of note that we have been looking at – when would you make that note?
A Something like changing a syringe driver or what I would call an important entry I would do at the time or very close to the time; but like a general overview of how the patient
C had been during the day I would take it from notes that I had made – because I used to carry a little pocket book and I would make general notes in that pocket book and then write the notes up before I went off duty.

Q So not necessarily made immediately at the time, but made ---
A Things like changing syringe drivers and doctors' visits and things like that were normally written at the time or very close to the time. I am not saying that it happened every
D single time but we used to like to try and do those things as close to the time as possible.

Q Could you go over the page again, and if we look on 19 January, do we see an entry of yours at 15.00 hours? Sorry, there is one at the top as well.
A There is one right at the top as well, yes.

Q "Code A has visited for most of the day. Appears comfortable in between
E attention. Oral suction given with some effect."
A Mm hmm.

Q So that would be a note relating to 18 January; is that right?
A Yes, because it carries on from where I have left off.

Q Then 19 January:
F

"Marked deterioration in already poorly condition …"

This is not your note, is it?
A Yes, it is.

Q It is your note?
G A It is my writing, yes.

Q You have not signed it?
A No, because it goes further down. It goes from <u>there</u> (indicating) to half way down the page.

Q Thank you very much. So:
H

"Marked deterioration in already poorly condition. All nursing care continued. Position changed strictly two-hourly. All pressure areas intact except for small discoloured area at the base of the big toe."

A Yes.

Q What is the next word?

A "Mouth care performed at each position change."

Q "Breathing very intermittent. Colour poor."

A Mm hmm.

Q For whatever reason I suppose that the note is obvious in what it means – breathing very intermittent?

A Yes. Very intermittent, and it is shallow usually.

Q And pausing for a period between each breath.

A Yes.

Q Then we can see that you recharge the syringe driver.

A Mm hmm.

Q With 120 mgs of diamorphine and 80 mgs midazolam and then we can see a note about Code A .

A Yes.

Q Does that finish your note?

A It does, yes.

Q The next note we see on 20 January, I do not think that is yours.

A No.

Q But we can see that there was a verbal order taken to double Nozinan and stop haloperidol.

A Yes.

Q Just in relation to that, was that the sort of thing that would occur from time to time?

A Occasionally, yes.

Q But Code A would have telephoned in.

A Yes.

Q And then as we have heard from him, visited later.

A Yes.

Q Again, if we go over the page to 212 I think you have made a further note. Is it your note on 22 January.

A Yes, it looks like my writing.

Q Can you just read it for us?

A A "Poorly but very peaceful. All care given today. Code A have visited and spoken to Sister Hamblin. At 15.50 driver recharged with diamorphine 120 mgs, midazolam 80 mgs, hyoscine 1,200 micrograms and Nozinan 100 mgs at a rate of 43 millimoles hourly."

Signed by me.

B Q "Poorly but very peaceful", would that indicate that the patient was unconscious?
A Yes, usually; not always but usually.

Q And "poorly" in the way that you have described – skin, colour, breathing.
A Yes.

Q I think that is the last note that you have made in relation to this patient.
C A Yes.

Q We have seen with this patient that there was an increase in the diamorphine.
A Mm hmm.

Q And you told us that in your experience, did you say that it was very rare to increase by more than 50 per cent?
D A Yes.

Q Did you ever know it to happen?
A Not in my experience, no.

Q If it had happened is that something you think you would have challenged, or not?
A I would have asked why.
E

Q In any event with this patient any decisions to increase were not yours?
A No.

Q We can put bundle A away. You have made a statement about Patient C and I hope my learned friends will not object if I just deal with one or two brief entries that I want you to help us with. If you take up the bundle for Patient C.
F

Code A That is the one where the bundle has still not been distributed, so I suspect it will not be at the witness's table either.

Code A Sir, I am sorry; I thought that they had all been distributed.

Code A It was the only one and the reason it was not distributed because you
G were still waiting.

Code A I hope it has been sorted out.

Code A, the witness has been up for just about an hour now; perhaps whilst we are sorting this out it would be a convenient moment for a break.

H

A (To the witness) We have a little break whilst a file is found and it has to be given to everybody else as well. So we are going to take a break now for 15 minutes, which should give you the opportunity to get a little refreshment, and our Panel assistant will assist you now.

(The Panel adjourned for a short time)

B Code A Welcome back everyone. Code A we have now received into evidence Bundle C. We previously agreed that it would be marked Exhibit C4, so perhaps everybody could mark it. May I ask if the bundle is now complete or if there is more to come?

Code A It should be complete.

Code A I know, for example, that in common with others it does not have a
C death certificate.

Code A That is correct. We have been trying to get the death certificate. We have asked the police for their help but they have not been forthcoming. Code A on Code A 's side may be more successful than we were but we will continue trying.

Code A Given that we are mid-witness, as it were, I am not going to ask that we
D take what has become our customary course of acquainting ourselves with the contents first, but perhaps you would bear in mind that this is a first hand viewing. That would be helpful.

Code A I will. In fact there are very few documents that I am going to refer to. Can I also mention something else in relation to timing? Because this witness was not expecting to be here tomorrow – I do not want to embarrass the witness – we have had to arrange for a prescription for her, but she will have to pick that up this evening.
E A Code A is picking it up for me.

Code A Hopefully we will be able to get that. The representative of my instructing solicitor is going to deal with that now so if there are any problems we will find out in good time, in case we have to rise early.

Code A We are most grateful to you for being here today and do apologise that
F we have not been able to get to you as soon as we would have liked.
A These things happen.

Code A We were about to turn to Patient C and we can do it relatively shortly. Patient C, if we go to the chronology at the beginning, was admitted to the Queen Alexandra Hospital following a collapse. Then she was in fact discharged back to the residential home in which she was living. In 1998 she was readmitted to the QAH on 6 February 1998, and
G this was with a diagnosis including,

"probable carcinoma of the bronchus and depression".

Then we see that on 19 February 1998 she was transferred to Charles Ward under Code A and on 27 February she came over to you at Dryad Ward.
A Yes.
H

A Q She was reviewed by Code A. We will find Code A's clinical note at page 304. It is dated 27 February and I am going to do my best to read it. It says,

> "diagnosis of carcinoma of the bronchus made on x-ray on...Generally unwell. Off legs. Not eating. Bronchoscopy not done".

I am afraid I need help with the next word,

B

> "Needs help with eating and drinking. Needs hoisting. Barthel 0. Plan get to know. Family seen and well aware of prognosis. Opiates commenced",

and we know the rest I think. Really that was for the Panel rather than you, as I think you appreciate. Turn, please, to page 174, which is the nursing note. Do you see your name there as the "designated nurse".

C A Yes.

Q Is that any different to the "Named nurse"?
A No, it is just another name for it.

Q What does that mean for you?
A When a patient is admitted it just meant that I was a point of contact for the family

D and other members of staff to find out what had been going on with this particular patient.

Q If we go to page 178, is this your writing?
A It looks like it, yes.

Q It is nice and clear:

E

> "Can make her wishes known".

A Yes.

Q Then what does it say?
A "Quite well. Does as she is asked. Helps all she can. Pain? Yes, on movement. Skin: dry, friable, paper thin. Client/Carer preference: Not discussed".

F

Then she is given a Pegasus mattress which I think is to relieve pressure sores.
A A pressure-relieving mattress, yes.

Q She is on a urinary catheter.
A Yes.

G Q "Pain on movement": we have seen that quite often. Did you use pain scores at the Dryad?
A Towards the end of me being on the ward, we did, but it was not something that we used on a regular basis at the beginning.

Q It is not something we have seen in any of these notes. Looking back on it now do you have any recollection of this patient?

H A None at all. The name does not even ring a bell.

A

Q These are your notes.
A Obviously it is my writing, yes.

Q I will not spend very long with this. If we go through the notes, I think we go to page 180 where we can see,

B

"Requires assistance to settle at night. To maintain comfort and promote restful sleep. Transfers with 2 nurses".

What does that actually mean?
A It means she needs two members of staff to help her into bed, out of bed, into a chair, to rise from a chair; to do any kind of movement, really.

C

Q Can we tell from this whether she is able to help herself at all?
A If I read that as just somebody coming in who read it, I would think that she was not really able to do much for herself, not in the way of movement anyway.

Q If we go to 272, which is the beginning of the drug chart, I am afraid it is just to ask for your assistance as to whether you have administered any of these drugs so we can identify your initials in the future.

D

A No.

Q None of those?
A No.

Q Over the page.
A At the bottom.

E

Q At the bottom of page 274, is this lactulose?
A Yes, lactulose 10 mls.

Q Where are your initials, 1800 or 9.05?
A They are at 9.05 and then on 1800 the following day.

F

Q Is that the following day?
A It looks like it, February/March. It looks like I have written at 9.05, which is my initials on 28 February, and then it is my initials on 1 March at 1800.

Q Page 278?
A No, they are not mine.

G

Q You have no recollection of this patient at all, do you?
A No. The name does not even jog my memory.

Q Then I will not spend any more time going through those. Could you take up Bundle F, please, which is Code A ? Again, we are going to deal with **Code A** quite shortly. Does that name ring a bell with you or not?
A I recognise the name, but in all honesty I could not put a face to it.

H

A Q This lady had a fall. She went to the Haslar. She was transferred to the Dryad Ward on 18 August. If we go to page 373, I think you will find a Barthel score. I do not know if this is your writing or not.
A I do not think it is, no.

Q She has a Barthel score of 9. We know that there is a maximum of 20, so how does that compare to the majority of patients on your wards?
B A Compared to the majority of patients, that was very good.

Q A Barthel score of 9, how would you translate that into reality? We can see she can groom herself, which means presumably brushing her hair, brushing her teeth.
A Yes. She was able to transfer with just one member of staff.

Q Could we have a look, please, at the following page, page 374? There is no named
C nurse on there.
A No.

Q If we go to 381, I think this is the nursing care plan and you are shown as the named nurse there.
A Yes.

D Q Do we see your writing, which is nice and clear, on this page?
A Yes.

Q Again, unless you have got any recollection of this patient, I am not going to take you through it.
A I recognise the name, but I could not put a face to her.

E Q All right. If you go to pages 376 to 377, would you just remind yourself a little bit about this patient, because I just want to ask you one matter? You will see on page 377 there is a note that she has small ulcerated areas.
A Yes.

Q Whose writing is that?
A That is mine.
F
Q Code A has small ulcerated areas on both lower legs".

One small area on her right and two on her left.

"Desired outcome to dry and heal them".

G This is dated 18 August, is it not?
A Yes.

Q Look underneath, "Nursing Action". Read that through to yourself and I want your assistance with the word "sloughy". Have you read that through?
A Yes.

H

Q We can see that you make a note of,

"Apply layer of zinc and castor oil to good skin and then aserbine to sloughy area".

A Yes.

Q Aserbine is what?
A It is a de-sloughing agent; it is quite a powerful de-sloughing agent.

Q Is "slough" dead skin?
A It is dead tissue.

Q That can be necrotic tissue, presumably.
A Yes.

Q Is it always necrotic tissue?
A Dead tissue is necrotic tissue.

Q Sorry, you are absolutely right. You get areas of dryness on the skin and that is dead tissue.
A But that is not necrotic. It is dry skin.

Q Right. Just looking at those notes again, how significant a problem does this lady have in terms of ulceration? Are you able to help us?
A Just by looking I would say that the right leg was not very bad at all because all I have applied is Paranet, which is a very gentle dressing. It is good; it heals, but it is very gentle. The left leg would seem to be a little worse because I have had to use Aserbine to the sloughy area.

Q Page 394, please. Also dealing with 18 August, we can see the note made at the top when she was admitted, and that I think is not your writing.
A No, it is not.

Q But underneath that,

"PM: Seems to have settled quite well. Fairly cheerful this pm".

A Yes, that is me.

Q That is you.
A Yes.

Q Do you still have no recollection of this patient?
A No.

Q At 1150, complains of chest pain,

"Not radiating down arm. No worse on exertion".

A Can you just help? I appreciate that is not your note, but as a nurse does that mean anything to you?
A To me it would indicate that it was something that could be quite serious because chest pain radiating down the arm is quite indicative of a heart attack.

Q Quite. This actually says, "not" radiating down the arm.
A If it was not radiating down the arm, then obviously the nurse who wrote it, that is the B first thing she has obviously checked and found that it did not radiate but that this lady was obviously still in pain.

Q Then we can see in the next entry that diamorphine 20 mgs, and the midazolam were commenced via syringe driver.
A Yes.

C Q You took no part in that decision.
A No, that is not my writing.

Q Or the administration of it.
A No.

Q If we can just go to the drug chart, 368, I think you will find a, b, c and so on. I want D to go to 368e. Do your initials appear anywhere on this drug chart?
A No.

Q We can see, I think, that on the 19 August, even with the better copy it is rather difficult to read – she was provided with 20 mgs of diamorphine and 20 mgs of midazolam. Do you see on 19 August and on 20 August she is given 20 mgs and 20 mgs?
A Yes.

E

Q Then on 21 August – just confirm; does your writing appear anywhere on there?
A No.

Q She is put up to 60 mgs.
A Yes.

F Q On my maths that is three times the previous dose.
A Yes.

Q Is that something if you were administering you would have queried, or not?
A Yes, I would.

Q Why?
G A Because it is not the 50 per cent increase.

Code A : Sorry, Code A to interrupt, but I too, in common with the witness, at the time you first referred to the diamorphine, was on page 368b. In fact it was Oramorph that was referred to on that page and it is specifically the diamorphine and the Midazolam that you are now referring to.

H Code A : Yes. It is 368e, which is one of the inserts.

Code A That is OK, but on the 19th it is clear that Oramorph was also administered.

Code A Yes.

Code A Thank you.

Code A Again, just on that issue, if you are setting up a syringe driver would you normally check when a patient was last given Oramorph or would you just take the doctor's instructions?

A No. If I was setting it up I would check to see when it had last been given.

Q From what you have seen of the nursing notes, and the nursing notes that you made – we can go back to them if you want – can you see why this lady was started on a syringe driver?

A I cannot see.

Q All right. If we go to page 612 do you recognise those notes?

A No.

Q So again, just going –

A That is Ward E3.

Q Which is where?

A Am I on the right page?

Q Yes.

A That is E3. That is at QA.

Q Just give me a moment, please. We were looking at 614. You are absolutely right. In fact that finishes on page 614 when on 18 August she is transferred over to you.

A Uh-hu.

Q I apologise. We can move on. Again, having looked at any of those notes do you have any recollection of the patient?

A No.

Q Just one other matter to help us on that one – I am sorry – page 368 please. Would you go to 368e again – I am sorry to go back to it. Do you see on 20 August three is a note that something has been destroyed?

A Yes.

Q Can you just talk us through that, please?

A If a patient is having medication by syringe driver and the constituents of the syringe driver have been changed for any reason or the dosages have been increased or decreased, or something has been added, or something has been taken away, then the previous dose that they were receiving would be destroyed and a new dose would be started.

Q You cannot add to the same syringe driver?

A A No. We do not do it like that, no.

Q So you get rid of the old syringe driver?
A Yes.

Q And a note is made that it is destroyed, as we see here?
A It is made. A note is made in the drug chart to say that it has been destroyed, and in
B the drug record book.

Q If this patient was being hydrated where would there be a note of that?
A She should have a dietary assessment, and if she had a Barthel of 9, I would presume that she was drinking and eating.

Q While on the syringe driver?
C A On her own, yes – with a Barthel of 9.

Q She would be able to, would she?
A She would be able to. According to the Barthel it says she was eating; she was feeding herself.

Q That is on her admission?
D A That was on admission.

Q Of course. If she has a syringe driver going into her at these sort of rates, is she going to be able to eat and swallow?
A Yes.

Q She may be able to?
E A Yes, she may be able to. Yes.

Q If she was able to take oral morphine can you think why this patient would be on a syringe driver?
A I cannot. I cannot answer that at all.

Q In any event, again, just to make your position clear, you do not recall this patient?
F A No.

Q Could we turn, please, to Patient H, Code A Again, I have a very limited amount to ask you about Code A Can we remind ourselves, please, because sometimes it is a bit difficult to keep everybody in mind, I am afraid. He had an alcohol problem and he was brought to your hospital on 14 October 1998?
A Uh-hum.
G

Q Do you have any recollection of Code A ?
A No.

Q Can we go to page 267, please? Perhaps that should be 266 and 267. I think you are going to find – just to make it more complicated – a 266A and 266B, but we can at least read those. Do you have 266A?
H A Yes.

A

Q Again, just cast your eye over these notes. Do you see your --?
A No, I do not see my writing.

Q --- writing on 266A?
A No.

B Q Or 266B?
A No, not on B either.

Q And on page 267 "pm", I think we see you?
A Yes.

Q
C "All care has been given. Oral suction has been required and performed. Condition continues to deteriorate."

Oral suction – why would that be required and how is it performed?
A How is it performed, did you say? Sorry?

Q Yes.
D A It is to clear the mucus from the back of the throat and to make the patient more comfortable. It is a thin tube that is on the end of a suction machine. It uses gentle suction to remove the secretions at the back of a patient's throat if they cannot cough them out themselves.

Q So a nurse would be inserting a tube into the patient's mouth?
A Yes. We try not to do it too often.
E

Q Why would a patient be needing that?
A If they were poorly, if they were unable to cough or if they were unable to get rid of the secretions themselves. It can get quite distressing for them because it obviously makes it difficult for them to breathe properly so we have to remove it that way.

Q Is that something you found when the patients are on a syringe driver?
F A I found it with both patients that are on syringe drivers and not.

Q Again, just looking at this note, I do not think you have made many other notes for this patient. I might be wrong, but if you go over to page 278 and 279 you will see that **Code A** was actually the named nurse. Please cast your eye over 279 and 280. If you have any recollection of this patient, please let us know. I do not think you have made any notes on 279, have you?
G A No, I have not. No.

Q I am sorry, I have a wrong reference. I have page 96 for the nursing care plan but that is wrong. I think it will be 279 and 280. Again, did you have anything to do with the writing up of this patient?
A No.

H

A Q Very well, I will leave it then. I am going to turn very briefly to the drug chart again, please, just to see if you made any entries or administered any drugs. Page 263, please. It is sometimes difficult to identify nurses' initials?
A No. Mine do not seem to appear there, no.

Q Let me move on. I am going to turn to a patient that I think you do have some recollection of; that is our Patient K, Code A I see you smile. Do you have a
B recollection of Code A?
A Oh yes!

Q I should call her Code A – I am sorry. Tell us before we turn up our notes why you remember Code A?
A Because she gave me a black eye, basically.

C Q Tell us what the circumstances were?
A She scratched me, and I ended up with a big bruise on my shin. I came on duty one morning. I usually got there about five past, ten past seven. I walked onto the ward to find Code A in the middle of the corridor opposite the nurses' station grasping one of my colleagues by both her wrists, trying to push her up against one of the wall bars. I tried to persuade her to let go of Code A my colleague, and hang on to me but she would not. She was getting really quite agitated, upset. She was shouting and screaming at us. She was kicking out at
D us. She then hit me and knocked my glasses across the ward. We eventually got her into the day room because it we were trying to get her into the day room out of the corridor because it was upsetting other patients as well. We eventually got her into the day room but she refused to sit down. She was still shouting and screaming at us, and she was getting really quite beyond herself really.

Q Let us have a look, please, at page 223 and see if we can put some dates on this
E incident, or a date on this incident. This was the lady who is under the care of Code A, just to remind the Panel again, who found insufficient evidence for a diagnosis of myeloma. She went into the Queen Alexandra Hospital on 9 October with an episode of acute confusion. Then she came over to you at the Dryad ward on 21 October 1999. If we look at the top of page 223, we see that she is –

F "admitted this pm with increasing confusion and aggression. The aggression has now resolved. Still seems confused …

Needs minimal assistance"

is it?
A Yes.

G Q

"… with ADL's. A very pleasant lady. Her appetite on the whole is not good and can be a little unsteady on her feet.

Quite cold"

is it?
H A Yes, yes.

A

Q "... on admission and both feet swollen.

[Seen by] Code A. See treatment chart for drug regime."

Let us keep a finger where we are and go to page 279C. I think we can see that there are
B some prescriptions written by Code A on 21 October. Is that right?
A Yes, yes.

Q And indeed, the page before, page 279B, can we see that Oramorph was written up?
A Yes.

Q It is quite difficult to read. Temazepam, Oramorph, thioridazine, is it?
C A Thioridazine, yes.

Q Hyoscine – no. That is later, I am sorry. Over the page, thyroxine?
A 100 micrograms.

Q Then back to your note. If we go to page 223 again, at the bottom of page 223, 19 November 1999 whose note is this?
D A That is Code A 's.

Q Can you help us whether this refers to the incident that you just referred to?
A Yes, that is it.

Q Can you just read through the note for us please?
A Yes.

E "Marked deterioration over last 24 hours. Extremely aggressive this a.m. refusing all help from all staff. Chlorpromazine 60 mgms given I.M. at 08.30. Taken 2 staff to special. Syringe driver commenced at 09.25 with diamorphine 50 mgms and midazolam 50 mgms. Fentanyl patch removed. Code A – seen by Code A at 13:00 and situation explained to him. He will contact his Code A and inform her of Code A's poor condition. He will visit later."

F

Q Were you part of the conflab that you spoke about earlier, about starting a syringe driver with this patient?
A Not that I remember, no.

Q This was an occasion when effectively your evidence is she had attacked members of staff?
G A It was very unlike her. Yes, she attacked me and she had got hold of Code A but it was very unlike her. She had not done anything like that since she had been on the ward.

Q There is no indication here, or is there, that she was in pain?
A Not that I can see, no.

Q She had been on a fentanyl patch. Did you know about fentanyl patches?
H A I know of them. I have used them in the past.

Q And what was the effect of those?
A What – in general?

Q Yes.

Q Well, in general I did not particularly think they were very good, but for some patients they did work.

Q If we to page 279B – keep a finger where you are – we can see chlorpromazine which is referred to on the page that you have just been talking about at page 223?
A Yes.

Q It prescribed chlorpromazine?
A Yes, chlorpromazine.

Q What is that used for?
A Sorry

Q What is that used for?
A It is a sedative.

Q It is a sedative?
A Yes. It is used a lot in psychogeriatrics. Well, it was. Not so much so now.

Q And that is an injection?
A Yes.

Q 50 mg?
A Yes.

Q Can we tell from this when the fentanyl patch was taken off? We can see the note at the top of page 224 – syringe driver commenced?
A Uh-hum.

Q Would a syringe driver be commenced while the fentanyl patch was still on?
A Not normally. it would be taken off first.

Q Did you say "not knowingly"?
A "Not normally".

Q Not normally.
A The patch would be taken off.

Q Would you have known how long fentanyl remains within the system after a patch is removed?
A Offhand? I think it is about six hours. Four hours. I am not sure to be quite honest.

Q So this patient has had a patch on. She is given chlorpromazine and she is started on a syringe driver about 9.30?

A A Uh-hum.

Q Yes?
A Yes.

Q With 40 mg of diamorphine and 40 mg of midazolam?
A Yes.

B

Q Do you know why that was done?
A I cannot say.

Q And you were not part of the conflab that made that decision?
A Not that I remember, no.

C Q Apart from this incident of you getting a black eye do you remember much else about the patient?
A Just odd things. I remember that she was quite a little tiny lady and she used to go rummaging around in other people's lockers and take their sweeties and biscuits and then we would have to persuade her to put them back, but apart from that I cannot remember an awful lot more about her.

D **Code A** Thank you; would you wait there, please.

Cross-examined by **Code A**

Code A do you remember I asked you some questions at the inquest?
A You did, yes.

E Q Can I ask you some questions about where patients came from during the time with which the Panel here are concerned. Did you get patients coming from their own homes?
A Occasionally.

Q Were they often transferred to the War Memorial from other hospitals?
A Yes.

F Q Was that the main way in which they came to you?
A Yes.

Q Did you get some transferred from nursing homes or rest homes as well?
A Some but not an awful lot.

G Q Would this be fair, that the overwhelming majority of patients that you were dealing with were post operative patients from surgical units?
A No.

Q No?
A No; we did not get an awful lot of post operative patients – we got some but not an overwhelming amount.

H Q **Code A** started there in 1988.

A A Mm hmm.

Q Do you know if you were there then?
A I started in '87.

Q So were you working at the War Memorial when Dr ---
A I was at the Redcliff Annex in '87 until we moved up to the main building.

B

Q So you were nursing with Code A in Redcliff.
A Yes.

Q And you moved up with her to the main building?
A Yes.

C Q Can I ask, over the time that you were doing the job until Code A resigned in 2000 were the patients and the condition of the patients the same or did they change over time?
A They changed actually.

Q In what way?
A When we were at Redcliff we went through a stage where we got really quite poorly patients that were transferred to us from other hospitals and we were not given the chance to
D get to know them or their families. When we went up to the main hospital we went through a period where they kept changing our remit; first of all we were a long stay unit, then we were slow stream rehab and then we were something else. And each time the name of the ward changed the patients sort of changed. Basically we used to get patients that nobody else seemed to want. Sorry, am
I allowed to say that?

E Q Of course you are allowed to say that. What does that mean for someone like yourself who was nursing that kind of patient?
A We used to get a lot of patients – am I allowed to use the word that we used to use? We used to call them being "dumped" on us because the hospital beds at the QA, which were usually the acute beds, could not cope with long term patients. There was nowhere else to send them and so we used to get them and we used to take all kinds of patients.

F Q Tell us why nobody else would have wanted those patients?
A Because elderly people can take an awful lot of nursing care and an awful lot of nursing hours and on an acute ward they do not have the time to care for them like we could.

Q So for the time with which this Panel are concerned – really 1996 through to 1999 – would it be fair to say that a lot of the patients were very dependent?
A Oh, yes! Yes.

G

Q It will be obvious that that creates pressures on nursing staff.
A Yes.

Q And should we have a picture that the level of dependency of the patients had grown worse over time? They had been more dependent over time?
A Yes, they were. Occasionally, as your colleague said about the lady that had the high
H Barthel, we occasionally got patients like that but a lot of the patients that we had on the ward

had Barthels of zero or one or two. We thought ourselves quite lucky if we got a patient with a high Barthel.

Q Again, when Code A started the patients had not been like that, or not as bad as that?
A When Code A started I was down at Redcliff and most of our patients at Redcliff were dependent and with us for a long time – and I do not mean just months, I mean years sometimes. So they were quite dependent, even at Redcliff.

Q I understand. Of the patients that were transferred in a number of them will have been transferred with the view that they should undergo some form of rehabilitation.
A Some did, not many.

Q I think that was an answer you gave to Code A when he asked you questions. You said that there was not a lot of rehabilitation on Dryad Ward.
A No.

Q Why was that?
A As I said, our remit kept changing and we kept being told that we were this and we were that, and Daedalus was actually the stroke rehabilitation ward for the elderly, so they used to get an awful lot of rehabilitation obviously because of their remit. But because we were not sort of continuing care we only got it if we needed it; if we had a patient that they thought had a little bit of potential then we used to maybe get a half an hour, an hour a week or something like that. It was quite scarce.

Q So half an hour or an hour of what – physiotherapy?
A The physiotherapist used to come, yes.

Q The Panel have seen medical records of one of the patients who was treated at one of the other hospitals, the QA or the Haslar, where they were seen day after day after day by physiotherapists. Did you have that facility at the War Memorial?
A No.

Q Can I take you to the sort of patients that you might have been nursing, if there were patients towards the end of their life? Patients may clearly arrive at the end of their lives in various ways. Some of them may just be involved in an accident or have some cardiac event and they drop dead. You would not treat those people clearly; they would not get to your hospital?
A No, they would not get to us, no.

Q But of those who might be approaching the end of their lives might there be some patients for whom there would be a lengthy decline – weeks, months?
A Oh, yes!

Q Yes?
A Yes.

Q And as a nurse who has looked after such people for years can you tell us how do those patients deteriorate over time?

A A It is a slow process usually. They stop eating, they stop drinking; they will not mobilise; they do not want to interact with other people. It is just a slow decline really.

Q As the end approaches are the various systems breaking down?
A Oh, yes; yes.

Q You have told us about reduced eating or drinking. Does the quality of the skin
B deteriorate?
A Yes. Most elderly people have got very dry skin, friable skin anyway, so it is something that the nursing staff on an elderly care ward would take an interest in from the very start anyway.

Q We saw with Patient A some notes – we do not need to look at them now – and you were making entries saying that the skin was marking.
C A Yes.

Q What does that mean?
A A normal person like ourselves, we would move quite regularly and so the blood supply to our skin would be okay – it would not be interrupted. But with an elderly patient they sit for long periods of time; they are not very happy about standing and they have to be encouraged, so their skin starts to mark and you get red areas that can very quickly turn into
D ulcers.

Q And you talked about the colour of the patient.
A Yes.

Q As something that can help you as an experienced nurse.
A Yes. If they do not eat or drink and they start sort of just withdrawing from
E everybody it is just ... I do not know how to describe it. When you have been looking after these people for a lot of years you look at them and think, "Oh, dear; you do not look very good; you do not look very well." It is just the case that they sometimes get very pale. I do not how to describe it; it is just something that you know really after years of experience.

Q Would it be fair to say that for someone experienced like yourself, although you cannot describe it you would recognise it?
F A I would recognise it immediately.

Q You would recognise the signs of someone deteriorating.
A Yes.

Q Or the signs of someone who may be terminally ill.
A Oh, yes.
G

Q Or dying.
A Yes.

Q I have asked you about patients who may have a lengthy decline – weeks, months, longer. Is it also in your experience the case that for some patients, particularly the elderly, there may be quite a rapid decline ---
H A Oh, yes; yes, I have seen it a number of times.

Q For relatives of those patients where there may be quite a rapid decline is it your experience that the relatives may be completely shocked at the speed of it?
A They find it very difficult to understand why they have declined so rapidly, yes, and they are quite shocked.

Q We have heard that there may be patients who have a number of medical conditions.
A Most elderly people have numerous problems.

Q Is it your experience that for a patient who may have a number of medical problems, if there is a decline suddenly all those problems can come to the fore at once?
A Yes. They all sort of reach a pinnacle and that is it, everything goes wrong at once.

Q For patients – and you have nursed them – who may be a day or a few days from the end of their natural lives, do they sleep for long periods? Can they?
A They do sometimes, but not always.

Q Are there some patients where the mental state will fluctuate?
A Yes. On Dryad especially we used to get a lot of patients with confusion problems; they were confused and ... Could I just possibly take a bite of my Mars bar please?

Q Of course you can. If you need a break you must say so.
A No, I am fine; I am okay, just so long as I can take something because I can feel myself shaking. (Short pause)

Code A Would it help if we got you a hot drink?

THE WITNESS: No, thank you; I am not a big fan of hot drinks.

Code A If there is anything you need at any time?

THE WITNESS: No, I have my water, thank you; that is very kind.

Code A If you need a break, say so.
A No, I am fine.

Q Can I keep going?
A Yes. I am okay.

Q Again, for patients who may be within a day or two of death may they drift in and out of consciousness?
A Yes.

Q Patients who are on no medication at all.
A Yes. I have known it happened; yes. We have had patients that have been admitted to the ward and died on the same day – it can happen.

Q I think that is bad for staff morale.
A The particular time that I was thinking of, when I was speaking with your colleague, at Redcliff we had about ten months where we got particularly poorly patients and they were

A passing away within days of actually coming to us; and on two occasions that I remember – I am sorry I cannot remember their names – the patients actually died on the same day that they were admitted, and the morale on the ward at Radcliff was quite low at that point because when you work with elderly people it is nice to be able to get to know them and also to get to know the relatives because nine times out of ten you are going to be looking after these people for weeks and months, and we just could not do that when they kept coming in and passing away within days, and it was quite upsetting for the staff really.

B

Q When patients are transferred to you there is obviously a named nurse system.
A There was at the time; I do not know whether that still is there.

Q Let us deal with the late 1990s. There was a named nurse system.
A Mm hmm.

C Q Would the named nurse take the lead in talking to relatives?
A Yes, I suppose you could say that. It was just like a point of contact. Personally, if I was the named nurse of the patient admitted I would make it my job to introduce myself to the relatives and tell them who I am, and maybe show them around the ward and tell them a little bit about the ward, what happens. But also say to them if I am not here please do not think that you have to wait for me to come back – anybody on the ward would be able to answer your questions. It was just a point of contact for relatives and for other members of
D staff really as well.

Q Was it clear that where you were able to build up a relationship with the relatives of the patient that things went better?
A Yes.

Q Because in a sense are you not looking after the relatives as well?
E A Yes, because we used to get some of these patients for months and we used to consider a lot of the relatives; we used to consider it like an extended family really because we got on first name terms and they used to come in on a daily basis or wherever they came in; and we used to get to know them quite well. Even though our remit kept changing so drastically and we were supposed to be getting patients that were going to be able to go home or go to nursing homes, nine times out of ten we ended up with patients for four, five and six months at a time.

F

Q But was it clear that where you were able to build up a relationship with the relatives -
--
A We liked to.

Q ... that the decision-making was easier?
A Yes, because they felt that they were involved in anything that went on.

G

Q Was it also the case that where there was a deterioration in the patient's condition, perhaps where the patient died on the ward, that having a continuing discussion, dialogue with family members made it easier for them
A If you have a relative that is poorly and no matter how long you have been waiting and people keep saying, "She is not going to make it," it is still a shock when that patient passes away, no matter how you have been waiting for it and thinking that it is going to

H

A happen. If you have a relationship with the relatives you can help them through that horrible time

Q What you have said is that in cases that there may have been where a patient died very soon after arriving on the ward ---
A You were not able to do that.

B Q You could not help the relatives or the patients.
A No. You could try but it was not the same.

Q After Code A left was she replaced by a full time doctor who was there Monday to Friday, nine to five?
A Yes, she was.

C Q Did that make it easier for the relatives of the patients nursed and taken care of after that doctor arrived for there to be ongoing discussion between the doctor and the relatives?
A I would not have said easier because Code A was always very good about coming in to see relatives. Obviously it made it easier in the fact that the doctor was always there, but she had her other duties – she could not just drop everything.

Q Indeed, but what the Panel has heard is that in at least a couple of cases there were
D relatives who went to see a patient who never saw a doctor there – they did not ask to see one, it is fair to say, but they never saw one because there clearly was not a doctor there.
A I cannot comment on that because obviously when I wanted a doctor I used to call for them.

Q I understand. But do you agree that if the situation was as it was after Code A had left, that there was a doctor there 9 until 5, five days a week, there would be a doctor there for
E relatives to talk to?
A Yes. If they asked for one there would be one.

Q Can I come back to the terminal stages of patients? If they are in the process of dying, was there occasionally or commonly a restlessness, an agitation in the patients?
A Quite commonly.

F Q Were patients often in pain as well?
A Oh yes.

Q You were asked right at the start of his questions by Code A whether, in your view, patients were ever overdosed with medication.
A Yes.

G Q Your answer was, "That would be rubbish".
A The same as last time, "Rubbish".

Q Why do you say that it was rubbish?
A Because we would not do that. We were there to give the best of care that we could for these patients and we would not overdose them. They would only be given the medication that they required.

H

Q Did you like your job?
A Towards the end, no; I have got to say no.

Q Why was that?
A Am I allowed to say? Because of what was going on with Code A a lot of the time. It made it very difficult when you went out with some of the relatives that were particularly not very happy about things.

Q Can I interrupt? There was a police investigation and a lot of publicity. Is that what you are referring to?
A Yes, it just made things horrible.

Q But before there was any talk of a police investigation?
A Before that I enjoyed my job very much. I used to enjoy going to work.

Q What can you say about the standard of care that you were able to give the patients that you were nursing?
A Excellent because Code A expected nothing but excellent care.

Q Was she a first class sister?
A Yes.

Q What about Code A
A Am I allowed to say? I have been thinking about this. Am I allowed to say what I feel?

Q You should.
A I have the utmost respect for Code A as a doctor and as a person. She gave of her time when she was off duty. We knew if we needed somebody she would be there. She was always available for the relatives whenever the relatives wanted a word. She would always make sure she made time for them. The patients used to refer to her as either, "The tall lady doctor" or, "The nice lady doctor" and the relatives have referred to her like that as well. Whenever she spoke to relatives she was always very honest.

Q Would you be there?
A Yes, there would always be a nursing member there. One of the trained staff would always be there.

Q When you say, "honest", why do you put it in that way?
A Because sometimes people do not want to hear bad news. I have been in with some doctors who have flowered it up and said, "We can do this. We can do that". Code A would say, "This is what is happening. This is what we are going to do. This is what we are going to try". She would always be very honest in what she said to the relatives. She was always very respectful and I have got nothing but good to say about her.

Q If the doctor has not met the relatives before, and the first meeting with the relatives is a meeting where the doctor is giving what may be bad news.
A Yes.

Q How was Code A handling that, from what you saw?

A A She would be very respectful. She would always introduce herself, tell the relatives who she was and then go into a conversation with the relatives about the patient that they wanted to discuss.

Q Because sometimes, if you have not met the other people before like the relatives, it is difficult to judge how they are going to take it.
A Yes. I think I have to say that Code A was quite a good judge of character. She
B knew just how much information they would accept in one conversation, but she was always very good. She was always available to have these conversations with relatives.

Q I understand. Let us come back to the patients. As a nurse you would be involved with giving basic nursing care to the patients you were dealing with.
A Yes.

C Q That would mean you were involved with feeding them, if they needed assistance.
A Yes.

Q Assisting them with toileting.
A Yes.

Q You would be washing them.
D A Yes.

Q Sometimes helping them to sleep or settle for sleep.
A Yes. It was the night staff. Obviously you could not do it just within meeting them the first day, but over a couple of days, over a couple of nights, they would find out how the patient liked to sleep – for instance, they might like to sleep on their side – and they would get the pillows and things right and do everything they could to make sure they were
E comfortable when they went to sleep.

Q You would be changing the sheets, the bed clothes.
A Yes.

Q Was that daily?
A Yes.
F

Q If there were medical conditions that needed nursing care, you would be dealing with that?
A Yes.

Q Pressure sores or bed sores?
A Ulcers we actually call them now. I was actually the wound care link nurse for the
G hospital for a time so that was my interest really.

Q If patients were liable to bed sores or ulcers, would you be making sure that they moved and their position was adjusted?
A They would be assessed when they came in, what they call a Waterlow Score would have been done.

H

Q We have seen the charts. I think we saw with Patient A, who did have some ulcers, you making notes to say that he should be moved, or his position should be adjusted at a certain hourly rate.
A Yes, depending on how thin the patient was. You had to assess the patient as a whole, especially if they were poorly or unable to move very much themselves, which we used to get quite a lot of patients who were not able to move themselves in bed an awful lot. They would be given a special mattress and the nursing staff would go in and assist them to roll over in bed or whatever they wanted to do.

Q Perhaps the answer is obvious, but if you are dealing with a patient in all those various ways – toileting them, changing their sheets, dealing with pressure sores, feeding, giving medication – would you have had a very good impression as to their level of agitation?
A Yes.

Q Their level of pain?
A Yes, you get to know them quite well.

Q How many patients would you be responsible for dealing with at any one time on the ward? Perhaps I put that badly. There were a number of staff on the ward.
A Yes, there were usually five or six of us.

Q If there were 20 or so patients on the ward, would you deal with each of those patients during the day, or would you concentrate on a limited number?
A You would be given a particular number. If I was in charge of the shift, then I would delegate who would do it. As I say the ward was split into two – not literally, but into 10 beds that side and 10 beds this side for the workload. I would say to people, "You do that four beds" and that is how we would do it. So you would do possibly three or four patients a day.

Q That is, each nurse would be concentrating on three or four patients.
A Yes, just for the morning to get them up and washed and dressed and ready.

Q So again, for nurses dealing with specific patients, would they know very well how their patient was coping?
A They would know immediately if there was anything sort of out of the ordinary.

Q Because what we have heard is that when medication was given, there would be two nurses involved in doing that.
A Yes.

Q So the nurses had their own professional obligations so far as patients are concerned.
A Yes. We have got our accountability and duty of care.

Q If your patient or one of the patients you were focusing on, was prescribed medication that you did not think was appropriate, you have already told us that you would speak out.
A Yes. I would speak up.

Q Leaving aside your professional obligations to do so, you would want to.
A Yes.

Q You are in the caring profession after all.
A It even came down to the fact that if I did not really know an awful lot about a drug or medication that one of the patients was taking, I would ask Code A what it was because she was quite happy to tell us. So I would definitely speak up if I thought something was being given inappropriately.

Q We know that Code A would be there in the mornings.
A Yes.

Q On weekdays. She would see patients then.
A She would see them all.

Q Doing the ward round
A Yes.

Q But for the other 23.5 hours in the day, other than the occasional day when there was a ward round by the consultant or some other doctor, is it right that there would not be another doctor dealing with that patient on the ward?
A Yes.

Q So where would Code A get her information from other than her own assessments on a weekday morning?
A The nursing staff would give it. Sometimes the night nurses, if they were still on duty when Code A came, they would actually go round with her and say what the patients had been like during the night. If not, the information given from the night staff to the day staff would be passed on by whoever went round with Code A

Q Let us look at a typical day. What time would you arrive to start a day shift?
A I usually got on to the ward about five past, 10 past seven, but my shift actually started at 7.30.

Q I understand. Would the night staff leave at 7.30?
A No. Their shift was officially supposed to finish at quarter to eight, but the nurse in charge was very often there until 8 o'clock and gone 8 o'clock sometimes.

Q So if there was handover, would that be 15, 20 minutes or more?
A More normally, depending on how many patients we had got obviously. It used to take between 20 and 30 minutes.

Q Tell us when that would start roughly?
A At 7.30. Whoever had been in charge of the night shift would go into our room – we used to have a little room we used to go into and have our handovers – and the person who was in charge of the night staff would come in and give us a report while the other night staff stayed on the ward and made sure that everybody was all right.

Q Code A, I think the Panel have heard, would get to the hospital about 7.30 on a weekday morning.
A Yes. It was usually between 7.30 and 8 o'clock, yes.

Q She would go and do a ward round. There were two wards, Dryad and Daedalus Ward.
A Yes.

Q Would she sometimes be there for handover?
A Sometimes, yes. If she got there early enough she would be there for handover.

Q She would be there for 40 minutes or so?
A Yes, sometimes longer.

Q So if you were full, that would be about two minutes a patient if one were to split the time up.
A Yes, but it did not work out like that because she would stay as long as she was needed, and she would make sure that she spoke to every patient and asked about each one.

Q If there were blood results or urine tests that had been sent off to the laboratory for analysis, would she see the reports in the morning?
A Yes.

Q Would that be part of what she did?
A Yes. She usually used to do a ward round and at the end of the ward round she would look at any results or anything like that. Sometimes, especially if Sister Hamblin was going round with her, she would take them with her.

Q What you have told us is that if there were any new patients admitted to the ward, Dr Barton would come back during her lunch hour.
A She used to just appear. We would ring and say, "Mrs So and So has arrived", and she would say, "I will be there", and she would just appear.

Q She would come in the evenings, I think in her own time.
A Very often, and at weekends as well. If she was on duty, if she was say on-call for her surgery, she used to very often pop into the ward as well.

Q So not part of the time that she was contracted to be there.
A No.

Q She would come back and often relatives may be there.
A Yes.

Q And that was a chance to see them.
A She quite often made appointments in her own time to see relatives, because sometimes that would be the only time it was available for them as well.

Q Would it happen that sometimes the nursing staff would ask for **Code A** to come in and see a relative?
A Yes. It was usually 50-50 really. The relatives would probably say, "Is it possible to speak to the doctor on the ward?" or we would actually offer, "Would you like to speak to doctor?"

A Q Would it sometimes happen – we have seen an example or two in the notes – that Code A said she would like to see the relatives?
A Yes. Then she would give us a little list of times and days that she was available for to try and coincide with the relatives to make sure it was convenient for them.

Q Would it be fair to say that Code A 's understanding of the patient's condition was heavily dependent on the feedback she got from nursing staff?
B A Yes, but she always knew things about the patient because she was always reading notes and things like that, so she would read what other doctors had written about them as well, especially on a morning when she would want to know what had happened during the night, and obviously the day before as well as in the evening shift, if anything relevant had happened then.

Q Was it clear that Code A was eager to know how the patients were doing and
C getting the information that she needed to do her job properly?
A Yes.

Q You have made it clear that it was easy to contact her during the day.
A Yes. We would just ring the surgery.

Q On her mobile phone I think.
D A I think she did give her mobile phone number to me and to Code A , but she did not give it to everybody.

Q I understand. Can I ask about syringe drivers?
A Yes.

Q Had you had training in syringe drivers?
E A When I first started using them, I would not call it formal training. I was shown how it worked. I then had to go and observe on several occasions when they were being set up, and then I had to do some where I actually did it but I had somebody observing to make sure that I did it properly. Then I believe I started an interest in terminal care and things like that so I went on several study days and what have you to do with it.

Q Was that doing that off your own bat?
F A We used to get a list on the ward of what study days were available. I would ask if I could go to the ones that I was interested in.

Q Do you know if all the other nurses on Dryad were given training in the use of syringe drivers, or were there some who found themselves dealing with syringe drivers before they had been trained in the use?
A No, because a syringe driver is something quite important. They would speak up,
G "I have never done this before so I need to know what I am doing". So they would not do it until they had been shown what to do.

Q Is it right that there were only a small number of syringe drivers, three or four?
A Yes. I think by the time I left Dryad, I think we had three and we thought we were really quite lucky because we had had one donated by a relative.

H Q I think they cost a lot of money.

A Then they were about £600 or £700 and are probably even more expensive now.

Q There was a limit on the number of syringe drivers, was there not?
A Yes. As I say, we only had three because one of them had been donated by a relative and the other two were actually provided by the hospital, but we very often used to have to lend them to the other wards.

B Q I understand. Is this right? The picture the Panel should have is that it was unusual for there to be a patient on a syringe driver?
A It was not the norm, no.

Q You did not have enough of them and it was not necessary?
A It was not the fact that there were not enough. It was that they were only used if it was necessary.

C Q Of course. You have told us that there was subcutaneous hydration?
A Yes.

Q I just want to ask whether you think that was in place when Dr Barton was there.
A Yes.

D Q I am going to suggest that it was not there at that stage. It may have been brought in later.
A It was used more after Code A left but we did do it when Code A was there; I am sure we did.

Code A Thank you very much. That is all I ask.

E THE CHAIRMAN: Code A, the witness has been giving evidence this side of the break for one and a half hours. I am wondering whether we should trespass upon her patience very much longer today given that, even if you are short, there is still the matter of the Panel's own questions.

Code A I only have one question, and if the Panel are going to take time to consider their own questions it may be helpful if I put it now, as it were. (To the witness) Then you
F are finished so far as the barristers are concerned at least – if you can bear it.

THE WITNESS: Yes, yes.

Re-examined by Code A

Q You told Code A that you had no formal training?
G A Uh-hum.

Q But really you learned effectively ---
A On the job.

Q On the job?
A Yes. At the time I do not think there was actually formal training.
H

Q I understand that works in terms of setting up the syringe driver itself and how you fill it up and how you insert, is it, via a cannula?
A A needle, yes.

Q Put a needle into the patient?
A A little tiny needle.

Q But who taught you about dosages?
A We had a pharmacist that came in, and we had a lecture from one of the pharmacists, I remember.

Q When was this?
A I honestly cannot remember when it was. The dosages and everything were always on the drug chart and we had to stick to that drug chart.

Q At what? The minimum dose?
A Yes. We always started at the minimum dose.

Q I see.
A Unless we were told otherwise.

Code A Thank you.

Code A (After a short pause) I am sorry – I just wanted to make a note of your last answer. As I indicated earlier, you have been on the stand for some considerable time now – in fact longer than we would normally ask a witness to endure, even when they are in the very best of health.

It is clear that although we have reached the end of the questions from the barristers, there is still the matter of questions from the Panel. Being realistic, we are not going to manage that today. I understand that the matter of staying over has already been canvassed with you.

THE WITNESS: Yes.

Code A That is going to be possible.

THE WITNESS: Yes.

Code A We are most grateful to you for agreeing to that.

THE WITNESS: No problem.

Code A It does make it much easier for all of us. I should, however, remind you that you remain on oath overnight.

THE WITNESS: Yes, I do realise.

Code A That means two particular things. One, you must not discuss this case with anybody at all, even if Code A is here supporting you.

THE WITNESS: I do not have one!

Code A: If you have somebody here. A Code A is it?

THE WITNESS: That is my Code A

Code A You look too young to be her s Code A If you have ---

THE WITNESS: I will stay here as long as you like!

Code A The other point is that this is a case that attracts a certain amount of press publicity. It is very important that you refrain from reading any newspapers that may be reporting on today's proceedings.

THE WITNESS: I can honestly say that I have never read anything in the newspapers, or watched the television. I will not do it. That is even from the start, when it all started.

Code A Excellent, because I was going to ask you not to do so, but that is clearly not going to be a hardship for you.

THE WITNESS: No. It is not going to be a problem for me.

Code A Very well. The next thing I need to do is to see whether we can give you a little lie-in tomorrow. That will depend on how long the Panel feel they would need before we would be ready for you. I am very quickly going to take some soundings from the other members of the Panel. (The Chairman conferred with members of the Panel) The general consensus seems to be that ten o'clock would work well for us, so that would mean we would be hoping to start at ten. Could you please be in the building a little bit before, but we will not ask you to be here as early as no doubt you were this morning.

THE WITNESS: It was only about nine o'clock this morning.

Code A Of course, the same remains for everybody else. The Panel will be in effect in camera first thing tomorrow morning, but we aim at 10 o'clock to resume for business. Thank you very much, ladies and gentlemen until ten tomorrow, then.

(The Panel adjourned until Tuesday, 23 June 2009 at 9.30 a.m.
and parties were released until 10.00 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 23 June 2009

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

Chairman:

Panel Members:

Legal Assessor:

Code A

CASE OF:

Code A

(DAY ELEVEN)

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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Code A, continued

Code A: Welcome back, everyone. I am sorry that the Panel needed a few minutes longer than we had anticipated to prepare, and we are now in a position to put our questions to Code A.
(To the witness) Code A, did you have a comfortable night?
A Unfortunately, no, my back is rather painful this morning.

Q If at any stage you either feel the need to stand up and walk around or to take a break, just indicate and we can stop there and come back to it. This is your time and we will do it at your pace.
A Thank you.

Q As you know the position now is that you will be having questions from individual members of the Panel. When we have all finished, the final thing is that there is an opportunity for each of the legal teams to ask any questions that might have arisen out of questions that we have asked you; then that should be it.
A OK.

Code A: I am going to start by turning to Code A who is a lay member of the Panel.

Questioned by THE PANEL

Code A: Good morning to you.
A Good morning.

Q I have a number of questions but I shall try to keep it as short as I possibly can. Did I hear that you started nursing back in 1972?
A I started my training in 1969 and got my qualifications in 1972.

Q That was at Hull?
A Yes.

Q Are you a Hull person?
A Yes.

Q You may be the only person in this room that knows my dialect well enough.
A I did recognise it.

Q You worked with Code A at the Redcliff ---
A Redcliff annex.

Q Back in 19--?
A I think Code A started in 1988.

Q But you were already there?
A I was already there, yes.

A Q We have heard about prescriptions that Code A has written, with quite a wide-ish range between, say, for instance, diamorphine 20 mg to 200 mg.
A Yes.

Q Were those prescriptions being done similar at Redcliff?
A Yes.

B Q When she first came to Redcliff?
A Yes.

Q Has there ever been any question about that particular type of prescribing, in such a wide range?
A No, because ---

C Q Not even then?
A No, because the other doctors were doing it as well.

Q The other doctors were doing it?
A Yes.

Q Were the other doctors already doing it before Code A came to the hospital?
D

Q I believe one of the consultants used to do it. I have got to be honest – I cannot say definitely, but I believe one of the consultants used to do it.

Q Do you know the name of the consultant?
A No. We had several while I was there.

E Q Did anyone else ever question the prescriptions?
A Not that I am aware, no.

Q When you were on the ward back into the 1990s, which we are interested in, did anyone else ever question the prescription?
A No.

F Q You never did?
A I never did, no.

Q You told us that there had been occasions when you used opiates not for pain but for agitation.
A I only ever used it once that I can remember.

G Q But you did say – I am sure you said that you had used it, but only under the doctor's instructions.
A Only under the doctor's instructions. We were not allowed to use any medications on our own back; it had to be under doctor's instructions.

Q That is fine. Can you just help me – and this has nothing to do with the questions that I have already put forward, but I am struggling with this and you may be able to help me.
H Could you turn to bundle F. Do you have that?

A A Yes.

Q Page 368B, which is the drugs chart – do you have that?
A Yes.

Q I shall also be asking you about 368E, so can you keep a finger in that. I am having difficulty reading this, and because you are the professional you will be able to read this a lot
B easier than I can, and it may be able to help me.
A Yes.

Q If I ask you the questions, you may be able to help. Can you tell me, for the Oramorph, it says 18/8/98.
A Yes.

C Q At a quarter past two, 5 mg are administered – is that right?
A Yes.

Q So the one below it, could you tell me what that one is?
A The one below it?

Q Yes, 19 ---
D A 19th of the 8th '98 – it looks like 12.15 in the morning, 10 mg in 5 mls.

Q Is that 12.15 in the morning?
A 12.15 – it is 0.15.

Q I am with you now, yes. Then below that again?
A 19th of the 9th '98 at 11.50 in the morning, 10 mg.
E

Q Right. So if you then turn the page – this is done differently. The date is at the top now, is it?
A Yes, the dates go along the top, because it goes *that* way for one, and *down* for the other.

Q I see. So at four o'clock ---
F A Sorry?

Q On the 19th it is four o'clock just below that, 16.00 hours?
A Yes.

Q Can you tell me what that word says at the time of it, because I do not understand that.
A "Destroyed".
G

Q What does that mean?
A It means that that dose that was put up at four o'clock in the afternoon was destroyed, and a further dose was put up instead – because there would have been – it looks as though there has been some change in either the constituents of the driver or the dosages.

Q So this patient did not get the 20 mg at four o'clock, then?
H

A A It does not look like – it does not look as though she had all that dose. That dose was destroyed, and another dose was put up. Well, that is what that indicates to me. Hang on a minute.

Q I just do not understand it.
A It is not my signature. I think the dose at 09.15 looks as though it was destroyed.

B Q What has been confusing me, the 19 and 20 and 21 are the dates across the top, are they not?
A Yes.

Q So on the 19th the patient got the 20 mg, but on the 20th they did not – it was destroyed?
A I think what has happened, I can only say, you know, looking at this, I think what has
C happened is that the dose was given on the – oh, I honestly do not know – on the 19th, possibly, at 9.15, and then that dose was destroyed because it was changed – the dosage was changed.

Q I think that is as far as we can take it, to be honest. I think we are both of us relatively in the dark.
A Yes.
D

Q You see, the reason I am asking that is because it seems to me that the patient got Oramorph on that day also, the 19th – got 10 and then 10 mg, and then a further 20 mg of diamorphine, and 20 mg of midazolam.
A Midazolam.

Q All on the 19th.
E A Mmmm.

Q And they would be given by syringe driver?
A No, the Oramorph is an oral solution, which is only sort of short-acting; the midazolam and the diamorphine are to work over 20 hours.

Q But if you turn to 373, which is the Barthel score of 9, this lady has one of the better
F scores of 2.
A Yes.

Q She is able to take things; and I thought syringe drivers were only used when ---
A I cannot comment on why it was done; I was not there.

Q Fine; thank you very much. Can I turn to Patient K with you, please, and may I ask
G you to turn to page 223. Are you with me?
A Yes.

Q As you can see, it says "Summary of significant events".
A Yes.

Q On the 11th, which is approximately half-way down the page, there is talk of a home
H visit by this lady. Is that the 1st? Sorry, look for the 1st of the 11th.

A A Yes, 1st of the 11th.

Q It says "Code A commenced 5 mg", or something, and then it says "For home visit to see son". Can you see that?
A Yes.

Q On the 3rd they are still talking about this home visit.
B A Mm-hmm.

Q Which tells me that the patient around that time was reasonably active, and ---
A She was able to move around. She was quite unsteady on her feet, but she was able to move around.

Q Then on the 19th you see "Marked deterioration over last 24 hours", and then it is
C "Extremely aggressive".
A Yes.

Q I think that is the thing when she knocked your glasses over, and ---
A Yes, I had a black eye.

Q It says "2 staff".
D A Yes.

Q There were three of us at one point, but then most of us sort of backed away to try and calm her down, and then after we managed to get her sitting down in a chair, two of the staff sat with her for all the morning, actually, to try and – you know, just talking to her, and ...

Q Can I just ask, what time did that happen?
E A That was about – I came on duty about five past, ten past seven, and it was going on at the time, when I walked in.

Q Right. So 7.30 by the time ---
A Yes.

Q Then it says the syringe driver was commenced at 9.25.
F A Mm-hmm.

Q With a diamorphine of 40 mg. I have looked through this note and I see no mention of pain. It does not mention it on the 1st, it does not mention it on the 3rd, on the 15th – I do not think it says it, but it is difficult to read. But on the 19th there is no mention of pain, and I am just wondering if this was one of the patients that you used the opiates for, because she was agitated as opposed to being in pain.
G A I cannot – I have got to say I do not know why the syringe driver was commenced.

Q I know it is not your handwriting, but you were part and parcel of this ---
A Yes.

Q --- because you were helping to ---
A I was around, yes.
H

A Q --- restore some sort of order, and getting a black eye for your trouble. I accept that. Do you know why she was started on a syringe driver?
A No.

Q But she obviously was.
A She obviously was, but I cannot say why.

B Q Right. I have looked again through this, and there is no mention of any hydration or rehydration, was there, since the syringe driver started; but you told us that was something that was done regularly.
A It was done, for most of the patients that we had on syringe drivers, but I have got to say not all of them, because sometimes we were able to get them to take it orally.

Q That is a question I have already asked; this lady was on a syringe driver, but there is
C nothing about hydration.
A Again I cannot comment, because I cannot remember whether she was or she was not.

Q Right. I think this is my final question. I think you said that you did rehydrate when Dr Barton was there, but you did it more after she had left. Why was that?
A I do not – I honestly do not – I honestly do not know. I think it was probably because the doctors that we had that were on duty there then were from the acute sort of side, and it
D was their – that was the first thing that happened, basically.

Q I am sorry, I do not understand that.
A On the acute side they can actually rehydrate either subcutaneously or I/V, intravenous therapy, and that is what we used to do. What we used to do, the subcutaneous rehydration, a lot more after Code A left. I do not know why; I do not know why.

E Q But surely, with the greatest respect, surely if you are commencing someone on a syringe driver, surely the need to be hydrated for this is the same back when previously ---
A Yes, I appreciate that, I appreciate that; but it seems to me that we did it more. Maybe it was just my way of – just my memory – I do not know.

Q A different policy, perhaps?
A Quite possibly. I do not know.

F

Code A Just bear with me for a second. Thank you very much indeed.

Code A is also a lay member of the Panel.

Code A: Can I take you to Patient K, and this is page 157. At the top there we see a note from a Code A?
G A Yes.

Q And I think Code A had asked him to come in ---
A Yes.

Q --- because of deterioration in this patient. I see here she is refusing medication, and not eating very well.
H A She was not eating very well when she came in, if I remember rightly.

A

Q So that continued all the time that she was there. Then you have this bout of refusing medication.
A Mm-hmm.

Q That must make it incredibly difficult to manage the care of the patient, when they are refusing medication, and ---
B A Obviously if they are consistently refusing medication, then obviously, especially if it is medication that is meant to keep them sort of calm and on an even keel, then it can get quite difficult, because their behaviour then gets quite difficult. But we do, you know, sort of try our best to get them to take it.

Q And also in terms of the eating.
A When you nurse elderly patients and you have sort of nursed them for quite some
C time, you can – how can I ---? – you gain strategies on how to get them to eat and drink. Obviously there are patients that you just – you know, you just have to let them sort of do what they want, basically maybe leave a sandwich or something around, so they can just go and pick it up. So some patients are difficult to get them to eat and drink, yes.

Q When we move down to the next paragraph, these are the notes by Code A ,
"Marked deterioration overnight" I wonder what type of deterioration that might have been?
D It goes on about confused and aggressive?
A I can only assume, as I say. I was not there. I can only assume that she would have become more confused overnight, especially if she was not taking her medication.

Q How often does that lead to the syringe driver starting to be used?
A Not on a very regular basis, no. As I have said before, syringe drivers are not only used for giving diamorphine; they can be used for other things as well. If it gets to the fact
E where a patient is refusing to make medication and it is vetting to the point where you cannot nurse that patient properly, then maybe your syringe driver would have been considered to give her her ordinary medication.

Q That might be an explanation for moving to the syringe driver in this case, although we have not seen any indication of pain.
A No.
F

Q If we move on just a little bit further down on that page:

"I am happy for nursing staff to confirm death."

What did that communicate to you?
A Actually, nursing staff were not allowed to confirm death. We could only verify that
G a patient had died. It was up to the medical staff to confirm, but it would just say to us that if anything did happen during the night or when Code A was not available during the day and unfortunately a patient passed away, that two trained members of staff were able to verify that the patient had passed away. Then we would not have to wait around for a doctor to come, and it would be less distressing for the family really.

Q We have heard frequently that the ward was involved in palliative care?
H A Yes.

Q And end of life care?
A Yes.

Q This sort of comment being made at this juncture with this patient, how much would that link together with the end of life in the minds of people? Is it that you have now moved into the terminal stage at this time?
A If there had been a fairly marked deterioration quickly then yes, we maybe would start to think that this was the slope down towards end of life.

Q Might that go some way to explaining as well why we are not finding any notes in here about hydration, fluid subcutaneous, or fluid intake et cetera?
A Yes. Maybe so.

Q So you think that this could be meaning ---
A That would indicate to me that she was then very poorly at that stage.

Q Although we had on the day before the fact that her physical condition was stable?
A As I said yesterday, we used to get quite a mix of patients. We used to get some patients that stayed with us for a long, long time and the decline was gradual, but we also used to get patients that were with us for a fairly short time. One day they would be up and walking around, and the next day they would be almost moribund really. That did happen.

Q What concern was there for the nursing staff, that sometimes medication may have contributed to that?
A I am sorry? I did not hear.

Q What concerns were there for the nursing staff that at times just the type of medication might have contributed to that deterioration?
A If the staff had any concerns about medication, they would have said something to Code A Code A or whoever was there really.

Q Were you aware of that occurring very often, or at all?
A I cannot ever... I certainly was not. Nobody spoke to me about it, but then again I was only a staff nurse. I presume that if anything was really troubling them they would have either taken it to Code A and it would have been probably a private matter; they would have asked for a private conversation.

Q When you get a statement like this, "marked deterioration overnight", what would be the questions that would be asked in relationship to that by the nursing staff?
A I would read this to see what had gone on previously, whether any of her medications had been changed, her general health, her health conditions, her problems. Those are the sort of things that I would look at to see if anything had changed in that way.

Q Because there had been a change because she had had the fentanyl patch?
A Yes, yes.

Code A I will probably leave that for a colleague to explore further with you. Thank you.

A Code A Thank you, Code A We are now turning to Code A who is a medical member of the Panel.

Code A I am going to stick with Patient K as well, if you have her notes to refer to one or two things. I am going to refer to bundle 1. It is in your bookcase. It has a big number "1" on it, and we will refer to that later.

A Thank you.

B

Q This is Code A who came from the QA. She had had some problems with confusion – confused at times, and on a drug called thioridazine to try and help that, damp her down, as it were. On a ward like Dryad would such patients be unusual?

A No. No. We had a lot of patients with confusion and dementia. The vast majority of the patients were like that.

C

Q It would be right to say that such patients, when they were agitated or confused, tended to improve as they got to know the staff better?

A On the whole, yes.

Q Would you say that perhaps part of the skill of being a nurse in a ward like that was dealing with these patients?

A Oh yes, yes.

D

Q With a conservative approach, talking with them?

A Yes.

Q Sitting with them?

A Yes.

E

Q Getting to know them?

A Yes.

Q And this lady had been admitted. Code A had written on her admission note: "Plan: get to know"?

A Yes.

F

Q And I think there was a consensus both from the QA and, indeed, Code A, that she would go on to a nursing home. This was a stepping stone ---

A Yes.

Q --- to going on to a nursing home. There came a day – 18 November is the first that we get a glimpse of it, and that is when Code A has written in the notes – when Code A was asked to come and see her, presumably because she was becoming more restless, as Code A

G

Code A said. That is on page 157 of those notes. She is refusing her medication. Then I think it is Code A again on page 407 – I am not sure about that; I think it is her writing. There is a note on page 407, and it is the bottom one there, the 18th. It is the second one.

A Uh-huh.

Q And in the middle of that it says:

H

"Reviewed on ward – happy, no complaints, waiting for Code A ...".

Putting the pieces together, it would appear from the prescriptions... The prescriptions are on 279. It is worth turning that up because we are going to look a little bit at the prescriptions and 279 has different pages, A, B and C. We know, because it is admitted in the charges, that a fentanyl patch was put on on the 18th.
A Uh-huh.

Q And corroboration of that is that it was taken off on the 19th?
A Yes.

Q Then we come to the day that you remembered when she was really aggressive and fighting?
A Yes.

Q That may seem unusual to the lay members of this Panel, but would you agree that that is not a terribly unusual situation?
A No. It happened quite frequently – not with just this patient but with --

Q In that kind of a ward, with demented patients?
A A lot of the patients, yes.

Q And it can happen for no reason at all?
A Oh yes.

Q And sometimes for reasons like a urinary infection?
A Yes.

Q How would you normally manage such a patient, because it is quite a common thing?
A Initially we would try and just try and calm them down by talking to them, trying to get them to relax; trying to get them to sit down – anything that you could do just to take the edge off the aggression. But if we could not, then obviously we would seek the doctor's help.

Q But you were mauled, like Albert in the lion's cage?
A It was quite embarrassing actually. As you see, I am quite a large lady; I always have been. Code A was quite tiny really.

Q A little lady.
A It was quite embarrassing.

Q They can muster enormous strength?
A Oh yes. The thing that was worrying me was because she had got hold of my colleague's wrists, and my colleague was a very thin, delicate little thing and she was really trying to hurt her by pushing her against the wall-bar. Code A was intent on hurting her.

Q And for that reason, really, an uncontrollable situation?
A She just would not take any notice of anybody. She was focused on trying to hurt somebody.

Q It is a bit desperate really?
A Yes.

Q She was given chlorpromazine?
A Yes.

Q Can you just describe to the Panel what you would expect that to do?
A We would have expected it to work fairly quickly. In my experience it is a drug that works fairly quickly, but with Code A it did take quite a few minutes longer than we would have expected.

Q Then she was started on a pump?
A Uh-hum.

Q With diamorphine and midazolam?
A Yes.

Q And she became peaceful?
A It did take a while. Before we actually could get her to her bed to get her laid down and comfortable, and get her changed and freshened up, it was round about lunch time before we actually managed to do that.

Q But by night time, she was peaceful?
A I presume so because I was not there. I had left the ward by then.

Q And the prescription shows us that Oramorph was prescribed by Code A on page 279B, but in fact none was given?
A No.

Q If you look at that bundle 1 and look behind tab 3, look for page 5 in the bottom corner this is the BNF. This is the Bible, yes?
A Oh yes.

Q This is what you turn to when you want to use a drug?
A Uh-hum.

Q And the table at the bottom is telling us what equivalents are – equivalent doses. On the left hand side it is oral morphine?
A Uh-hum.

Q And on the right hand side it is diamorphine and on the far right it is diamorphine by subcutaneous infusion?
A Uh-hum.

Q We had that little discussion about whether co-codamol was first or second on the ladder?
A Yes.

Q I think we all agreed in the end that opiates are third on the ladder?
A Yes.

A Q And in general Oramorph would be third on the ladder, and subcutaneous would be fourth on the ladder?
A Yes.

Q You would go up that way?
A Yes.

B Q So Code A was not on Oramorph and if we take this table, the smallest dose shown there on the top right hand of that column is 15 mg every four hours?
A Uh-hum.

Q That looks to me like, if you like, a starting dose, but it might be – it might be – further that that is for a patient who is on Oramorph. But 15 mg in 24 hours is a figure just to keep in the back of the mind?
C A Uh-hum.

Q Yes?
A Yes.

Q If you go to page 11 at the bottom right-hand corner, it is the BNF telling us about diamorphine.
D A Uh-huh.

Q It says, "Indications", then "Cautions" and then it says:

"Dose: acute pain, by subcutaneous ... injection, 5 mg ... every 4 hours".

A Yes.
E

Q Indeed, it says up to 10 for heavier well-muscled people.
A Yes.

Q So 5 mg every 4 hours in a syringe driver for 24 hours is 30 mg.
A Uh-hum.

F Q That is for acute pain. Then further down, for chronic pain, 5010 mg every 4 hours but again the starter dose is 5. That is 30 mg in a day?
A Yes.

Q Okay?
A Yes.

G Q So that is another figure to keep in mind – 30. But if you turn now to page 6, it tell us that when you have somebody elderly, you reduce the dose by a half to a third. Let us be generous. Let us say a half.
A Uh-hum.

Q Half of 30 is 15 again?
A Yes.
H

A Q In 24 hours. Yes?
A Yes.

Q But you have described Code A as a little lady?
A Little but stocky.

Q No. You said a "little lady"?
B A Yes. She was little. She was only short.

Q Okay. You have said in quite florid terms really, I think, "We did not overdose patients. That is rubbish. That is rubbish."
A Uh-huh.

C Q Let us just think about the drugs. Let us go back a moment. Fentanyl. I will not take you to the BNF but I will quote form it. Fentanyl was given the day before, I understand. Side effects: its side effects are mood change, hallucinations and dysphoria. I looked up "dysphoria" in the dictionary, because I have never heard that word before, and it said: "A state of unease or mental discomfort". Does that ring bells?
A It does now.

D Q It does now? Strictly speaking, it is not for us to conjecture, but perhaps that lady's acute confusion was made worse by the fentanyl?
A Perhaps.

Q Perhaps not. Perhaps she would have got worse anyway. But the prescription which is on page 281 was 40 mgs to 80 mgs of diamorphine, and the first dose given was 40 mgs. That dose was given at 9.25 am on the 19th, the aggressive day?
A Yes.
E

Q The chlorpromazine was given at 8.30, three quarters of an hour earlier, the fentanyl patch was put on the day before. Fentanyl patches are applied how often?
A Every three days, every 72 hours.

Q So 24 hours after a patch is put on, the patch is running pretty well?
A Yes.
F

Q In this little lady, we have fentanyl, an opiate, motoring, we have chlorpromazine in a pretty steady dose. I think it would be reasonable to say, I am not sure whether you would agree with this, that if you had a big bloke and you gave him chlorpromazine, you would probably give him 100?
A Yes.

G Q Now she gets diamorphine started at a dose which, I might be convinced by the BNF, should have been at least half of that dose. But midazolam is with it and midazolam is prescribed at 20 mgs to 80 mgs, but the starting dose is, what, 40?
A Forty.

Q So I have an opiate, fentanyl; we have a tranquiliser and chlorpromazine is in the group known as a major tranquiliser; we have a very large dose of diamorphine; and then we
H have midazolam. What does midazolam do?

A A It is another sedative.

Q It is a sedative, and if you take it on one dose further, a bigger dose, what is its effect, sedative into – sedative makes you feel?
A Relaxed.

Q Relaxed, and a bigger dose would?
B A Put you unconscious.

Q Make you sleep.
A Make you very sleepy.

Q A bigger dose would?
A It would probably kill you.
C

Q It would shut you down.
A Yes.

Q So the next note is that she had a peaceful night. The syringe driver is changed the next day and the same dose of diamorphine is going in.
A Yes.
D

Q The fentanyl patch must still be active?
A The fentanyl patch had been taken off.

Q But it lasts three days. All right, a fentanyl patch is on for – if you leave it on it lasts three days. If you take it off after 24 hours, say 24 hours for the sake of argument, is it not true that you have a drug inside you which is not very short acting?
E A Yes.

Q Two things. "We did not overdose, that is rubbish". We just gone through a series of facts and cross references. Do you think in this case it is possible that you did overdose?
A Possible.

Q You also said that you would never increase or reduce the dose – in brackets – of a
F syringe driver?
A Yes.

Q You would never take that initiative, you would cross reference with the doctor, a doctor?
A Yes.

G Q But it was not changed and the patient was peaceful and died 48 hours after it was started. This is a patient who was transferred to get to know, to move on to a nursing home but who had an acute confusional episode. Would it be too much to suggest that this poor lady was not given a chance to show whether she would improve and go to a nursing home?
A No.

Q That would be a reasonable thing to say, would it not?
H A Yes.

Code A: Would it be unreasonable to say that her death might have been caused by this cocktail of powerful drugs?

Code A May I just intervene at this particular point. The questioning has slowly moved on and it is right, Code A, that this nurse was involved heavily in the care of patients. You may think it appropriate that she should be given a warning in respect of self incrimination. That would arise if the situation were that a reply given by a witness might form information or evidence on the basis of which the prosecution might wish to establish guilt or decide to prosecute. The terms of the warning would be for the court to warn the witness that they need not respond if the answer might clearly tend to incriminate her. Of course it is a matter of judgment, it is a matter of difficulty, but the Panel may think that the line of questioning is beginning, at least, to move into that area. That is my advice to the Panel.

Code A: Thank you, Code A. (To the witness) Did you understand what the Code A just said to the Panel by way of advice?

A Not really, no.

Code A He was indicating to us that some of the questions that have just been asked could, in certain circumstances, lead you into giving answers that potentially could have you not as a witness in a case but as a defendant in a case. What I want to say to you, first, is that I think the Panel have heard it from other witnesses as well as from yourself that the decisions in this case were not made by yourself, the prescriptions were not made by you. What the doctor is seeking to do is to understand the situation at that time with this particular patient and, as the Legal Assessor has pointed out, it is absolutely right that you were involved in the care of that patient. I am sure that it was not for a moment in the doctor's mind that you should be feeling at all, personally, under attack.

A I said, looking at this, all this, I was actually on the ward when all this was going on and the setting up of the medications thing I had no say-so anyway.

Code A Absolutely. Your evidence is extremely helpful in enabling us all these years later to get a clear picture and understanding of what happened, but the Code A has made the point, and out of an abundance of caution and in total fairness to you I think I should act on that advice and simply say to you – and it is called a warning – that you do not have to answer any of these sorts of questions if you feel that they might incriminate you or put you potentially in a position where you could be in trouble. That is the point. Is that clear to you?

A It is now, yes.

Code A Are both legal teams happy with the explanations given?

Code A: Yes, thank you.

Code A Thank you.

Code A It is a matter for you now, but you can at any stage say, "No, I am not going to answer that question" and that is the end of that question. We will go back to the doctor. Thank you, Legal Assessor.

A Code A Do you want to answer that question?
A I cannot remember what the question was.

Q The question was that, having discussed these dosages, their combination, whether it is possible in hindsight to conclude that, maybe, these drugs – shall we put it this way – hastened this lady's death, if not caused it?
A I would rather not answer that.

B

Q That is fine. You said you would not... Sorry, do you want time?
A No, I am fine.

Q I am sorry, it is distressing. As the Code A said, we are trying to understand a whole situation.
A I do realise that. I am okay.

C

Q You said you had never, or hardly ever, questioned a doctor or Code A about dosages. You also described another patient as having shallow breathing and how it was that you would assess a patient's condition by looking at their colour. Patients, as we have heard, on syringe drivers with diamorphine and midazolam, became peaceful, their breathing became laboured, I do not think we have specifically heard about colour change. If that happened, would you question the doctor and say, "Perhaps these drugs are too powerful at
D this dose"?
A Again, I would rather not answer that.

Q Were you Code A 's named nurse?
A I cannot remember, I honestly cannot remember whether I was, I do not think I was.

Q Do not worry about that. I can take this in a generalisation. We have heard, and I am
E not sure whether you were asked about this, a named nurse is the one who looks after that patient?
A Their point of contact, yes.

Q As somebody said, is the patient's champion?
A Could be. I just used to say it was the point of contact on the ward.

F Q Could you not expect the patient's champion perhaps to say, "I think this patient is dying", or "This patient is over sedated", for who else is to say it?
A Yes.

Q Except a relative?
A Yes.

G Q What would you do if a relative said, "I think my Dad is dying, "I think my Mum is dying, I think it is the drugs"?
A Then I would refer them to the doctor.

Q Would you think about in the first place ---
A I would probably go and have a look at the chart and see what was going on in the medicine chart. If I felt anything was – if I needed to speak to the doctor about anything
H myself, then I would do so.

Q Another nurse witness has said to us that in his experience the doses were never reduced once the syringe drivers were started?
A Yes.

Q Would that be your experience?
A Once I have known it reduced.

Q I would like to ask you this question because we have asked it of two previous nurse witnesses. How would you know when the pain has gone if the patient is unconscious?
A Because even when a patient is unconscious or unable to respond, if they are still in pain, when they are moved they indicate that they are not comfortable. They grimace, they tense up, so that indicates to us that there is still some pain there.

Q Is that the only reason a patient would grimace or tense up?
A No, I suppose not, but if I was turning a patient, I would look to sort of assess whether they were comfortable when they were being moved or whether they did indicate that they did not want to be moved.

Q I am struggling with this concept that, for instance, in a patient who has had acute pain, say he had a fall and hurt themselves, and you start them on a major analgesic treatment – I nearly said pathway, it seems to us that it is a pathway that goes straight ahead – but for acute pain, as a physician, I would say you treat the pain and see what happens. Is that not the principle?
A We try and treat the pain.

Q Does it not appear when you think you about it in these terms, can it not appear to you that sometimes you are not giving the patient the chance to show whether they are in pain or not if they just go unconscious and they never wake up?
A We do not intentionally make them unconscious, you know, we try to give them the best care that we can and manage the care as best we can.

Q One other question. If we go back to the beginning of this, there is no indication anywhere, I think you agreed, that this patient was in pain?
A Looking in the notes I cannot see it written down anywhere no.

Q **Code A** said she is happy.
A Yes.

Q So she was given opiates for her aggression?
A On that day she was aggressive, yes.

Q The opiates were continued in large dose, indication aggression. That would be the conclusion, would it not, from reading the notes?
A From reading the notes.

Q You cannot help us on that any more than the notes.
A No.

Code A Thank you very much.

A

Code A, you have been answering questions for over an hour now. As I mentioned to you yesterday, an hour is usually about the time that we think witnesses in the best of health probably deserve a break. The position we are at now, is that you have had questions from three members of the Panel. There is still Code A and myself to go. Would you welcome a break at this stage?

A No, I am okay to carry on in if everybody else wants to.

B

Code A We will be happy to continue, but if at any stage that answer changes, just say so and we will take the break. It is very important that you do not feel unduly stressed or pressured at a time when, inevitably, some of the questions are going to be tough for any witness to deal with. I will pass you to Code A and she is a lay member of the Panel.

C

Code A: Good morning. I just have a couple of questions. My questions relate back to Patient K, but this is a general question. We have seen from your description of the aggressive incident ---

A Mm-hmm.

Q --- that Patient K – you said she was extremely aggressive.

A Mm-hmm.

D

Q And she was quite strong and quite determined.

A Mm-hmm.

Q We have seen from the *BNF* the guidance on prescribing for elderly patients. What I am trying to understand is, the fact that she was extremely aggressive, whether that would have an impact on the dosage she received. What I am driving at, could it have been

E

appropriate to prescribe outside the guidance because of her aggressive behaviour?

A I cannot really answer that, because I would not know what was in Code A's mind at the time when she prescribed that amount.

Q Just talking now generally, from your experience, not specifically Patient K, but in a very aggressive patient who is elderly, is frail, but is very aggressive, so it stronger than they normally would be ---

F

A Mm-hmm.

Q --- would there ever be a justification, based on your experience, for prescribing outside of the guidance? Does that make sense?

A It makes sense, but I have never known it happen. Not that I can remember, anyway. I honestly cannot remember that far back.

G

Q If the patient is aggressive would that have an impact on how much they could endure in terms of the dosage, in your experience?

A I would say yes, because I am not just sort of nursing elderly patients. I have nursed, you know, patients like us that have got aggressive, and it does take more to calm them down.

Q So you would need to use more?

A You know, in aggressive patients you may have to. I have not seen it, you know, used

H

commonly.

Q But it could ---
A I presume it could, yes.

Q --- be a justification?
A I presume it could, yes.

Q So in those circumstances it could be appropriate to prescribe outside the guidance, in your opinion?
A Possibly, yes.

Q Just turning to page 223, I wonder if you could help with a note, on 19 November, where you describe – where it talks about the incident.
A Mm-hmm.

Q Have you got that?
A Yes.

Q Just at the very last line it says: "... taken 2 staff to special ...", and I just wondered what that meant.
A When nursing staff say that they are specialling a patient, it means that it is usually on a one-to-one basis – you have one patient to one staff, and they are responsible for that patient for the entire shift that they are there, ensuring that when they go on breaks and things, that somebody comes and takes over from them. In this case it was two members of staff that sat with Code A trying to sort of talk to her and calm her down.

Q And those two members of staff would have been with her throughout?
A They stayed with her for the rest of the morning. I think one of them was – I honestly cannot remember – but I think one of them was still with her when I actually left the ward some hours later to go off duty.

Code A Thank you.

Code A It is just me left. Are you still ready to go on?
A Yes, I am fine, thank you.

Q My role is largely trying to sweep up any bits of pieces and deal with loose ends, so there are a few things I need to ask you. First of all, dealing with opiates, and the effect – and I am asking you and will try always to ask you questions as a nurse, and not as a doctor.
A Mm-hmm.

Q I appreciate that for a lay person sometimes we can invest more knowledge in you than it is fair to expect of you, and if it is outside your remit just say so.
A OK.

Q But with your experience over the years, it must be quite considerable in the administration of opiates, and the question that I wanted to ask you concerns the business of the half-life in particular of hypnotics.
A OK.

A Q The effect as a pain reliever may be quite short-lived, but is it right that many of the hypnotics such as diamorphine have long half-lives, which give serious hangover effects such as drowsiness, unsteady gait, slurred speech and confusion?
A I think – I honestly do not know what the half-life is. I know they do stay in the system a little while.

Q Yes. But in your experience have you noticed ---
B A Oh, yes.

Q --- long after the pain-relieving effect has gone ---
A Yes.

Q --- there will still be what the *BNF* calls the hangover ---
A The patients sometimes say that they sometimes feel a bit woozy.
C

Q It takes time for that part to clear.
A Yes.

Q If you have ever been a patient having those sorts of drug yourself, you probably know.
A I am afraid I have not, no.
D

Q I am pleased to hear it, from your point of view. You also mentioned, first of all, so far as syringe drivers are concerned, you told us that of course syringe drivers are not only used for the purposes that we tend to be seeing them here, with the cocktail of opiates.
A Mm-hmm.

Q We do I think understand that; it is evidence that we have heard elsewhere as well; it
E is just that here it tends to be that particular mixture.
A Mm-hmm.

Q You mentioned that there was a time that you saw with a syringe driver where a dosage was lowered.
A Mm-hmm.

F Q Was that where the syringe driver had been loaded with a mix of opiates, or was it something else?
A I think it had got diamorphine in, but – can I just take a couple of minutes?

Q Yes, of course.
A I remember being on the ward round with Code A, I think it was, and we came to one of our poorly patients in one of the side wards, and he actually decreased the amount of
G diamorphine that was in it, I believe; yes.

Q That stirs a recollection in my mind, as well, when one of the consultants ---

Code A There will be evidence on that.

Code A I am told we are going to hear evidence on that, so I will not trouble you
H for further detail. You told us that "we don't intentionally make patients unconscious when

A we give them this mix of opiates and put them on the driver", but you accept, do you, that it is pretty much an inevitable consequence of continued time on the driver with that sort of combination of opiates, that ---
A On a continued basis, yes.

Q In fact we have been given evidence by a ward manager that once patients start on that sort of regime, that sort of mix, on the syringe driver, that really is a clear indication that
B they are now in the terminal stages?
A Yes, I would agree.

Q We have heard a great deal about hydration in those circumstances, and prior to today I had understood that at the times in question, the potential for rehydration, or hydration, intravenously was just was not there.
A Not, intravenously, no.
C

Q No. So once the patient had started on the syringe driver, there was going to be no prospect of getting hydration into them.
A Not I/V, no.

Q Is that another reason why it clearly was an end-stage process?
A Yes.
D

Q Thank you; that is very helpful. You told us that there were a very large number of patients – I think at one stage today you may even have said it was the majority – who were elderly and dementing.
A Mm-hmm.

Q Is it fair to say that for patients such as those, Dryad Ward was likely to be the end
E place for them?
A Yes.

Q Where they would ultimately expire with you?
A Yes.

Q Is it right that those patients typically, the final day or days would be eased with the
F syringe driver process?
A They did not – not all our patients died with syringe drivers, no.

Q No; but it was a common stratagem to use at the end of life where a patient was in pain and having difficulty swallowing?
A If it was appropriate, then yes, the driver would be used; but only if appropriate.

G Q You say only if appropriate, but I think it is right, is it not, that you have conceded that at least in the case of Patient K there does not appear to be any of the normal justifications for it. I accept that although you were involved, you are a nurse, you are not a doctor, you were not making all the decisions, and indeed you were not privy to the detail of some of the decision making, so you would not necessarily know; but as you candidly said to Code A looking at the records – which of course is all we have, other than the evidence of parties such as yourself, to enable us to piece together the picture – looking at those records,
H there do not seem to be any of the usual ingredients that we have been told you would expect

A to find if a syringe driver was to be used with that sort or combination of opiates. There is an absence of any record of pain.
A Mm-hmm.

Q We are also told that because of the significance of putting patients on to these combinations of drugs with syringe drivers, that wherever possible families are consulted first, they are brought on board so that there is a consensus; but that did not happen in this
B case, did it, to Patient K?
A I think – I think we were talking to Code A, because I believe Code A was away in London a lot, so Code A --

Q I think the note shows ---
A So we were talking to her son, Code A

C Q And he came in at one o'clock, did he not?
A And we were under the impression that he was passing the information along.

Q Yes. He came in at one o'clock on the day in question, lunchtime?
A Mm-hmm.

Q And of course she had been on the syringe driver since 9.30?
D A I cannot remember him coming in.

Q No, it is in the ---
A Apart from reading the notes, I have got no memory of him being there.

Q There is no reason why you should. You might even have been in a different part of the ward.
E A If it was about one o'clock I might even have left the ward, because, you know, one o'clock was sometimes my time for leaving, so ---

Q Of course. I will be corrected at a later stage if I am wrong, but my recollection is that the notes indicate that the son did come on the ward at about lunchtime; but of course by then the syringe driver was already well commenced. Can you recollect at the time of the tussle with the patient and the hour or so that followed, whether Code A was actually
F present in the hospital or on the ward? We have heard that she would come in early in the morning.
A Yes, she was.

Q She was?
A Yes.

G Q That would explain a great deal, because I was going to ask you who made the decision first of all, at – I guess it was 8.30, was it not?
A Mm-hmm.

Q --- to dose her with the chloro---
A Chlorpromazine.

H Q So just for the record, who indicated that that should be administered?

A A Code A wrote it up.

Q Then again there was the prescription for the diamorphine and the midazolam to be given in the syringe driver.
A Mm-hmm.

Q Again, who initiated that?
B A Code A

Q You have told us already that you had worked with the doctor for a long time ---
A Mm-hmm.

Q --- and you had the greatest of respect for her. I am sure all of us can understand, it would be very difficult for a nurse – and you told us you were not the most senior nurse ---
C A No, no.

Q --- to be questioning what a doctor had prescribed. So if you were even aware of the doses that had been written up, and the doses that were actually administered, you probably would not have felt it appropriate to be questioning your doctor, since she was actually there.
A Maybe not at the time.

D Q That is a very good point; let us take that up. Having had the opportunity of listening to our own learned Panel member taking us all through the records of administration and cross-referencing with the *BNF*, had you got all of that knowledge at the forefront of your mind, on that particular occasion, had you known the detail of the prescription, would you have queried it?
A Yes.

E Q I think that is very clear. Thank you. We have heard from one of the ward managers that there were certain phrases that might appear in the notes, which would have different meanings to those in the inner circle, the team ---
A Yes.

Q --- than they might for members of the public.
A Mm-hmm.
F

Q Although, confusingly, sometimes we are told some of those phrases might mean for the medics what they also meant for members of the public. An example is the phrase 'TLC'.
A Yes.

Q To the public that is 'tender loving care'.
A As it is to the nursing staff.
G

Q What can it also mean to nursing staff?
A That this patient is – and in my experience it was always after discussion with families and doctors and things like that – it is just that this patient was here to be loved and cared for.

Q Palliative care?
H A Yes.

Q It is an indication for end of life, is it not?
A Yes, it is an euphemism for end-of-life care.

Q And one can well understand why it is put in that way ---
A Yes.

Q --- rather than a stark ---
A Well, it is a bit stark, is it not, end of life?

Q Yes, of course. And 'TLC' was not the only euphemism; there were a number in use at the time, were there not?
A Mm-hmm.

Q We are told that another one was 'make comfortable'.
A Yes. That would indicate to me just to sort of make sure that they were comfortable at all times, and, you know, that they had got everything that they needed, that the families were involved in what they felt their relative would like and would need towards the end of life.

Q Towards the end of life?
A Yes.

Q What we heard from the ward manager was that on the one hand there was the normal explanation, which means what it says.
A Yes.

Q And on the other it was again a euphemism for those in the know ---
A Yes.

Q --- reading the note, that 'we have now moved to palliative care'.
A Yes.

Q In this particular case that we have all been focusing on, Patient K, of course that does appear in the doctor's notes for 19 November, which is perhaps not surprising since it was that very day that the patient, on the doctor's instructions, is moved to the syringe driver with that cocktail of opiates.
A Mm-hmm.

Q We have also been told that at least one nurse has indicated that the phrase "I am happy for nursing staff to confirm death", whilst it is not necessarily in the same camp of the euphemism, but it does not necessarily mean the patient will shortly die?
A No.

Q Can you recollect any occasion when that appears in a patient's notes, and the patient then made a recovery and left the ward, at least reasonably fit and healthy? It is not a trick question.
A No, I am trying to think. It is four years ago now that I left Dryad. We did – I can remember a couple of patients that we got in that were really very poorly when they first

A came to us, that they went on to nursing homes, but whether that phrase was actually in their notes, I cannot remember.

Q No, okay. I am just checking through to see if there are any other questions. The very last answer that you gave Code A in re-examination – you may recall there was a bit of a pause while I was writing this down, and I said, "I am sorry", I was making a note to keep the last answer. What that was is this. My note of it is that you had told us that this is in
B terms of the dose that you would give when there was this wide range of potential dosing. You said, "We always started at the minimum dose unless we were told otherwise."
A Uh-huh.

Q I do not know whether you were involved. Again, I am going back to Patient K because that seemed to be a convenient example for all of us. That one, you will recall from your questions from Code A involved albeit arguably an overdose of diamorphine in that
C the BNF figure would have been about 15 and, in fact, 40 was administered. But the diamorphine had a starting point ---
A Yes.

Q --- of 40. There is no change there. But the midazolam had a starting point of 20?
A Yes.

D Q It was 20-80, I think. But in fact right at the beginning it was initiated at 40.
A Uh-huh.

Q We were told there would be two persons ---
A Yes.

Q --- who would administer. Would you have been one of the persons administering?
E A Not on this occasion, no.

Q We will have to take it from this occasion to the general then. You have indicated that generally the minimum recorded figure would be the one that you would start on?
A Yes.

Q And would that be true of everybody else?
F A Yes.

Q Without exception?
A Can you just ask the question again, please.

Q Yes. I am sorry. You have told us that whoever was administering there would be two of you?
G A Yes.

Q Qualified nurses to do that, and the procedure was always to administer at the beginning whatever the lowest figure was at the starting dose?
A Yes.

Q And you told us in answer to Code A 's question that the only time that you would do
H anything different would be if you were told otherwise?

A A Yes.

Q I am just checking. Would that be the same for everybody else?
A That is the same for everybody because, as nurses, we are not allowed to alter the dosage of drugs unless told so.

Q Who is it, then, that would authorise ---
B A A doctor.

Q Would it be fair for me to conclude, then, that on this occasion the two nurses, and you were not one of them ---
A No.

Q --- would have looked at the starting dose of 20, but instead of giving 20 of
C midazolam they gave 40, and your only explanation for that would be that they must have been told by a doctor to ---
A I can only say that they must have been told. As nurses we are not allowed to alter the dosage of medications.

Q And the doctor who was present at that time was?
A Code A
D

Q The ward that you were on at this time was Dryad?
A Yes.

Q But you had been involved around the hospital for a number of years before joining that ward?
A Uh-huh.
E

Q And on other wards where Code A and Code A and various others were also to be found?
A Yes.

Q I think it was Code A who asked you whether at any time there had been any concern expressed by others – colleagues, fellow nurses – about the way in which drugs were
F administered, in particular opiates. Do you recollect – I think you said no at the time?
A I honestly do not recollect anything being around, or anything being said.

Q I am talking specifically, if it helps, about 1991, so it is a bit before the time where these incidents occurred. Do you recall attending a meeting?
A I recall attending a meeting, but what it was about I do not know because we had one or two meetings going on, I think it was about that time.
G

Q I have before me a summary. Perhaps you would like to look it up because you should have it too. It is Panel bundle number 1, behind tab 6. You can see that this was a meeting that had been called as a result of concern among some members of the nursing staff at the hospital about issues such as diamorphine being given where a patient did not have pain, such as we actually saw in the case of Patient K; the sliding scale for analgesia not being used; the suggestion that patients' deaths were sometimes hastened unnecessarily; that
H the use of the syringe driver on commencing diamorphine made it impossible for trained staff

A to adjust dosage to suit patient needs; that too high a degree of unresponsiveness from the patients was sought at times. Do you remember that one?
A I have to say, no, I do not.

Q You say you ---
A Not even reading these notes, I do not. It does not come to mind.

B Q You see the list at the top of those present?
A Yes. I know. I can see my name there. I was there.

Q I was just checking that it was you and that there was not another Staff Nurse Barrett?
A No, that is me.

Q They are pretty explosive concerns?
C A Very, very.

Q If I understand number 6 correctly – "too high a degree of unresponsiveness" – that means putting patients unconscious so that they do not give trouble, does it not? What that be ---
A That is what it suggests, yes.

D Q As a sort of chemical cosh?
A Yeh.

Q The ward that you were on, Dryad ward, you told us already that there were a large number of end of life patients processing through it?
A Uh-huh.

E Q Within the hospital, did it have another name – Dryad?
A Not that I have ever heard, no.

Q We have heard evidence from a patient who was inquiring where it was that –
A I know. I was asked at the coroner's court.

Q So you know what I am going to say?
F A Yes.

Q It was referred to by some, at least, as the "death ward"?
A Yes, it was. Well, I am told it was, but I have to say that I never ---

Q You personally had not heard that at the time?
A Nobody ever had ever said it to me, no.
G

Q Would it be an accurate description, given all that would happen in that ward with the end of life patients?
A We used to have quite a few patients that died, yes, but that was because of the nature of our ward. We cared for elderly patients. That is the type of patient we used to look after.

Q Yes. And in the main your view, even now after all these years, is that in the main
H patients were well looked after and everything was done in patients' best interests?

A A The staff that I worked with – and I include myself in that – we always gave the best of our ability. We used to actually come in and sit with patients that were nearing the end of life that did not have relatives. On several occasions I have sat holding patients' hands because we knew they had no relatives, or the relatives were far away. We used to do all we could for them. Even in our own time, we used to go shopping we used to buy them toiletries and things if we knew that they did not have much. We gave the best that we could to those patients.

B

Q But do you accept that even in the best run worlds, things sometimes go wrong?
A In whatever job you are in, some things do go wrong, yes.

Q Would you accept that on this ward, Dryad ward, there were occasions when what you would regard as the normal rules, for whatever reason, were not applied?
A Looking at the one occasion, yes; but I would only say the one occasion. But we
C gave the best we could to the patients on Dryad.

Code A I think that is the end of questions from me. It follows, therefore, that is the end of the questions from the Panel, so you are almost there. What I have to do now is turn to the legal teams and see what questions they might have arising. Code A

Further cross-examined by Code A

D

Code A Thank you very much. What the Panel know is that they have been asked to consider eight patients from Dryad ward over a four year periods. Yes?
A Yes.

Q And questions have been focused on one in particular, and the Panel do not know who selected those cases, or why they have been selected. All right? What you have told us is
E that there were hundreds and hundreds of patients ---?
A Many.

Q --- who were treated over that four year period?
A Yes.

Q 1996 to 1999?
F A Uh-huh.

Q And what you told us was that many, many of the patients that were transferred to the ward were in very poor shape?
A A lot of them were, yes.

Q No one else would take some of these patients?
G A No, no.

Q You told us that there were three syringe drivers for the ward?
A Uh-huh.

Q And you told us before that it was only a few patients that might receive a syringe driver?
H A Yes.

A

Q Yes?
A Yes.

Q You have been asked by one member of the Panel about the prescribing range that we have seen for some of these patients?
A Yes.

B

Q That Code A might prescribe a range of medication – diamorphine, midazolam or hyoscine – and you told us that other doctors used to do the same, including a consultant?
A Yes.

Q Nursing staff are obviously very familiar with that process?
A Yes.

C

Q Yes?
A Yes.

Q And was it done to be in the best interests of the patients, so that if there was no doctor there and it was necessary because a patient was in pain to increase the medication the doctor did not have to come in to write it up?

D

A It was done initially for that, yes, but the nursing staff got into the habit, at least we would ring Code A and explain what we were doing before it was increased.

Q If it had not been written up in advance you would have to wait for a doctor to come to the ward?
A We would have to ring the doctor and wait till the doctor appeared.

E

Q Now Code A we know, was very willing to come to the ward, and did so obviously extremely readily.
A Uh-huh.

Q Was it sometimes difficult to persuade other doctors, or one of her partners, to come?
A Yes.

F

Q It was?
A Yes.

Q Can I just explore that. What do you mean by "difficult to get one of the doctors to come"?

G

A I will not say "difficult", but whereas Code A would say, "Right, I'll be there," and she would appear' "I just have to finish surgery and I will be there," it was sometimes quite late in the evening when the other partners used to arrive, even though we had rung them maybe late morning, early afternoon. It was sometimes seven, eight, nine o'clock in the evening when they arrive.

Q And but for the anticipatory prescribing – the prescribing of a range – if the patient had been in pain, presumably they would have remained in pain?

H

A We would have tried ---

A Q Because there was nothing written up.
A We would have tried, as nurses, to make them comfortable and try and relieve the pain as much as we could, but they would have to wait for the doctor to come.

Q I understand. You were asked about hydration.
A Uh-huh.

B Q And you told us that it is your recollection that there may have been more hydrating of patients after Code A retired, and when there was a full-time doctor?
A Uh-huh.

Q At the hospital?
A Yes.

C Q And you told me earlier that there was a full-time doctor there Monday to Friday, from 9 a.m. till 5 p.m.
A Yes.

Q In other words, the management decided after Code A resigned that the needs of the patient could best be met by somebody being there all the time?
A I think it was a gentleman that came after Code A went. He was not just on Dryad
D ward. He was ---

Q --- doing Daedalus as well?
A He was doing Daedalus as well.

Q I understand. But half his day was on Dryad rather than half an hour or forty minutes that Code A had?
E A I have to say that he probably spent more time on Daedalus than he did on Dryad.

Q But if you needed him?
A If you needed him, we knew where he was.

Q He was 30 yards away.
A We knew where he was.
F

Q Not a phone call away. Can I ask you about Patient K. You were not the named nurse, as I read the notes?
A No, I do not think I was.

Q I will demonstrate that to you. Would you look at page 155. That may help you for Patient K. This is just identifying when it was that she arrived at Dryad. It is 21 October
G 1999.
A Uh-huh.

Q We then turn to page 189 bearing that date in mind and page 190. It shows the named nurse as Code A
A Yes.

H Q And those are Gosport documents, I think?

A A They are, yes.

Q Page 189, 190 and if you look at page 191 the named nurse is Code A and ---?
A Code A

Q Yes?
B A Uh-huh.

Q But not you?
A No.

Q What we know – we have looked at page 279B – that Oramorph was prescribed. Do you have that?
C A Yes.

Q And we know as well that it was never given?
A Uh-huh.

Q Again, I do not need to take you to the records but we know that this lady was refusing medication at that stage?
D A Yes.

Q Oramorph is obviously in liquid form?
A Oral medicine. Yes.

Q You need the patient to cooperate. You cannot just ---?
A You cannot force it down.
E

Q Now we know that a fentanyl patch was used, which is a form of opiate?
A Uh-huh.

Q We have it written up at 279C?
A Yes.

F Q There is no indication on the document when the fentanyl patch was actually put on?
A No.

Q We have said you are not the named nurse?
A No

Q But if this document was being kept properly, someone should have written a time in
G so that we know when it went on?
A Oh yes.

Q There are other nursing records that cover the date. Let us look at page 223. 223 covers the period when the fentanyl patch went on, I think?
A Uh-huh.

H

Q You were not asked by the Panel about the equivalence of the fentanyl with any other form of morphine. I am not going to ask you about it. I think I may be taking you right outside your field.
A Thank you.

Q All right? I am not going to use the word "cocktail" because it may be a rather loaded word. All right? You told us about the chlorpromazine and you told us that it took quite a few minutes longer than it might normally do?
A That is how I remember it.

Q I understand. And if we look at page 223 and over to 224, we see that there was a marked deterioration at the bottom of 223?
A Uh-huh.

Q Extremely aggressive?
A Uh-huh.

Q Chlorpromazine given. There is reference over the page "Code A"?
A Yes.

Q And I think he was the relative who was there most of the time?
A Yes, he was.

Q For Code A
A He was still living in the area.

Q Code A - the lady the Panel heard from over the video link – her Code A was getting treatment in London and she could not be there, I think?
A Yes.

Q She did not get there until very late on in the picture?
A Yes.

Q We see the entry on 224 that Code A visited then on the 19th?
A Yes.

Q She unfortunately had not been able to be there, but Code A was the person?
A We used to see him when he came on the ward.

Q I understand, and I think he was there quite a lot?
A From what I remember, I remember seeing him a couple of times but I cannot honestly say how often he came.

Q There is reference on 224 to him contacting his sister and that may be what triggered her to come in later that evening to inform Code A's poor condition?
A Yes.

Q Does "poor condition" relate to her general condition?
A Yes.

Q If we look at her medical record, the one done by Code A at page 157, we will remind ourselves at the top of the page that:

"When seen by Code A ..."

who I think was a woman psychiatrist?

A I believe so, yes.

Q That Code A has:

"... deteriorated, has become more restless and aggressive again."

I think that was before any patch was put on.

"She is refusing medication."

That is why the patch was used, I think?
A Yes.

Q If the lady is fighting, and I do not mean that in a pejorative sense, but that was her demeanour, is it safe to approach them with a syringe?
A Not really, no.

Q Then Code A s note midway down the page:

"Marked deterioration overnight, confused, aggressive, creatine 360, fentanyl patch commenced yesterday, today further deterioration in general condition".

It is not talking about her being aggressive – general condition. You and I went through a list of indicators of a patient's general condition yesterday and that included skin colour and tone, matters of that nature?
A Yes.

Q Do you really have to see the patient to appreciate a deterioration in condition?
A Yes, you have to know them and see them.

Q The one thing these records do not give us, perhaps, is a clear indication of what a deterioration in general condition means, but that is something you would have seen in patients, that sort of deterioration in general condition?
A Normally if that is written, "general deterioration", it means that the patient has probably stopped eating and drinking, they are not as mobile as they used to be, generally going downhill.

Q I want to ask you about one other matter you have not been asked about yet in relation to this patient. Code A s note records on the second line, "Creatinine 360". I am not going to ask you what creatinine is or what it relates to, but I am going to ask you to look through some other documents that the Panel have but which no-one has referred them to as yet.
A Yes.

A Q I am going to start at page 21 first. This is a letter from a consultant physician. I am picking out a few words from the first and second line, "This lady suffers from moderate, chronic renal failure". Chronic means long term in medical parlance?
A Yes.

Q I am going to take you to page 85. This is the picture in April 1999, so six months or so before Code A 's death. In the middle of the page you see a few words, "Her
B creatinine is 151"?
A Yes.

Code A I am not going to ask you what it means or what the relevance of it means, just creatinine 151. If I can take you to page 53.

Code A I am loathe to interrupt, but the purpose of this opportunity
C for you is to deal with matters that arose out of Panel's questions.
A Yes.

Code A I do not at this moment see which question it arose out of and, indeed, even if I did, taking the patient to references which you are then not going to say anything to her about, would appear to be straying somewhat from the ambit that is open to you.

D Code A I do not agree with that at all.

Code A I gather that, but you are either going to explain to my satisfaction why I am wrong, or else you are going to stop that line. It has to be one or the other.

Code A I have one more document to show the witness that the creatinine went to 192 by July. There is a reference in there which is relevant and it may be we can look at it
E later in the case.

Code A If it IS not arising out of the Panellists' questions, it should be looked at later in the case and, certainly, with somebody who is able to comment on it.

Code A Sir, it certainly arises out of questions asked by the Panel. What was put to the witness was that the deterioration in the patient's condition was due to the medication that
F she received. I am exploring whether there may be some other condition to which it is clear on the papers that this witness has not had her attention directed. It is right that the Panel should know about it now and I will be drawing attention to the fact that Code A has made a record of creatinine 360.

Code A What you are doing is bringing to the Panel's attention a series of documents that you could perhaps bring to their attention at a more appropriate juncture.
G

Code A Sir, there is more to it than that. What I would like to do is to ask the witness to consider again the answers she has given to the Panel. The thrust of her answers now to the Panel have been that it looks as though this lady's deterioration may well have been to the medication. I am inviting her to consider her dramatic decrease in kidney function.

H

A **Code A** You have also indicated that you are not going to ask her what creatinine levels mean and, presumably, the reason behind that is because you do not have confidence that it is an area within her expertise.

Code A That is right, but in a similar way I was not going to ask her about drug equivalences and she has been asked about that by members of the Panel.

B **Code A** Let us stick to the point in hand. You have not convinced me that this is the appropriate time to be dealing with this and you have indicated that it is something you could do at a later stage and I would invite you to do that.

Code A Can I try again?

Code A You can try again as long it takes note of what I have said and you do
C not just continue regardless.

Code A I mean try again with you, sir. The Panel are concerned, obviously, about the deterioration in this patient's condition. What is relevant from this witness is what she dealt with. She can tell you about the medication that is recorded. What I would like to invite her to consider is whether the clear deterioration in kidney function is a factor that she was not bearing in mind when she gave the Panel the answers that she did. That is why I
D want to ask the questions, but I have to lay the ground work for it and that is what I am doing.

Code A Deterioration in kidney function in this instance will require her to have an understanding of the significance of the different creatinine levels and, unless you are going to be giving evidence, I do not see how she is going to be invested with that knowledge.

E **Code A** Sir, I have tried and I have not succeeded with you and I will stop.

Code A No, you have not. Is that the end of your questioning?

Code A Yes.

Code A (To the witness) You have now, for nearly two hours, been in the hot
F seat and I have noted you are getting a little uncomfortable. There is only **Code A** still to go, but if we have reached the stage where you need to take the break say so and we will take it now.

A No, I think I would rather carry on.

Further re-examined by **Code A**

G **Code A** I will try and keep it short, but there are questions I have to ask you. Can I start with hydration and questions that were asked of you both by **Code A** and also by the Chair. You told us that there was no intravenous hydration.

A Yes.

Q Is that right?

A Yes.

H

Q "Intravenous", does that mean going into a vein?
A Straight into the vein, yes.

Q You have mentioned subcutaneous hydration?
A Yes.

Q I want to make sure we all understand the difference between the two. You described subcutaneous hydration as putting a needle into a fleshy part of the body?
A It goes into the subcutaneous layer underneath the skin, a little needle.

Q What is passed through the needle?
A Normal saline.

Q Do you know how the process works?
A It goes very slowly into the subcutaneous layer and is absorbed by the body.

Q When you say "very slowly" it is not the same as an intravenous drip?
A No.

Q It is much smaller than that.
A Yes, you can give intravenous fluid much quicker.

Q If you are hydrating via a subcutaneous needle alone, presumably, unless you go very slowly, all you are going to do is to cause a swelling?
A Yes.

Q Are you able to tell us anything about the rate of hydration using a subcutaneous needle?
A We used to try and get at least a litre in 24 hours in subcutaneously.

Q If that was being done, would a note be made that it was being done?
A It should be.

Q I appreciate it should be. If you inserted a needle into a patient and attached, presumably it is via a bag, is it?
A Yes up to a drip stand, yes.

Q Presumably you would have to draw that bag out of a store somewhere?
A Yes.

Q Would you have to do that with another nurse?
A Not for normal saline, no.

Q You would be able to do it?
A Yes.

Q Is that something of which you would normally make a note?
A I would normally, yes.

Q Still sticking with the issue of hydration, you said to Code A – and again I was going to trying to note quickly the essence of what you were saying – that hydration was the first thing that happened when the new doctors came in. I want to understand what you were saying to the Panel about that?
A I suppose I put that rather badly. Looking back, as I say in hindsight, we seemed to use it more towards the end of my stay on Dryad than we did at the beginning.

Q Was that after Code A had left?
A It got more regular while Code A was there, but we did use it a little bit more after she had gone.

Q So your answer that it was the first thing that happened when the new doctors came in, do you want to reflect upon that?
A Yes, it was probably not the first thing that we did.

Q Did the new doctors insist on hydration?
A Not always.

Q It depended on the state of the patient?
A Yes.

Q Again, just sticking with hydration but turning back, you will be pleased to know, to Patient K because we are using Patient K as an example, did you keep on your ward, fluid charts?
A We did have patients on fluid charts, yes.

Q Could you give that answer again?
A We did have patients on fluid charts, yes.

Q Did you keep food and fluid records?
A Yes.

Q You did?
A Yes.

Q Just as an example of the sort of record we are talking about, could you go in Patient K's bundle to page 260. You can look at the preceding page. She transferred to your ward three days after this note was made?
A Yes.

Q On the 18 October, by way of example, there is a note that Code A had Weetabix and poached egg for breakfast and left none of it, she had two cups of tea. For lunch she had soup, cottage pie, jam sponge and custard and she had several cups of tea thereafter, so she was eating and drinking pretty heartily, was she not?
A Yes.

Q The only document that we have been able to find reflecting fluid intake in your ward is the one I am about to pass to you. It is an additional document which I passed to my learned friends a little earlier. (To the Panel) We are going to ask the Panel to put it in at page 205. (Document distributed) It is going in at 205 because it is the beginning of the

A nursing note at the Gosport War Memorial Hospital. It is dated, as we can see at the top, 21 October, which is the day of her admission. Could you find page 223 in the bundle and put it in.

Q (To the witness) Whose note would this be?
A That is my writing.

B Q This is 21 October, so the day of her admission:

"Mental health problem – confused."

The way that we have copied it, what is the next heading, do you know?
A I think it is supposed to be "appetite".

C Q Then underneath that, "Ability to eat – 0",
meaning independent?
A Independent.

Q It is "appetite", but it is showing that it is reduced. Is that right?
A Yes.

D Q We have not been able to find, and I am happy to hand the original records to whoever wants to see them, any other fluid or food charts on your ward at all?
A No.

Q Can you help us as to why that might be?
A Not really because, apart from this here, I have not filled any of the other care plans or anything in.

E Q Could you then have a look at page 203, the page before, just to look at the Barthel. We start off on the day of admission at the top, 21 October. Is that right?
A Yes.

Q We can see that her feeding is shown as, "She needs a bit of help", and she had just transferred to you then, had she not?
F A Yes.

Q Is that quite common, as you told us?
A She would not have known who we were and it does take them a couple of days to get used to us.

Q Right at the bottom we can see that her Barthel on 21 October is still reasonably good
G for your ward, it is up at 8?
A Yes.

Q But after that it gets much higher on 31 October up to 16?
A Yes.

Q Which is very good indeed for your ward?
H A For our ward, it was wonderful.

Q 7 November – 10, the next entry is 4 November – 10, and the 21 November it is down to 1?
A Yes.

Q At that point, would it be right to say that she was then on the drugs?
A It certainly looks like it.

Q The fentanyl patch, I just want to try and tie this down. It was put on her, we have heard, and it is on the chronology that we have all been relying on, on 18 November. The clinical note we know is at page 157, so that is Code A 's note. The note that we have from Code A is actually the following day, is it not – 19 November?
A 19 November, yes.

Q On 18 November, the day that the fentanyl patch was put on, we can read – and this is a note from Code A, I think, is it not?
A Mm-hmm.

Q

"Elderly Mental Health

Thank you. This lady has deteriorated and has become more restless and aggressive again. She is refusing medication and not eating well."

So that is what happened on the 18th.

"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" –

which was the elderly psychiatric ward?
A Yes.

Q If we keep a finger there and go to page 407, the other note for 18 November: "Code A now at Dryad".
A Mm-hmm.

Q "Aggressive, wandering, moving other people's clothes" – you mentioned that.
A Yes, she was.

Q "Refusing medication, poor appetite.

Reviewed on ward – happy, no complaints. Waiting for Code A not obviously" –

is it "paranoid"?
A "Paranoid".

Q "Says tablets make her mouth sore.

Plan – Transfer to Mulberry Ward when bed available."

Have you seen anything from your knowledge of this patient and how things worked to cause a fentanyl patch to be put on her?
A I cannot even remember it being put on.

Q No. I was troubled as you were being asked questions to try and identify exactly where we had actually got the information that the fentanyl patch was put on on 18 November at 9.15. We have the controlled drug record. Can I just show you that, so we have it in evidence, because it is not in the nurses' notes and it is not on the drug chart. I have left a yellow sticker. (Handed) Can you find the patient's name, Code A ?
A Yes.

Q Can you just confirm what it says.
A Do you want me to read the whole line?

Q Yes.
A 18th of the 11th 1999 at 9.15 a.m., it was – the patient's name, Code A , the amount given, 25 mcg. It was given by – which meant it was actually put on to the patient by – G Hamblin. It was witnessed by Code A , and there were six remaining in the box.

Q And it gives the time when it was put on?
A 09.15.

Q That should be reflected, I think, at page 279C of that drug chart. I am sorry, it is difficult to keep all these papers in order. 279C – we can see that it has been prescribed by, I think, Code A – do you see right at the bottom?
A At the bottom.

Q I just want to understand how this works. What comes first, the withdrawal from the controlled drugs cabinet or the prescription by Code A
A Code A would have written it on the prescription chart. The nursing staff should then have taken this prescription chart with them to the cupboard where the patches are kept, in a locked cupboard within a locked cupboard, and then they are withdrawn from the cupboard.

Q Right. Then they have to make an entry ---
A They have to make an entry into the book, and then it should have been entered on the ---

Q And somebody goes and puts it on the patient?
A Yes.

Code A Can I just clarify something? When I dealt with this entry I had not noticed – and it is my fault entirely – that the dates on the top of the page do not go as far as 18 November; the dates on the top of the page go as far as the first week in November. I think we have to look at the other side of the sheet, and that has not been copied, but I think the original will be available.

Code A I am grateful for that interjection, and we will see if we can get the original. We may find indeed that it has been noted there.

A A Because I think these charts at the time were sort of double sided.

Code A I hope we have not missed something like that, but it is quite possible that we have, so apologies.

(To the witness) So on the face of the record that you have seen, are you able to give us any indication as to why the fentanyl patch was deployed?

B A No, I cannot even remember it being put on.

Q All right; but it must have been prescribed obviously prior to 9.15 when it was put on?
A Oh, yes.

Q One other matter that I wanted to ask you: you said that other doctors – and you were answering questions asked of you by Code A – that other doctors used to prescribe variable

C doses. Yes?
A Yes.

Q First of all, are the sort of variable doses that you are talking about in the same wide range of 20 to 200 mg of diamorphine?
A Not always, no.

D Q Not always. Are you saying – and this may be important – that other doctors prescribe diamorphine in a range of 20 to 200 mg?
A No.

Q What sort of range are you talking about?
A 20 mg to – I think the highest I remember was about 120 mg.

E Q Who did that?
A Was it Code A ?

Q Code A ?
A Yes.

Q We are going to be hearing from Code A and Code A ; and in fact we are going to

F be hearing from Code A Are you saying that it is any of those?
A I honestly cannot remember.

Q You were answering questions and explaining to Code A why it was necessary to give a range.
A Mm-hmm.

G Q Why was it necessary to give such a wide range, over 100 mg of diamorphine, to patients who had never had it before?
A I think it was just the range that Code A used.

Q It was just ---?
A It was just the range Code A used. I cannot ever remember giving anybody that amount.

H

Code A I see. Just give me a moment, to see if we can identify what has happened with the fentanyl. (Short pause) I am going to give you everything that we have, and I think it does become clear – and we have missed it. I will just hold it up for the Panel – there are two strips of paper that have obviously become separated from the original. I will pass those to the witness first of all, together with the original prescription sheet, so that we can then get it on the transcript what has happened with the extra page. (Handed)

A Thank you.

Q I think if you put those two sheets where they should be, which is as a third page, as it were – because I think the prescription sheet folds out into three pieces, does it not?

A Yes. We just used to sort of have strips, so when we came to the end we added a new strip.

Q Does that seem to be what has happened here?

A Yes.

Q Does that show in fact that the fentanyl was applied on the 18th?

A Yes.

Q At what time?

A 09.15.

Q And that links up with the controlled drug record?

A Yes, the controlled drugs.

Q Does it also show when it was taken off?

A "Removed 12.30" – it is initialled by Code A

Q On what date?

A On the 19th.

Q So removed the next day at 12.30 on the 19th, after the diamorphine had been started – is that right?

A Yes.

Code A Thank you very much. That is all I ask.

Code A you made it. Thank you very much indeed. It has been quite an ordeal for you and we are enormously grateful to you for your patience and willingness to assist us over such an extended time. You have now reached the point at which I am able to say that you are released and you may go. You go with just one request, please, and that is that you do not discuss with any future witnesses who may be appearing before us anything that has occurred.

A No. I was having dinner with one of the witnesses that you will be seeing today, last night, and it was very difficult. I had to sort of think about what I was saying – because we had worked together so long ago, we were trying to discuss staff that we had worked with and other patients that we had worked with, and it was quite difficult to remember not to – but I got ---

Code A We are very grateful to you for embracing the spirit as well as the letter of it. Thank you very much.

A Thank you to everybody.

(The witness withdrew)

Code A Can I just explain what we are going to do in relation to the drug record.

Code A Yes, please do.

Code A What we are suggesting is that we are going to copy it on to an A3 piece of paper, then we will replace 279C with that, because it is really the only way of seeing how matters progressed with the fentanyl, and I am sure we will be able to deal with that by folding it.

We are ready with the next witness, but I expect the Panel may want to have a break?

Code A Yes. The Panel have been at work, as it were, since before nine o'clock without a break, and I think we have had a lot to absorb. So what I am going to say is that we will break now for an early lunch, and we will return at 1.30, please.

Code A Can I just say that at 1.30 I will have an application to make, but I will need to make the application itself in private, because it relates to an application to go into private, and I will have to reveal why.

Code A Yes, very well. So the Panel secretary and assistant will note that, and it will just be the parties and the Panel at 1.30, please. Thank you very much, ladies and gentlemen.

(The luncheon adjournment)

Code A Sir, before I make the application that I indicated that I would earlier, can I deal with some housekeeping. The first is to provide you with some documents in relation to Patient E, which I think one of your number asked for yesterday.

Code A Yes.

Code A This is pages 41, 42 and 43 to go into Patient E's file. (Handed)

Code A So we are receiving replacement copies of pages 41, 42 and 43 for patient bundle E – and yes, they are very much clearer. Thank you very much, Code A much obliged.

Code A Could the Panel assistant or secretary also deal with the witness bundle. This is to go into the E file.

Next, there are some pages which we are going to come to in a moment with the next witness, which is actually just one page for Patient H's file. (Handed) It is page 263, and if you look at the very bottom of your current 263 it is very difficult to read the writing, and the

reason for that is it is in red on the original. I hope you will find that the new page is slightly easier to read.

Code A: Yes, it is easier to read, but it is also not the same. The second rows for diamorphine, on the right-hand side of the page that we currently have – unless it is me that has written it, and I think it is not – it looks like it is a photocopied – there appears to be in brackets the words "Code A", which does not appear on the replacement page.

Code A It does not. I suspect the reason for that is we are working from the original, and you are working – or the main bundle has what I suspect is a copy from a police file. It may be that somebody has written that there. I do not think it matters; I can see Code A ---

Code A There is no significance to it, so we will happily remove it and replace it.

Code A It also has the advantage that the first hole has not gone through the beginning of something.

Code A Yes.

Code A Then on to Patient K. Instead of making it into an A3 copy we are trying to make do at the moment with a reduced A4. So this is to replace page 279C, which is part of the drug chart we were looking at earlier, which has the fentanyl on it. Sir, if I can hand this out – if the Panel do not find this satisfactory, then we can get an A3 version, but I think it is in fact now legible.

We are looking right at the bottom of a fentanyl entry, and if we follow it along to 18 November we can see 09.15, and then there is an initial, and then to the right-hand side "Removed on the 19th at 12.30".

I hope that that is sufficient.

Code A We do not have that yet.

Code A I am so sorry. (Document circulated) I am going to say that again if I may. We are looking right at the bottom of the document, the fentanyl entry; then if we look across the columns to the right we can see underneath "18 November, 09.15" and there is an initial to show when it was put on, and then we can see that it was removed on the 19th at 12.30. I hope that is now clear. Are you happy with that?

Code A Yes, we are all happy with that.

Code A Lastly, some documents. These are new documents to go into the F file. This is for Code A, and I think Code A has spotted that these are documents to which he might be referring in due course which you do not have, I think, at all. It is page 297 to page 320. You will need to pop pages 297 and 298 in before 300, and then the rest follows perhaps rather obviously. (Documents handed) You will have to split them up.

Code A The Panel have inserted those pages as appropriate in bundle F.

Code A As I indicated before lunch, I have now an application to make. Can I take it we are now in private session?

Code A No. There just do not happen to be any members of the public present.

Code A Then I should make an application?

Code A Yes, please.

Code A It is an application to go into private session. There is a witness who wishes to give evidence anonymously so that you know her name but the public do not and more importantly, that the press do not. I cannot make that application properly unless you are prepared to hear it in private session. If the application fails and you wish me to repeat any details that you think are relevant, then of course I can do so in public. In order to make the application, I would respectfully ask you to go into private session.

Code A Is this pre-application, as it were, opposed?

Code A I do not think either application is opposed.

Code A Thank you. We will briefly hear from the Code A

Code A The law here is governed by rule 48(1) and (2) of the old rules, particularly rule 48(2). I will not read it out. You will have it in front of you.

You have heard the submissions of Code A in relation to this, and you will have heard that the defence do not argue against the granting of this pre-application, as you put it. You may conclude from that that the parties concede that there are at least arguable grounds for hearing this application in private. You will doubtless bear in mind also that, if the application is heard in public, the stating in public of the grounds upon which the GMC rely may well render the substantive application pointless.

The only other matter I would add is that under rule 48(2)(c), the announcement of your determination as to this must be given in public.

Code A Thank you. Members of the Panel, do you wish to retire to consider that, or are you able to deal with it now? (The Code A conferred with members of the Panel) Thank you very much.

DECISION

Code A I have taken very quick, non-verbal soundings from the members of the Panel. Having had the advice from the Legal Assessor, it is clear that we all agree that if it were not possible for this to be done in private, then the whole purpose of the application would in effect be subverted. In those circumstances, we are happy to allow it. As of this moment, Panel Assistant, we are going into private session and you need to put the appropriate marker on the door so that no members of the public come in until that status changes. Thank you.

STRANGERS, ON DIRECTION FROM THE CHAIR, WITHDREW

(For hearing in private, see separate transcript)

STRANGERS HAVING BEEN READMITTED

Code A I want to make sure there were no members of the public who want to come in because we are going to be in open session. For the record, we are now moving back into open session.

DECISION

Code A The Panel has heard an application from Code A that the name of the next witness be communicated in writing to the Panel but not mentioned in public. That application is not opposed by Code A who is fully aware of the identity of the witness. The Panel is satisfied that withholding the name of the witness is appropriate because:

(i) not to do so would cause the witness undue prejudice;

(ii) the circumstances make the public announcement of this witnesses name unnecessary or undesirable; and

(iii) it would be in the interests of justice and desirable having regard to the evidence to be given.

Accordingly, this application is allowed.

Code A you will no doubt give us an appropriate pseudonym for the anonymisation process. May I say, first, to the shorthand writer, if by any inadvertence the name is mentioned it should immediately be deleted and replaced with the appropriate anonymisation. Similarly, since we are in public session, even though there appear to be no members of the press present at the moment, if such a slip were to occur, we would rely on the cooperation of members of the press not to repeat or make use of that name. Code A

Code A I know Dr X sounds somewhat James Bond-ish, but Dr X will have to do.

DR X, Sworn

(Following introductions by Code A

Examined by Code A

Q Doctor, The first thing I am going to ask you to do is to write your full name down on the paper in front of you.
A I hope you can read my handwriting.

Q Try and make it legible! That may be counter intuitive for a GP but try and do so. (Same handed to parties and the Panel). As you have been told, the Panel has granted your application to give your evidence anonymously. I will try not to refer to you by name. If your name does slip out, rest assured there is nobody, apart from Code A in the public gallery at the moment, but we will be extra careful should any members of the public come in. Could I ask you about your training as a doctor. Did you complete your training in the mid-1970s?
A I completed in Code A

Q Did you go on to take your GP training qualifications in 1982?
A I completed them in 1982 at the Code A

Q I think you are a member of the Royal College of Medical Practitioners. There is a Royal College of GPs?
A I am a member of the Royal College of GPs.

Q I think you share a practice with Code A ?
A I do.

Q How long have you worked with Code A in that practice?
A For 28 years and three months.

Q I think for a period, a relatively brief period, you were also employed as a clinical assistant at the Royal Hospital Haslar?
A Yes, I worked in the casualty department. I worked whilst the regular doctors were at their training session and I covered for them on my half day.

Q Can you tell us, what is the role of the clinical assistant?
A I actually did the work of the casualty officer who was not present. It was slightly different to other clinical assistant jobs. I was actually there and I actually just took over the duties for the time period and then left.

Q Did you also perform some duties at the Gosport War Memorial Hospital?
A I did, I was a member of the bed fund at the Gosport Hospital for over 20 years. That meant I had my own patients on a GP ward and, because of our partnership, I also covered the duties for Code A as a clinical assistant when she was not covering the job.

Q The GP ward, we have heard, was that Sultan Ward?

A It was latterly Sultan Ward. Originally the Gosport War Memorial had three wards. It had a male ward, a female ward and a children's ward. That was before the new hospital was built. I worked there for 14 years before the new hospital was built.

Q Dealing with the new hospital, which is the one we are most interested in at the moment, Sultan Ward, was that one of the wards at the new Gosport War Memorial?
A Yes, that was the GP ward.

B

Q When we talk about a GP ward, bearing in mind there are a number of people in the room who are not medically qualified, does that mean it is a ward which is reserved to people who are referred by a GP to hospital?
A The GP was actually responsible for patients and if I had patient in the community that I felt was not getting better at home, I could admit them under my care to hospital beds and looked after them totally there.

C

Q Apart from your duties on that particular ward, the Sultan Ward, did you also cover for Code A when she was unavailable, either on Daedalus or on Dryad Ward?
A Our contract at that time was 7 days a week, 24 hours a day as general practitioners. Obviously, we could not do that, so we actually took it in turns and we had a duty night each night. When it was my duty night, I covered for Code A on that ward, yes.

D Q What does that really mean? Would that mean you attended the hospital necessarily or would you only come out when a call was made?
A It meant I was on call. This was really for out-of-hours, it was not for routine work. If I was needed, I would be contacted and if I was in my own practice doing a surgery I would attend, if necessary, at the earliest possible opportunity or I could give advice over the telephone.

E Q Are you able to give us a thumbnail sketch. In what circumstances might you be called at night, for instance, if you were on duty?
A I could be called for various reasons. The patient could have fallen out of bed, the nurses could require a prescription, a patient could require anything – could require catheterisation, or could require an injection that the nurses were not qualified to give; anything that the nurses on duty were unable to do and they required my help with.

F Q Would you on occasion prescribe painkillers?
A I would on many occasions prescribe painkillers for any patient who had pain.

Q Would that include diamorphine?
A Diamorphine is a painkiller and I have used that for the past 32 years on thousands of patients.

G Q I was going to ask you, do you have any reluctance to prescribing diamorphine?
A When I did my general practice training I worked as an SHO in a small ex-TB hospital and I worked in a terminal care unit. As an SHO I actually looked after 32 patients on my own with terminal care. My consultant and registrar would visit two or three times a week. During that time it was my sole responsibility to care for the patients so I acquired a lot of experience in prescribing diamorphine and using it.

H Q Would that include the use of syringe drivers?

A I think it did. Syringe drivers came in in about – I cannot recollect that because syringe drivers came in in the – 80s? I cannot confirm that, I cannot remember.

Q If you cannot recall, you cannot recall.
A I may have, I may not have. I am afraid I have been in practice 28 years and when syringe drivers came in I cannot exactly remember.

B Q Did you in fact have cause at either Daedalus or Dryad Ward to prescribe syringe divers?
A I must have having worked there at that time because the majority of the patients who are on that ward were admitted because they were dying and had pain or discomfort and required strong analgesics. If they required strong analgesics, I would prescribe them for them and as their condition, if their condition, deteriorated and they were unable to take anything orally, they would need it intravenously so I would prescribe a syringe driver to
C provide that.

Q If they were unable to take medicine orally?
A It depends on the condition of the patient and what the drug is given for. If a patient is vomiting, it would be pointless giving them an oral medication.

Q Apart from using diamorphine to control pain, did you ever use it for any other
D purposes?
A Yes, I did. I used it for congestive heart failure on patients. It is a very effective drug.

Q Which is a legitimate use of diamorphine?
A Yes, it is. It was given together... In those days we did not have the newer ace inhibitors and we used to use diuretics and diamorphine. Diamorphine had a dual role, it would relieve distress and it also had a very helpful effect in congestive cardiac failure. It is
E very useful, but we do not see that in patients any more. With the new drugs we hardly ever get called out. Usually it is about 3 o'clock in the morning we get called out to a patient with heart failure and we have to give an injection of diamorphine and they would be very much better the next day.

Q When did ace inhibitors come in so that that was no longer needed? I know that is testing your memory.
F A Well, yes, you must forgive me, I do have senior moments. Ace – the very first one came in about 12 years ago, 10 or 12 years ago.

Q Regular use of ace inhibitors?
A It was not actually given for that at the time, it was actually given for hypertension and it is only as the years have evolved that it has been realised that it has a dual effect. Many, many drugs have different effects and, with experience, GPs learn how to use them.
G

Q I am going to ask you briefly about three specific patients who you dealt with. The first is a lady called Code A, our Patient B. I am not going to take you to ---
A I remember Code A very well. She was a patient of mine and she was a large lady. I remember her very well.

Q Was she a diabetic?
H

A She was a diabetic. She was a very brittle diabetic and she had numerous admissions with hypoglycaemic attacks, usually 2 or 3 o'clock in the morning, and usually resulting in hospital admissions.

Q I am going to lead you from your statement. She also had an irregular heart beat and mild heart failure. That is from 1985?
A I have not got the notes with me to confirm that.

B

Q I am taking this from a statement you made to the police. We can give you the notes if you need to see them?
A I have not had the opportunity to read that statement since I made it in 2005, so, again, my memory from four years ago, I cannot confirm that without looking at my statement.

Q Sorry, I thought you were given all your statements.
C A No, I was only given one statement. I have only read the statement about one patient.

Q I am going to give you a thumbnail sketch of Code A If you think that I am putting it wrong in any way, just let us know.
A I have not got the notes with me to confirm it, and I have not got the statement, so I can only give it to you from the best of my memory.

D Q All right. Can we take it that at the time that you made the statement that you would then – because you give specific dates and things – you would then have had reference to the notes?
A If that was – was it an officer Code A?

Q The first statement that I am looking at is 13 September 2005 to Code A
A Code A? Then, yes, he brought the notes with him.

E

Q All right. I am just trying to get a general impression of the patients rather than any specifics.
A I do not want to mislead you with answers that I cannot confirm.

Q No; and I do not want you to be here any longer that we need you to be. If you need to refer to the notes, please do, but just see if this triggers any memories. You said that she
F was diabetic, she was overweight and she had mild heart failure. Is that a brief description of some of the problems that she had?
A I can remember distinctly that she was very overweight and had diabetes.

Q You do not remember the heart failure?
A Not specifically, but ...

G Q All right. I think you record in your statement that you had previously, back in the '80s, given her frusemide. That would be for what?
A That would be for – frusemide is a diuretic, and it is usually given for heart failure to relieve fluid on the lungs or legs, or ...

Q I think she also had the misfortune that her vision deteriorated – do you remember that? – and in due course she was put on the blind register?

H

A I vaguely remember that, yes, but I cannot confirm that because I have not got the notes.

Q We will put your statement in front of you and see if you can then remember it. We know that in due course in February 1996 first of all she was admitted to Haslar Hospital. Do you have any recollection of that?
A None whatsoever, because – sorry, what year was it again?

B

Q 1996.
A That is 12 years ago. I am sorry, I cannot remember.

Q Will you take up to your left a file marked 'B'. Do you have your glasses? Would you go, please, to page 242, and it is the page numbers with a line either side of the number itself. I am just trying to find a single document that perhaps will remind you a little bit about
C this lady.
A 242, I have a letter Code A.

Q That is right. Do you want to just glance through that, please. She was at this stage in February 1996 an 83-year-old lady who had been admitted to the Royal Haslar. She had had a fall, she was complaining of pain across her shoulders and down her arms, and on examination ---
D A I only have one page, and it has got "Continued" with no continued ---

Q You are right, but let us just stick to what we have at the moment. Do you see that she had atrial fibrillation?
A Yes, "AF".

Q Can you recall whether you were aware at the time of her admission to hospital?
E A The problem with discharge letters and letters like this, it does not actually give a date that it was sent to us, and sometimes these letters arrive three months, six months, afterwards. This might even have got to me after this lady died, so I cannot tell you when I actually read this letter, or indeed *if* I read it, because if it was in my GP notes then I would have received it, but I am afraid hospital discharge letters and notes are notorious for (a) taking a long time, and sometimes we never see them, so I cannot confirm that unless it is in my own notes.

F Q In short it appears that although you remember the patient generally, you have no specific recollection of her treatment?
A She was on insulin, I seem to remember.

Q Yes.
A Because I used to attend regularly in the middle of the night in response to the ambulance service to give her intravenous glucose for her hypos, so I well remember visiting
G her at three o'clock in the morning, many times.

Q Would that be at her home?
A That would be at her home, yes.

Q Put that file away, if you would, please. I am just going to ask you very briefly about another ---
H

A Code A May I just interrupt? There is the second page of that letter, if people want it, at pages 935 and 936 – the whole letter.

Code A Thank you.
(To the witness) Have a look at 936, if you want to. Does that trigger any recollection?
A (After a pause) Well, I can remember it, but it does not trigger any recollection because it is 12 years ago. Now I have read it again, it reminds me, but it does not trigger any
B recollection.

Q All right. Can I turn, please, to another patient of yours, and that is somebody called Code A Do you recall Code A at all?
A No, not at all. I have had many patients over the past 30 years called Code A and many called Code A, and I really cannot remember a Code A

C Q Could I ask you, please, to take up bundle H, and we will see if you can remind yourself of anything about this patient and at least recognise your writing. Patient H, we know, was admitted to the Queen Alexandra Hospital on 17 February 1997, diagnosed with alcoholic liver disease, then he had to go back there in September 1998 following a fall where he had fractured his left humerus. Then he was admitted to Dryad Ward on 14 October, and I am going to ask you about four days later than that, on 18 October. Could you turn up page 180, please.
D A Sorry?

Q 180. These are the clinical notes in relation to this patient.
A Yes, that is indeed my writing.

Q What is? Right at the bottom?
A Two-thirds of the way down.
E

Q Just starting at the top, first of all, is that writing at the top Code A s?
A It looks very much like Code A s.

Q We can see the note that Code A had made. Your note is where, please? What is the date?
A Mine is under Code A s. I cannot read Code A s.
F

Q We might not be able to read yours.
A The photocopying is not very consistent. It looks – it could be an "8" there or it could be a "3", but your photocopying machine has not copied it very well for me to read.

Q We can get the original if you need that. Can you read that?
A The one below it says "18", so I presume it is the 18th. Yes, it says:
G

"Comfortable
But rapid deterioration.
N/S" –

which I usually put for "night staff" or "nursing sister" –

H "to verify death if necessary".

Q Right. You can glance through the whole page, obviously. Can we take it that if you had had any other dealings with this patient in Dryad Ward on this admission, you would have made a note about it?
A No, if I had visited the patient I would have made an entry.

Q That is what I have just asked you.
A Sorry, what was the question again?

Q Can we take it that if you had any dealings with this patient on Dryad Ward, you would have made a note about it?
A Yes.

Q Right. So can we take it that on this date, which I think is the 17th, this would be the only occasion – or the first occasion, I am sorry – that you had been to see him? Can you remember the circumstances in which this note has been made?
A The entry above says:

"Decline overnight with [shortness of breath]
On examination: bubbly, weak pulse, unresponsive to spoken words, oedema ++ in ankles & legs
? Silent M.I" –

I cannot read the next bit –

"Increase frusemide".

So I presume I had been called in because this patient had – it sounds from the entry above that he was very severely ill or close perhaps to death, and I had been called in because he deteriorated further.

Q Can you just help us, please, with your notation: "Nursing staff to verify death if necessary".
A The position is, as a GP, I work – we had a seven/seven commitment in those days, so I actually worked – I did night duty, which meant I started work at eight o'clock in the morning and finished work at six o'clock the next day. At weekends I started work on the Saturday morning and finished on the Monday night. Because of that I had to work the next day, if I felt that – for instance, in this case, the patient was dying, and I have seen enough patients who have been dying to recognise that. I would inform the nurse "If they do die overnight" – there is not really an awful lot that a doctor can do if a patient dies at three o'clock in the morning, and I was quite happy for the nursing staff to affirm death. In fact the – I think it was the Hampshire trust – no, it was not a trust – Hampshire health authority had allowed the nursing staff, the night staff, to be trained and affirm death for I think it was about 15 years before that. So they had been doing it for about 15 years when I made that note. So all I did was confirm that if the patient did die, then I did not really want to be disturbed at two o'clock in the morning.

Q This allows the nurse to verify death?
A To affirm the death.

A Q I was just using your words, "to verify death", but if you want to use different words --

A The one for the nurses is they are allowed to affirm death, but I put "verify", because --

Q It is the same thing in your mind, is it?
A Yes.

B Q Could I ask you to go to another page, please, page 263, where you will find a drug chart. Do you see your writing anywhere on that page?
A I do, for "Hyoscine 1200, see in 24 hours".

Q Is that right at the bottom?
A That is right at the bottom, yes.

C Q Is that the following day?
A No, that is 14.30 on the 18th, the same day. The date is at the top, and it states 18th of the 10th, '98. What has happened is, as they have put down "Verbal order", what has happened is probably I have been in my surgery seeing patients and the nurse has rung and said "This patient's breathing has probably become much worse". The layman's term is 'death rattle', actually, and it is because patients have much more secretions in their throat
D and chest and they are unable to clear it, and it does produce an audible rattle which to most doctors is a sign that death is imminent. It is quite distressing for the patient and for everybody else, and one of the treatments is hyoscine. The dose that I see **Code A** started off as 200 to – is it 600? – and the nurses--

Q Just pause for a moment. That is half-way down the page, further up, and that has been given on 16th and 17th?
E A Yes.

Q That is 400 and 600 – is it micrograms?
A That is correct.

Q And 800 mcg?
A That is correct. So 400, 600, 800, and I have written up 1200, which is a natural
F increase. In my statement I think – I did see that statement, actually – the *BNF* recommends a dose of between 600 and 1200 milligrams (sic) for such symptoms.

Q Apart from drying up secretions does hyoscine have any other effect that you know of?
A It is used also in seasickness, actually; it is quite good at dealing with nausea.

G Q An anti-nausea?
A Yes. There are various preparations you can get, actually, that you can take orally or in other ways. It is very good for nausea.

Q Can I just ask you about the verbal order and how that worked. You were entitled, were you, to give a verbal order for a prescription of this nature?
A Oh, yes, because hyoscine is not a controlled drug, and if I had been in the middle of a
H surgery seeing patients I would have been unable to get away. In usual circumstances the

A nurses will ring and ask for this to be approved, and then at the earliest opportunity, which looks like 14.30 – so I have probably done my morning surgery, finished about 12, and this would be one of my visits, and I would have called in to sign at the earliest opportunity.

Q So you went along, having given your verbal order over the phone, you then go along to the hospital ---

A And that is where the entry is, I think, that is dated. I think – the problem is I have B been rung up by a nurse to say "This patient has deteriorated", and they may even have said to me "They have a death rattle. Can we increase the hyoscine to 12?", and I would have agreed with them and then come in and written it up, or signed for it.

Q Just glance through this page and the previous page, if you would. It certainly does not appear to us as if you have prescribed any other medication for this patient, but just confirm, if you would – it is sometimes difficult ---

C A No, my signature is not on that previous page, or my handwriting on the previous page. No.

Q Would you go right to the back of the bundle, please, behind the last tab, and you should I think find the death certificate.

A I have it, yes.

D Q Does your writing appear anywhere on that?

A Yes, that is my writing.

Q Could you help us with this, please.

A Yes. Name of deceased, Code A Age 75, place of death GWMH – which stands for Gosport War Memorial Hospital – Dryad Ward, last seen alive 18/10/98. Post mortem – there is then a list on the other part, which says "post E mortem not being asked for". "Whether seen after death", (a) is by me, and that is what I would have done. Cause of death, congestive cardiac failure, (b) secondary renal failure, and additional contributing factor, which is II, would be liver failure. So it looks as though this chap had almost total body failure, apart from his brain, actually.

Q What would have brought you, as it were, to make those notes? Would you have reviewed his file?

F A I would have reviewed his file, yes. I would have gone through the notes.

Code A Very well. Would you wait there, please.

Cross-examined by Code A

Q As you will have gathered, I am asking questions on behalf of Code A. As

G I understand it, in terms of your visits to the Gosport War Memorial Hospital, they would take place if you were on call on a particular night?

A That is correct.

Q And sometimes, I think you probably did about one weekend in five, would that be right, on call?

A Yes. There were five of us, so it usually was about one in five, yes.

H

Q And so on occasion you might be going in at the weekend?
A That is correct.

Q And if you were on call on the week-end might you visit the hospital in any event just to see how things were getting along, or would it always be because you were specifically called out?
A A mixture of both. It depends how busy I was and where I was. Sometimes, depending really on how busy I was.

Q You have told us about your use of the GP ward which at the time we are talking about was Sultan. Correct? So you would be visiting Sultan from time to time in any event to see your patients?
A Only if I had patients there. There were only a limited amount of beds and we did not always have patients there.

Q Assuming you had a patient there, we can think of you going into that ward from time to time?
A Oh yes.

Q You told us about some experience that you had, I think you said, as an SHO looking after some 32 patients, was it, with terminal care?
A I worked for six months, yes.

Q I think as you described yourself, you had quite a lot of experience in relation to that. Would that also embrace palliative care?
A That was palliative care.

Q I was going to ask you: people sometimes use the expressions differently. Is palliative care in your book in effect the same as terminal care, or something different?
A Palliative care? There is a subtle difference. Terminal care is when patients are not going to go home again, and you are really giving them the treatment they need towards the end point of their life. Sometimes palliative care was the same thing but there was not always an exact distinction between them because to actually give lengths of time that patients die, even for doctors, is very difficult. We are not always right. Sometimes we say weeks and it is months; sometimes you say months and it is days. It is not always the easiest thing to give an exact timing for deaths.

Q Similarly, would it be right to say from your experience that in terms of patients deteriorating, sometimes they could deteriorate very rapidly?
A Yes.

Q Without there being any immediate obvious cause?
A Most patients had some sort of history. They may have had ---

Q Sorry, it is my mistake for putting the question badly. A patient obviously is poorly – let us put it like that. Some people may deteriorate gradually over a period of time. Some people may deteriorate very rapidly. In terms of the deterioration in a patient who is in that sort of condition – poorly, I will use that word – sometimes the rapid deterioration may be difficult to determine in terms of its cause. It is just something that happens.

A A For some patients deterioration was so rapid that they would die very, very quickly, and other patients... Every patient is different.

Q Yes?
A In some patients it was very rapid; some patients not so rapid.

Q You told us that the majority of patients on Dryad, I think you were saying, who were
B admitted were admitted because they were dying and they required strong analgesia?
A If they had pain, yes. They would need the adequate doses of analgesia that were required.

Q You have told us obviously that you had experience working with patients who needed analgesia administered subcutaneously and therefore syringe drivers. I think syringe drivers came in in the late 1980s, something like that?
C A I have distinct recollections of giving intravenous diamorphine myself in very large doses in grams. I did that to patients in extremis when I was caring for them. These are patients with fungating carcinomas through the chest, where the heart, et cetera, was visible. Patients were in severe distress. So I have given large doses.

Q Did you yourself, in terms of patients on either Dryad or Daedalus wards, did you yourself every write prescriptions for subcutaneous analgesia?
D A Yes.

Q And that involved diamorphine?
A I am sure it must have.

Q And also midazolam?
A Yes.
E

Q And depending on the condition, depending on the circumstances, might well prescribe those two together?
A Of course.

Q Administered by syringe driver. You say "of course" and, again, I would like you to assist us, why the two together?
F A Because they have different functions.

Q Yes?
A Diamorphine is an analgesic. It is a strong analgesic which is given for severe pain. If somebody is in pain, and they are distressed, they will still be distressed even though they have pain, and they can still be very anxious. The midazolam is a very useful hypnotic sort of drug which relaxes a patient so they are not as anxious and as distressed. I think one of the
G main duties of doctors in palliative and terminal care is to relieve their distress. We cannot cure them. We cannot make them better. At least we can relieve their distress and part of relieving the pain we use diamorphine, and the distress, one of our tools is midazolam, and hyoscine for the secretions. We often gave cocktails. Before these drugs came in we had some marvellous drugs called "Brompton's cocktails" which was gin, morphine and a few other things that we used to give patients, and they were fabulous concoctions that were given to relieve patients' distress. That is what hopefully my job is, or was.
H

Q May I just ask you in terms of prescribing, again bearing in mind that circumstances differ and patients differ. When you prescribed subcutaneous analgesia, did you prescribe a dose range?
A Yes.

Q It might vary, but might the actual range itself vary in relation to patients?
A The range would vary enormously. As I said, I can recollect one lady who had a fungating breast lesion – this is when I worked in my house job – who had a whole in her chest with a red object that was pumping through, and the carcinoma was eating into that. I gave her an injection of 2.6 grams.

Q Yes, I ---
A Which is a huge dose.

Q I appreciate. I am trying to focus on the position in the 1990s when you were attending Gosport War Memorial Hospital for obvious reasons, because those are the matters which have been raised against **Code A** In terms of that hospital, did you prescribe subcutaneous analgesia with a dose range from time to time?
A Most of the time. Different patients, as they needed it.

Q Yes?
A The other problem, I am afraid, with diamorphine is the dependence... Not dependence; the patients actually get used to a certain dose and what might control their pain one day might not control it the next day, and one would have to increase the dose. Depending on the length of illness or the degree of pain, the dose might be increased incrementally regularly to control that patient's distress. The dose was not a fixed dose. It was not a dose that worked today and not tomorrow.

Q Let us deal with the dose range.
A Sorry.

Q Not at all. When the dose was actually increased within the dose range, did that increase of the dose by the nursing staff require your authority, or was it something they were authorised to do because of the range of your prescription?
A If that range was written on a drug sheet, and it was with appropriate instructions on how and when to give it, and the nurse was trained in doing that and was confident, or needed a nursing sister to do it in her presence, then yes, that would happen. But it would only happen with the specific instructions and if the nurse was trained.

Q Do you mean that you would give instructions or you would be relying on the nursing staff to use their experience if the patient's pain was increasing, for example, to increase the dose?
A If the dose was written on a drug sheet?

Q Yes.
A As required?

Q Yes.
A If a patient did not respond to, say, 5 ml, then another 5 ml, that would be written in to give them an extra 5 ml.

Q They could increase the dose within the range you had prescribed?
A Of course.

Q Without having to come back to you every time, otherwise there would be no point in prescribing the range?
A There would be no point in writing the instructions up. The instructions, we hoped, were always clear.

Q Did you yourself ever write a prescription for subcutaneous analgesia on an anticipatory basis, because it was your view that there might come a time when the patient might well need this. It might occur when you would not be available .
A If I needed to write a dose range up for that patient, if I felt it necessary I would do so.

Q Yes. What I am asking about is something slightly different.
A Because I did my own nights and my own week-ends, I never had to anticipate.

Q I see.
A Code A – the deputising service covered for her. The deputising service was covering for her. Then at that time the deputising service was not... What is the word? I also worked for the deputising service and they covered an enormous range. They covered the whole of Portsmouth too – several million patients. To get a doctor in time might take a long time. Also, the doctor you got would have varying experience, and so anticipatory prescribing in that case would be done. In my case, I would not need to because if I was needed, I could give the information and I would be there that night or that week-end. I was never needed to because I was there.

Q Thank you. You have explained why it was you did not need to, and you have explained what I was going to ask you about in any event. Your knowledge of and understanding of the reasons for Code A prescribing anticipatorily?
A Code A was not in the same situation as I was and she could admit a patient on a Friday afternoon.

Q Yes.
A The patient may need strong painkillers or whatever. To get a doctor out, they may not have arrived until 8 o'clock the next morning, or may not have arrived at all. I am afraid the deputising service at that time was not very reliable. Also, the quality of the doctors – well, the training of the doctors was variable.

Q All right.
A I will leave it at that.

Q Those are the reasons. Obviously, when you went in and saw patients at the Gosport War Memorial Hospital who were new to you, because you were coming in on an on call basis, you would obviously be looking at what their drug administration and prescription history was?
A Yes.

Q If necessary. And therefore you would, no doubt, very often see what it was that Code A Code A had prescribed. I am concentrating on analgesia. You would see what she had prescribed by way of analgesia, and see the dose ranges and so on?
A Code A had been working with Code A for many, many years. She was far more experienced. When I used to write up these drugs I would have to refer to a book. Code A is very experienced in writing up the doses and ranges because she had been doing it regularly, and for many patients. I did not have the same experience as she did so I used to look it up when I did it.

Q All right. Bearing in mind the difference in experience, if you had thought there was anything untoward or questionable about Code A 's prescribing, you would not have hesitated at the very least to discuss it with her?
A I would have written it all over the notes, I am afraid.

Q Maybe you ought to have done. You would obviously have raised the point one way or another.
A I never had the opportunity to raise it actually with Code A. There was no need to.

Q May I just ask you some further questions about her. I think it probably follows from what you have already told us. Code A was obviously extremely hard working. We have heard that from other witnesses and it is not a matter in dispute in terms of this hearing. How did you find her to be in terms of her commitment to the interests of her patients?
A I think you only have to ask her patients. She is one of the most popular doctors in our practice, and her surgeries have always been booked up. I have known her for 29 years, 28 years, 28½: she has always been totally committed to her patients.

Q Perhaps I can just ask you this following on from that. In your experience of her, was she the sort of person who would be likely to write up a prescription for the administration of a drug in order to shut up a patient – a patient, say, who was being troublesome?
A She would only write up a prescription if it was necessary and to relieve that patient's distress.

Q I think you on occasion would actually clerk in patients, patients who were being admitted?
A I would do, and if Code A was on holiday or not present, yes.

Q I think amongst the twelve patients that we are considering in this hearing there is an instance of your writing up an admission of one, and I am just going to check it with you to make sure we have deciphered it properly. Would you go, please, to file D on your left. Patient D is Code A . In that file, again using the numbers which have a little dash on either side of them, would you go to page 99A. We can see on that page, and I appreciate this is out of the blue and is referring to something back in 1998, at the top of the page we have notes made at a review by Code A . You will be familiar with her, I think?
A Yes.

Q Is that her signature there?
A I do not know. I am sorry.

A Q Do not worry. I think that is right. I hope I have that right. In any event, that is referring on 4 August, as we can see, to transfer to Daedalus in due course. Yes? On 6 August?
A Yes.

Q If you can pick up that date. Then, going on to the next entry which indeed is dated 6 August. Can I just ask you this. Is this your handwriting ?
B A That is my handwriting.

Q It says: "Transferred from ---"
A Phillip ward.

Q Phillip ward? Phillip ward being?
A That would be the ward that Code A presumably, looked after in the QA.
C

Q In the QA? All right. "For 4-6 ---"
A Weeks.

Q " ... /52." And then what does it say. Is that weeks?
A No, that looks like... "Obs" that looks like. O-b-s.

D Q For four to six weeks obs – observation. "On Augmentin for ---"?
A "UTI."

Q UTI?
A That is my abbreviation for urinary tract infection.

Q When you clerked that patient in, although that is obviously a very brief note, would
E you have conducted an examination of the patient?
A That might have been just for transfer. If a patient had been transferred to the ward and it may have been late at night, or whatever, and it would just be that I would be asked to go and see them, that is not a clerking. That is just a note.

Q I see. It is a note – you would have been called out, would you, specifically to admit them? Tell us what the procedure is?
F A I may have been called out because they were there and there was nothing in the notes, so I would write that: "Been transferred from Phillip ward".

Q In those circumstances you might not have carried out an examination – is that right?
A I might not. I have not because I have not recorded it. That is just a note that I put down there, "Transferred from Phillip ward 4-6 [weeks] obs on Augmentin."

G Q But there is nothing else in relation to that particular patient which appears to be in your handwriting or involving you. Let us just check one other page to make sure that is right. No. If ---
A The next page says ---

Q Hold on. Hold on. Would you go on to page 206 in that file. There is nothing from you on the following page but if we go on to page 206 ---
H A The next page says "... no specialist or nursing problems".

Q Doctor, forgive me. Do not worry about that for the moment. It is only if there is anything to do with you because the Panel will have been through this file and will be going through it again, I suspect, in a different context. If it is nothing that you dealt with, I need not ask you about it. We should just go on to 206, please. I would just like you to deal with this. It is not an entry by you, but there is a reference to you having seen the patient. Do you see at the top – it is the same date we were looking at: 6 August. Seen by you and the nurse's note reads: "And clerked in".

A Yes, I see that. It could be "checked in" – I do not know.

Q Sorry? Who knows?

A I cannot read the writing.

Q Either "clerked" or "checked". All right. That will do for my purposes, thank you. I just wanted to clear that up with regard to that particular patient. Then can we look please --

Code A I think we have reached a point now where we need to break. The witness has been on the stand for some time and we need to keep the Panel fresh.

We are going to break now, Doctor, for twenty minutes. I hope you will be taken somewhere and given some refreshment. You remain on oath. Please do not discuss the case with anybody whilst we have this break. We will all return, please, in twenty minutes. Thank you.

(The Panel adjourned for a short time)

Code A Welcome back, everyone. I remind you that you remain on oath and I hope you are refreshed with that brief pit stop. I know it was good for the Panel.

THE WITNESS: I started work at 8 am yesterday morning and (microphone off rest inaudible).

Code A If at any time you feel you need to take a break or to stop, then please tell us. It is important that you do not feel that you are being made to answer questions when you are not feeling able to answer properly.

Code A Doctor, another patient and, again, it is just a question of you helping us with an entry where I think you were involved, albeit briefly. The file I want you to look at is for Patient E, Code A Would you turn in that file to page 47. We can see at the top of the page there is an entry dated 17 August. We will all be familiar with the fact that on that day, 17 August, this lady was brought back to Daedalus from the hospital, the Haslar, and brought back in such a way that she was in a very painful and distressed condition, having not being transported, it would appear, in the proper fashion. If you look halfway down the page, it says:

"PM – hip X-rayed at 15.45."

Does it show you as seeing the films together with the radiologist?

A I have not got that, I have page 47.

Q Does your page 47 have at the top, 17/8/98 on the left?
A It does.

Q Below it another date, the same day?
A It is but my writing does not appear there.

Q Opposite the second time – 17/8/98 appears, at the top of the page – does it them have a time 13.05.
A Yes.

Q There is then a section filled in by one of the nurses we have heard from, Code A Code A There is then an entry immediately after that in different handwriting which has "pm" written beside it, and:

"Hip X-rayed at 15.45".

Apparently it shows the films of the X-ray being seen by you and a radiologist and no dislocation seen. Is that right or is that wrong?
A That appears to be written there, yes, but it is not my handwriting though.

Q Can we take it though that it is you, or is there a radiologist with the same name?
A I presume it is me. There was another [Dr X] in the town at the time, but I presume that is me.

Q It must be a doctor because the doctor is giving a medical instruction to the staff for "pain control overnight and a review by Code A mane". Does that make sense?
A It makes sense, yes.

Code A I need to interrupt you there. The shorthand writer is already aware of the situation. There was an inadvertent mention of a name there. Members of the press, the Panel have determined that that name is not going to be used in our open hearings or in our public transcript. If you did make a note of that name, I would appreciate it if you would not use it in any of your reporting on today's events.

Code A Are you able to say whether that is you or whether it is another doctor, with the same name.
A I am not happy with what you just said actually. I am sorry, you have thrown me now.

Code A A particular name was mentioned and it was yourself who mentioned it.
A There is another doctor with the same name in the town, but I presume that is myself.

Q You said, "for pain control overnight and a review by Code A ", would it follow that in such a circumstance you would obviously have looked at what analgesia the patient was being given?
A None of that is in my handwriting. I presume that if that is what has been written, that is what has happened. I cannot confirm any of that because it is not my handwriting.

Q What I am trying to establish is that, if it was you, in order to say, "For pain control overnight", you would have checked what analgesia the patient was already receiving?
A Presumably.

Q We have seen the drug chart and we have seen what the patient was on at the time. It appears that instruction was followed?
A You are asking me questions which, from this information, I cannot answer.

Q Do not worry, I am not asking you to answer the question in that sense. I am making it clear to you why I am asking because the Panel have had to consider quite a quite a lot of evidence about this already.

That is all I need to ask you about that particular patient. If we can move on to a patient you have already been asked about, and that is Patient H, if you would turn to that file please. It is a page you have already been asked about but would you turn to page 180, Patient H. You will remember that you told us that you probably would have been called out because he was very seriously ill. That is what it looks like to you. Is that right?
A Is that a question?

Q I am asking you a question.
A I am sorry, you have really thrown me with the last one and I am having difficulty now in knowing what your questions are and what they are not.

Q All right, I will take it as briefly as I can. It was a question designed to make sure I have understood your evidence correctly because do you remember you said, in respect of this patient, that you presumed you had been called in because he was very severely ill, having had your attention drawn to this record?
A Yes, I remember saying that.

Q It would follow, would it not, that in respect of that examination of the patient by you, where you wrote, "Comfortable but rapid deterioration", you would have checked what analgesia he was on?
A Sorry, is that a question? I am having difficulty. You are not asking me questions, you are making statements and then asking for a response and I am not sure what you are asking for.

Q We will not argue the toss about it. I do think I began that by saying, "Does it mean that..." This is a question which I would like you to confirm what the position is. Does it mean that, in carrying out that examination and saying what you did in the note, that you would have checked what analgesia the patient was on?
A No. What I have written does not mean that, it means exactly what I have written. It means that when I saw the patient the patient was comfortable, there was a rapid deterioration and I have advised the nurse to verify death if necessary. That is all I can say from what I have written. If you are asking me for what I presume I meant from 12 years ago, I cannot help you with that.

Q Sorry, it is my fault I am sure. I am just asking you, if you had been called in to see a patient in those circumstances, you would have taken the opportunity to see what it was that the patient was receiving by way of analgesia?

A A I am still not quite sure – you are not asking me questions. You are giving me presumptions and making me make statements about presumptions and I do not know what your question is.

Q I am going to try once more.
A Right. I am sorry, am I being particularly stupid here or are you not explaining yourself correctly?

B

Q I am sure it is me, and I hope this is clear. I appreciate that you do not remember this specific patient but when you would go in and see a patient in these particular circumstances, a patient who is very severely ill, would it be your normal practice to look to see what analgesia the patient was on?
A In those days the drug chart was at the end of the bed and on approaching the patient's bed I would see the drug chart and I would normally pick it up and look through it as I was
C examining the patient, yes.

Q We are there, thank you. If I dare, I am going to ask you one more thing about this particular patient in relation to the hyoscine. Do you remember you were asking about that?
A Yes.

Q In this particular case you were indicating that the dosage was not an excessive
D amount to give?
A It was the normal range to give.

Q In respect of this patient, one other entry, and I am not going to bother to turn up the one you looked up before, page 267, you will see that is a summary sheet, top right?
A Yes.

E Q Do you see a date five or six lines down on the left, 18 October 1998?
A Yes.

Q

"Further deterioration in already poor condition. Code A has remained overnight. Seen by a [doctor] who spoke to Code A. Syringe driver renewed..."

F Can we take it that that is a reference to you or not?
A I am sorry, I thought this was going to be *in camera*. If it has my name on it, yes, but I would appreciate it if my name is not mentioned each time.

Q That is why I have specifically been avoiding mentioning your name. I have not mentioned it once. Looking at that entry, can we take it that that is you?
A Yes.

G

Q In your experience, when patients were in the stage that we were talking about and focusing on in this hearing, palliative or terminal care, if you were involved, would it be important for you to speak to relatives?
A On such an occasion, I would have words with the relatives and I would inform them of the seriousness of the patient's condition and I would probably advise them that the patient would die very soon; not quite in those words, perhaps, but in a compassionate manner so
H that the patient would know what was happening – so the patient's relatives, sorry.

Q Circumstances would no doubt differ depending on the state of the relatives and how much they appeared to be in the picture or not?
A Yes.

Q Lastly this. With regard to the other patient you were asked about, and I do not think we need to turn up any papers, but when you were asked to look at the previous history with regard to Code A who had been a patient of yours for years, you told us, and you have given us the general picture, that when you were asked to make a statement about it years ago, all the information to enable you to confirm things was available because the officer had the records?
A Yes.

Q We can take it that the information in the statement is accurate?
A It is as accurate as I can remember.

Q It is a very brief scenario. You described in that statement when you had all the records about the situation with regard to her having fallen unconscious way back in 1982 and so on, you had seen her regularly until she was admitted to hospital prior to her death in 1996. Her medical condition, you said, was kept generally under control, "However, as the years progressed, she deteriorated with age"?
A Diabetes is an insidious disease which affects all blood vessels. One of the problems is strokes and heart attacks and this lady had one of the long term complications that we try and prevent, but as it is a long term complication of age as well she succumbed to it.

Q You made the point in your statement that she was also very over weight which did not help?
A She was very over weight.

Q With regard to any heart problems, those had gone back to January 1985 when she had an irregular heart beat and mild heart failure. You spoke about a period of time in 1983 when she had an irregular heart beat and so on, and in 1972 swelling of her ankles which, in your view again, was due to her heart failure?
A That would be right-sided heart failure.

Q You stated to the police when you had all the records that this was a condition she had until she died in combination with diabetes, and a cataract extraction and so on. I need not trouble you with that?
A Cataract is another complication of diabetes and old age.

Q You made the point that her vision had deteriorated and she was put on the blind register. Chronic bronchitis in 1995, on strong inhalers to combat that?
A Yes.

Code A Then you went on to the more recent history which we have already covered in respect of the records we have already looked at. Doctor, that is all from me. Thank you very much.

Re-examined by Code A

Q I have two short matters to ask you about. The first is to go back to bundle D. Go back to your entry at page 99A, which I think you described as a note made on transfer, your note right at the bottom. I will give you an opportunity to find it. Do you have that?
A Yes.

Q All I want to ask you is, if you had been performing an assessment on this patient, can you tell us what that assessment would have consisted of and what your note would have been?
A If I had done a normal clerk-in, I would have had the history.

Q The previous medical history?
A The previous medical history, I would have noted that, and my examinations that I performed and conclusions and any investigations I wanted to perform.

Q I am sorry to ask you to state what may for you be the obvious, but your examination would have included what?
A A full clerk-in is a full examination where I would do the respiratory system, cardiovascular system, abdominal system, central nervous system, muscular skeletal system.

Q Then would you have written out a plan?
A I would have written out a plan, yes.

Q If the patient had been complaining of pain, would you have recorded that?
A Yes, if I had taken the history, yes.

Q Would you have recorded where the pain was and any diagnosis you could perform?
A If I had taken the history, I presumably would have, yes.

Q You would have made a note of it?
A If I had taken the history, I would have made a note of it, yes.

Q The only other matter I wanted to ask you about is the evidence you gave about ranges and instructions. You told the Panel that you would, in the past certainly, have yourself prescribed a range of opiates?
A In 32 years of medicine I must have.

Q For you, are you saying that that is a rarity or was it a common occurrence?
A At the moment it is a very rare occasion because I do not have hospital patients any more and the system we have now for palliative care we have a much different support system, so I have not actually prescribed diamorphine for a syringe driver for six months or a year.

Q All right; but can I just take you back to the time when you were writing out such prescriptions. First of all, what sort of instructions would you have given, and would they be written or oral instructions?
A For?

Q If you are writing out ---

A A If I am writing out a drug sheet I am writing out a drug sheet, and obviously if I am writing out it would be written.

Q Right. So what sort of instructions would you give?
A I would write out the name of the drug, the dose, how often it was to be prescribed, and also there is actually on the drug sheet – there is a space for time, timing, and I would have written the times that that drug should be administered. I would also put the date, the
B dose and my signature.

Q I think the law requires you to do that if it is a controlled drug?
A If it is a controlled drug the law requires that you actually write the amount in letters as well, but in days of computers now, the computer ---

Q We are pre- – we do not have to worry about that. If you are writing out a drug for
C use PRN would you give any instructions as to the circumstances in which that drug should be used?
A Controlled drugs cannot be given PRN. More specific instructions need to be given.

Q Can you give us an idea, please, of the type of instruction that would need to be given?
A I could put "Tablets, diamorphine", or "Solution 5 mg every 4 hours, can be increased
D to 10 mls (sic) as required" – if necessary. But the dosage would not be a PRN, it would be for pain, for specific pain.

Q Would you write that out, or not, "for specific pain"?
A On the drug sheet itself it would just have the instructions – the name, the dose and the times.

E Q And when you are writing out a range of diamorphine, which you have done in the past?
A I think for the syringe drivers – I think there was a specific form which actually allowed you to put a dose range on it, and it was – I cannot remember the exact forms, but it gave you that opportunity of increasing the dose.

Q You have spoken about drug ranges, and I think we had better have an idea from you,
F please, what sort of range you have prescribed in the past and in what circumstances.
A Of?

Q Diamorphine.
A Diamorphine? I have prescribed anything from 2 mg three times a day to 2 grams every two hours, so you are talking a range of a thousand-fold.

G Q But in a variable dose – we have seen in this case some variable dose ranges. Have you ever written out a variable dose, say between *x* and *y*?
A In 32 years I must have.

Q Can you give us ---
A No, I cannot give you a specific example; I cannot remember.

H

Q You cannot? All right. You were asked if you had seen Code A s prescriptions on occasions, and you told us that Dr Barton was very experienced – yes?
A She was a very experienced GP and also experienced in palliative care.

Q Did you ever challenge any of Code A s prescriptions?
A I have never challenged any of Code A s prescriptions.

Code A: Thank you very much.

Code A Thank you, Code A
(To the witness) We have reached the stage now where the barristers have completed their questions, and it is the opportunity for the Panel to ask questions of you. What we have tended to do in this case, to avoid prolonging that questioning, is to take a break at this point in the proceedings so that the Panel can confer together and work out precisely what, if any, questions we are going to ask. At the end of the day it should shorten the proceedings. So what I am going to do now is that the Panel will break, in terms of the openness of the hearing; everybody can go and have a coffee or tea, and we will remain to confer, and we will call you all back as soon as we are able.

(The Panel adjourned for a short time)

Code A Welcome back, everyone. Thank you very much indeed for the indulgence of that time. I think I can say that it was time well spent, and it has resulted in our being very focused in what we hope to achieve with this.
(To the witness) Doctor, I am going to pass you now to Code A, who is a medical member of the Panel.

Questioned by THE PANEL

Code A Doctor, I am a general physician/cardiologist. I realise that this has been quite an ordeal for you – it is very difficult for you to sit there and fence questions. What I am going to ask you is directed this way, that we have the opportunity to talk to a doctor who worked in that hospital and is, if you will forgive me using this word, an average doctor; and to understand how you would do something. I am not going to ask you to comment on what Code A did, what happened.

You said that in many ways you would defer to Code A because she had lots more experience than you, and that you would want to go to the *BNF* and check doses.
A That is correct.

Q For the sake of the rest, for counsel and for my fellow panellists, I am referring back to Patient K. You were not involved in Patient K, and we will not need to go to Patient K's notes, but we will need to go to file 1 – great big number 1 – and would you turn behind tab 3, we will start at page 5. It is all about opiates, and how you work out the dose of opiates – yes? Just to go back a moment and to put it in perspective – I know the answer to this but the others do not know the answer to this. You said that on occasions in palliative care you might give grams of diamorphine – indeed I have too – but it would be true to say that those patients had been on a pretty long journey of increasing opiates, would they not, normally?
A It varied.

A Q Very long?
A It varied.

Q Varied?
A Varied. Some were, some were not. The one that sticks in my mind – as I said, I am sorry, I have mentioned it several times – a particular lady that I have given the largest dose I have ever given in my life to, and to be very honest with you, that was over a few days.
B This lady was about to rupture her heart with a cancer going through, and we gave – I did this under supervision – I gave her enormous doses intravenously.

Q But incrementally, maybe even dose to dose increasing?
A I had given the previous dose about 30 minutes or an hour before, of about the same amount.

C Q Judging each dose and each increment?
A Yes.

Q That is OK. But that is a very unusual situation.
A That is unusual, yes.

Q So let us look at that table there. You go to the *BNF* and you have a patient who –
D well, you have a patient in pain. It is a little lady – a qualified witness said actually she was stocky, a little stocky lady, old lady – and she had not had opiates except that she had had a fentanyl patch put on the day before, about 24 hours before. We now want to start her on subcutaneous diamorphine with midazolam – yes?
A Yes.

Q It does not matter what the reasoning of that is; I am trying to understand how you
E would then refer to the *BNF*.
A It depends what dose of fentanyl she was on, what patch it was.

Q It is a one-off, she has never had it before, and she had not been on opiates.
A So what dose of fentanyl was she on? There are several different patch doses.

Q I think it was 25 micrograms.
F A 25 micrograms?

Q If you had turned to the *BNF* and the first page you turned up was page 5 there, you see that it is an equivalence kind of table, is it not? It is kind of saying morphine sulphate on the left-hand side, and on the right-hand side it goes to the fourth column, this is the equivalence of what you would give if you were giving diamorphine subcutaneously. The table starts at 5 mg of morphine and says that it would be equivalent to 15 mg of diamorphine
G every 24 hours. Is that right?
A Yes. So that means that 30 mg of morphine oral sulphate is equivalent to 15 mg of diamorphine every 24 hours.

Q Just to remind us, what is the lowest dose of Oramorph that one would normally start at?
A 5 to 10. 2.5 to 5 to 10 mls.
H

A Q A little old lady, 2.5?
A 2.5 to 5.

Q And that would be equivalent – 2.5 would be equivalent to 7.5 mg of diamorphine subcutaneously in 24 hours.
A Depends which dose. Hang on, I have to work this out.

B Q I do not want to confuse you. If you say, and I would say, that if you are starting somebody on Oramorph and it was a little old lady, you might well start at 2.5, or you might start at 5. It depends on certain situations.
A Yes.

Q That being the case, if you wanted then to swap into subcutaneous diamorphine, say because the patient could not take by mouth any more, you would refer to the right-hand
C column and you would say "OK, that is equivalent to 7.5 or 15" – 7.5 to 15 mg. Yes?
A (No reply.)

Q Agreed?
A Agreed.

Q It is for the shorthand writer.
D A That is what it says in the book.

Q It is just that we have to say "yes".
A Yes.

Q If we go to page 11, this is the *BNF* – and the *BNF* is the bible, is it not?
A It is a guidance.
E
Q Well ---
A A bible is something you believe in. The *BNF* gives you guidelines. We follow guidelines but we do not stick to them.

Q It is true to say that it is the document to which every doctor would, in day-to-day practice, refer?
F A Either that, or *MIMS*.

Q You are quite right. In general practice you would go possibly to *MIMS*. But if you wanted authority on a drug you did not know anything about, you would go to the *BNF* normally?
A That is correct.

G Q Yes. So it is an accepted focus point for therapy?
A Yes.

Q In the bottom right-hand corner it says "Diamorphine", and the third heading is "*Dose*", and it says ---
A Sorry, what page are you on now?

H

A Q 11. It says "acute pain", does it not? It says: "*Indications*" and then it says "*Cautions; Contra-indications*", and then it says "*Dose*".
A "*Indications*", it says "see notes above; acute pulmonary oedema".

Q Yes, but if you go down, the next heading in bold is "*Cautions*", and the next heading below that in bold is "*Dose*".
A Yes.

B

Q It says: "acute pain, *by subcutaneous ... injection*" - "*or intramuscular*" – "5 mg repeated every 4 hours".
A "If necessary".

Q "If necessary". That would translate to 30 mg in a day, six four-hourly doses, 30 mg – yes?
C A Six fives are 30, yes.

Q And it says that if you have a muscular, beefy guy, you can give him 10 – heavier, well-muscled patients. That is acute pain. If you go down a little bit further there is a heading for "Chronic pain", and it says "5-10 mg every four hours". Are you with me?
A Yes. I am reading "regularly every 4 hours".

D Q That equivalent is in 24 hours, six times five is 30, to six times ten is 60?
A 60.

Q Milligrams in a 24 hour syringe driver. Yes?
A Yes.

Q Agreed?
E A Agreed, yes.

Q There is no confusion about that. That is what the book says?
A No. Six times five is 30. There has never been any confusion about that.

Q That is what the book says. Now go back to page 6. We are dealing with a little old lady – a little stocky old lady. This is "Prescribing for the Elderly." It gives caution to
F reduce the dose. I am afraid I have totally lost ---
A It is the very first thing it says; "Old people, especially the very old, require special care and consideration from prescribers."

Q Go to page 7. This is the half page - yes?
A Yes.

G Q And it says on the left hand side "Guidelines".

"First always question whether a drug is indicated at all."

If patient was not in pain? Is that something to question?
A Well, yes. Something to question. It depends on your indications. As you said before, it is also given for pulmonary oedema, it gives on the indications. Pain is not the only
H use.

Q You would say, you give it for pain and you would give it for the acute distress of pulmonary oedema?
A Yes.

Q And in addition in pulmonary oedema, it does other pharmacological things which actually relieves the problem. I think that is what you said, is it not?
A Yes.

Q Then it says limit the range. Yes?

"Guidelines

First always question..."

The next heading is "Limit Range". Yes?
A Yes.

Q Sorry – you have to say "yes" for the verbatim note. Then the next heading is "Reduce Dose", and it says:

"Dosage should generally be substantially lower than for younger patients and it is common to start with about 50% of the adult dose."

Yes? Yes?
A Well, you are reading it out. Sorry.

Q Do you agree?
A I agree what you are reading out is what it says, yes.

Q Right.
A Yes.

Q We have to go about it this way ---
A Right.

Q --- for the transcript. It is rather like medical notes. It is when somebody comes to read what has happened they have to understand exactly what we have said. We have already said that for acute pain, you would give 5 mg times six, 30 mg a day in a syringe driver.
A The guidelines advise, but it all depends on the patient in front of you what ---

Q I agree. I agree.
A So it is guidelines, and it depends.

Q But if we stick down this road the logic is, acute pain, 5 mg times six, 30 mg, for a little old lady should be reduced to ---?
A It depends on the little old lady. I would not make that decision without examining the patient.

Q Of course. Of course. But the logic is that you would read into that guideline that you would not give 30 mg.
A The logic is, they are guidelines and I would read into it after seeing the patient as well.

Q Wait a minute. You have to first of all read the guidelines, have you not?
A No, because I know that. You have just said to me what the dose was. I know roughly what the dose is. We have multiplied five by six several times.

Q You said that you would refer to the BNF. You said that earlier.
A I would refer to the BNF if I did not know the dose. I do happen to know the dose of Oramorph, which is 2.5, as I explained to you without looking it up in the BNF. If I am not sure of something, I will look it up in the BNF. I am certainly not sure of midazolam, the dose. I do not know that. The doses of diamorphine that I have used, I have been using for the past 32 years. I would not actually have to look those up. Midazolam I would. I really do not have a clue what the starting dose of midazolam is, how long it has to be given for. Hyoscine, I have been reminded all afternoon, but diamorphine I have been using, as I said, for 32 years and I would not have to look up that dose.

Q Let me put it this way then. If I read this, and I also am not naïve in the use of opiates as a general physician, I read this as saying that if the recommended dose for an adult – to use the word in here – is 30 mg/day, if you are dealing with a little old lady adult, you halve the dose to 15 mg in a day?
A It depended on the little old lady.

Q But I am trying to get you to ---
A You are trying to make me say things ----

Code A Can I just assist here for a moment. Can I just give some general advice about questions from Panellists. It is this – and I hope I am helpful.

It is very important that Panellists ask clarifying questions of a witness. Of course, it is right that if evidence is given which appears to conflict with a personal experience of a Panellist, that Panellist should raise the matter in open hearing with a witness so that all parties are aware of that issue and can deal with it. Of course it is quite appropriate, I advise the Panel, that questions should be probing but it is not appropriate, I advise, for a Panellist in effect to give evidence when asking questions of a witness.

Furthermore, in putting any personal view to a witness, a Panellist should bear in mind that the Panel will eventually come to its determination on the basis of all the evidence that it has heard. No Panellist certainly should come to any concluded views before hearing all the evidence and discussing matters in camera. It may be that it would generally be sufficient for a Panellist to ask questions of an open nature.

That is the advice I give to the Panel at this stage.

Code A Thank you, Legal Assessor.

Code A I understand that advice. What I am trying to probe is how one as an average doctor – me, you – how we read the BNF?

A A We read the BNF if we need to, but how we do everything as a doctor. We first of all take a history, which means we ask. We do an examination. We look at the patient. Then we do special investigations. Then we prescribe. We only prescribe after we have taken a history and examine the patient. So to prescribe without doing those first two things first is impossible for me to say.

Q You are right.
B A Thank you.

Q But I am not asking about that.
A Okay.

Q I am asking about general principles of approaching the BNF for advice.
A The general principles: I would approach it if I was not sure. I would certainly
C approach it for advice and also as a guideline, but I would only approach it after I had taken the appropriate history and done the appropriate examination of the patient. So for you to ask me my opinion without the patient being here, I am afraid I cannot answer that question.

Q Can I ask you this way round then? If you are looking for a starting point – just a starting point – from which to make up your decision, using all the things you know about the patient, is the BNF not telling us that 15 mg a day of subcutaneous diamorphine is the starting
D point of the argument?
A The BNF is giving you guidelines. They are guidelines to be used in conjunction with the examination and the history of the patient. We do not follow things blindly. As doctors we do not even believe everything we read. We should not do. We should question it. We should look at it and say, "Is this the right thing to do in the best interest of my patient", and if it is in the best interest of my patient and the BNF says it is wrong, I will do the thing in the best interest of my patient first.

E

Q Thank you, Doctor, I am not going to ask any more.
A Thank you.

Code A I am going to go to myself directly because I think I understand what you are saying. I am going to attempt to paraphrase it. I am sure you will tell me if I have got it wrong or if I have not. Guidelines are not tramlines, I think is what you are saying.
F A Guidelines are for narrow-minded people.

Q Guidelines are not tramlines but they are precisely what they say. They are there for guidance, and you have indicated that you are aware in the case of diamorphine what dosages are normally required but, of course, you will always look at the individual patient first because that may take you either above or below what is in the guideline. Is that correct?
A That is correct.

G

Q And if I understood you correctly, you do not need to keep going to the guideline each time to look it up because you already know?
A That is correct.

Code A That is very clear for me, thank you. Are there any other questions from any members of the Panel? (None) No. Very well. That concludes the Panel's side of it.
H There is just one tiny bit now. That is, I have to give the barristers the opportunity to ask any

A questions they may have that arise out of the questions asked by the Panel. Code A do you have any questions arising?

Code A: Just one.

Further cross-examined by Code A

B Q I have just one, Doctor, and I am afraid I am using you to look at another document. Nobody will be surprised if you say, I can read what it says too. We all have to concentrate on certain issues. We have a lot of material to look at. Just on the point you were asked some questions about in relation to fentanyl, do you remember, and a 25 mg patch, if that is the right expression. I just want to use you while we are all thinking about that to see what is said about a conversion for fentanyl in the palliative care handbook, or the Wessex protocol, or whatever it was technically called. Were you familiar with that in those days?

C A I am familiar with the book, but not with the conversion tables.

Q No. That is why I want to use you just to point something out. Would you look back in file 1 again, please, tab 4. Using the printed numbers in the bottom right hand corner of the page as you look at it, holding it the right way up, would you go to page 5. In fact, that is pages 6 and 7 of the handbook. Do you have that?

A Yes. I have that.

D

Q Do you see over on the right hand column which is dealing with strong opioids, towards the bottom, in the section numbered 4 it is dealing with fentanyl – all right?

A Yes.

Q And just after the first four or five lines, is there a little table saying "Conversion from oral morphine to transdermal fentanyl"?

E A There is.

Q Then, underneath that, we can just pick up the figures: fentanyl per hour, 25 – which I think is the patch we are talking about?

A 25 per hour, yes.

Q Just above it is the conversion to oral morphine?

F A Yes.

Q Which I think is 135?

A Yes. Less... Yes. Under. Yes.

Q Assume that is right. That is what the conversion rate shows.

A Yes.

G

Code A: I appreciate that is a statement rather than a question, but thank you for dealing with it in that way. That is all I need to ask.

Code A: Thank you, Code A Code A

Code A No questions.

H

Code A Thank you. Doctor, you have made it. That is the end. Thank you very much indeed for coming to assist us today. It is always difficult for witnesses to have to deal with these questions, but it does help us enormously to build up a picture of what happened very often months, sometimes years, in the past. For your part in assisting us to do that, we are extremely grateful and I am pleased to be able to tell you that you are free to go.

THE WITNESS: Thank you. I am grateful to Code A in clearing up what should and should not be required of a witness. Thank you, Code A

(The witness withdrew)

Code A Perhaps that would be a good moment to break.

Code A I think it probably would. Code A

Code A Before we do, may I just say this. I mean no disrespect to the Panel, but I will not be here tomorrow because I have to be in another court. I am sure Code A will be able to cope on his own.

Code A: You will be appearing in the appropriate capacity elsewhere. Thank you very much indeed. We shall rise now and start again at 9.30 tomorrow. Thank you.

(The Panel adjourned until Wednesday 24 June 2009 at 9.30 a.m.)

GENERAL MEDICAL COUNCIL **IN PRIVATE**

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 23 June 2009

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

Chairman:

Panel Members:

Legal Assessor:

Code A

CASE OF:

Code A

(DAY ELEVEN – 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 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: Code A)

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(For decision and the continuation of the proceedings see page 46 of the transcript in public)

A Code A The application, I confess, is not an unusual application. It is an application you will be well used to, but it is certainly for an unusual reason.

The next witness is proposed to be Code A I gather that she now goes by the name of Code A [redacted]

B She is a GP who practises with Code A at the Forton Medical Centre in Gosport. Four years ago [redacted]

[redacted]

C She describes herself as being stalked and door-stepped and she found the experience extremely unpleasant. Her concern now is that if her name is repeated in open session, it is very likely that the press, if they are here – and we have to presume that they are for these purposes – will make the link. There has been, as you know, a good deal of publicity about this case already. The focus, of course, so far has been on the evidence and upon Code A but the witness is concerned – and it may be with good reason – that there would be at least a flurry of activity if the press do make the link and that they are likely to report her background.

D She has moved on effectively to a new life. She is still working at the practice but there are at least some patients there who do not know of her background. She also has a social life where a number of her friends and colleagues socially do not know of her background and she would much rather it stayed that way.

E Accordingly, she would ask to be able to give evidence by writing her name down on a piece of paper so the Panel will know – you will know who it is anyway – but formally, so that the Panel know who they are dealing with.

F It seems to me that it would be appropriate, if you are prepared to hear from her or if you think it is necessary (and you may not) to hear from the witness herself in relation to this application. Unless what I have said to you persuades you, I think it is important that she has the opportunity, because it is essentially her application that I am making, of making it clear to you why it would have such an adverse effect on her new life potentially for her name to be revealed. I do not know if you feel it would be appropriate for you to take soundings within the Panel first.

G I can tell you this. I have spoken to my learned friends. Neither of them has any view about this. As I understand it, they have no objection to the application whatever, and they are just keen that this doctor is able to give evidence because they have questions to ask.

Code A Sir, can I simply add to that? Obviously my learned friend has set out the position very clearly. One naturally has every sympathy with the concerns of somebody whose private life has been used by the press for the purpose – it sounds as if – of a press story which no doubt carries with it an awful lot of damage to the person concerned. I am not seeking to dissuade the Panel in any way from the sort of considerations that my learned friend has mentioned. I think we also should point out that we have an extra sympathy, if you like, with the position of Code A because if it was not for the defence saying we actually

H

need her to give evidence – there is nothing particularly contentious in her statements – her statements would have been read.

Obviously it is a matter for the Panel, and the Panel will want to be fair to the witness and also the public interest that is also involved. I am not seeking to take a firm position on the matter. I certainly do not disagree with my learned friend's suggestion that it might be sensible for the Panel to hear from the doctor. We are certainly not opposing the application in that sense.

Code A I am most grateful for that clarification.

Code A Can I just add this? Of course the rules provide that the hearing shall be in public except as provided by 48(2)(a). We are asking that a small part of this evidence be in private – that is, the witness's name – but the public, of course, will be able to hear all of her evidence.

Code A As a matter of practicality, if the Panel were to accede to that and the substantive evidence was in public, are you going to be able to adduce that evidence without, as it were, identifying the individual in any event? Presumably there would be reference to places of work and the like.

Code A There would certainly be a reference to the fact that she is a GP and there would probably have to be reference to where she worked.

Code A Is there a likelihood that other witnesses yet to be called may be asked to comment on something that is said by this witness, or that there may be any overlap between that evidence? It is just a matter of how we would handle it.

Code A It is unlikely, certainly until we get to expert evidence. It is possible once the expert gives evidence that that would become relevant.

Code A So far as the expert was concerned, the usual anonymisation principle would handle that.

Code A The reality is, and I will have to be open about this, that you have already heard her name mentioned. I think I have mentioned the fact that there were difficulties in securing her attendance. The press could make that link in any event. I think the witness's concern is the immediacy of giving evidence now and her attendance here as a witness rather than the fact that she may have dealt with one or two of the patients which is revealed by the notes. It is the fact that she has come along and given evidence and presumably the evidence that she gives which might, of itself, create a press story.

I absolutely accept there is no way of completely concealing her name for the period of the proceedings. We have not really sought to do that. It is now.

Code A I just wanted to understand the parameters within which we were working. I should first, then, turn to the **Code A** and see if he has any additional advice for us, or if it was in effect covered in the initial advice.

Code A I think I should just give this initial advice. I will have further advice to give in a moment, but it is really on the question of whether or not the Panel wishes to hear from the witness. That is a matter for the Panel to decide, but my advice to the Panel will be that if they do not hear from the witness – and the Panel may take the view there is no need for them to hear from the witness – but if they do not hear from the witness, it is only fair that the Panel accepts at face value everything that has been said by Code A about the past difficulties caused to this witness by publicity. I advise that that is the first question, really, for the Panel to decide.

Code A Thank you, Code A I am going to take initial soundings from the Panel in this way. We have all heard the application, and we have heard the advice from the Legal Assessor. Does anybody wish to go into camera to discuss this further? (The Chairman conferred with members of the Panel) No. Apparently not. Is everybody therefore content to proceed at this stage on the way indicated in the application? (The Chairman conferred with members of the Panel) Okay. Thank you.

Legal Assessor?

Code A Just before we go, just to clear in my own mind, are you asking us now whether we need to hear from the witness?

Code A I was asking first of all whether you wanted to go into camera to discuss that, and the indication having been given that you did not, I am now just making sure that that is because everybody is agreeing with the application to proceed without the need to have the witness. Or is it in fact the opposite view?

Code A No, it is a point of clarification I would like.

Code A Do you want to hear from the witness?

Code A No, no. I do not want to.

Code A My advice at this stage is limited simply to the question of whether the Panel should hear from the witness concerned. I will advise in due course that the Panel must go into camera to consider the merits of the substantive application.

DECISION

Code A (The Chairman conferred with the Panel) I think it is clear that the Panel do not feel it necessary to hear from the witness at this stage.

Code A Thank you, sir. I express no personal view on the merits of the application. It is entirely a matter for you. You have heard the GMC's application. I repeat what I said earlier. You have not heard from the witness. You have decided not to, and it is only fair that you accept at face value everything that has been said by Code A concerning the past difficulties in relation to publicity caused to that witness.

A Panel is, of course, given the power to order anonymity under the new rules but there is nothing to assist directly with this in the old rules which, of course, are the rules applicable to

this case. Rule 48 does not deal with anonymity. It deals with the question of the exclusion of the public.

It is relevant, however, I advise you, that rule 48 of the old rules makes it clear that subject to the power to exclude the public the general position is that hearings shall be held in public. You may think that if a witness is permitted not to mention their name in public, but to hand it in to the Panel on a piece of paper, the evidence in the case is not being given fully in public.

You may have heard – and I mention it only to dismiss it – there is some new statutory criminal legislation concerning witness anonymity. That does not apply to this case. It only applies to situations in which it is sought to withhold the name of the witness from the defence. That certainly is not the case here.

The situation is covered by the common law and by such guidance as there is in the old rules. Under the common criminal law there remains a discretion to allow a witness to give evidence anonymously if it is in the public interest. It has happened, for example, in relation to cases involving prostitutes or blackmail, and that discretion is clearly very limited.

You may think that while the old rule 48(2), which I hope you all have access to, is not of direct relevance, as I stated the principles it contains are of assistance to you. The reason for that, as I have said, is that you may think that the withholding of a name prevents a hearing from being fully held in public. Looking particularly at rule 48(2)(a) and (b), my advice to you is as follows.

In deciding whether as a matter of your judgment to allow the witness to hand in their name rather than state it in public hearing, you should consider whether that witness would suffer undue prejudice from giving their name in public or whether for any other reason the circumstances of the case make the stating of the name in public unnecessary or undesirable.

You should also consider whether to allow the witness to hand up their name is in the interests of justice or would be desirable, having regard either to the nature of the case or to the evidence to be given.

In this case, neither side objects to the witness being permitted to hand in their name, rather than read it out loud, but that is by no means decisive. The general rule is that the hearing should be held fully in public without anonymity being granted to any witness and that you should only depart from that principle on the grounds that I have referred to. You should guard against the danger of creating an unjustifiable precedent in relation to what should in principle be a fully public hearing and you will bear in mind that the name of this witness has already been given in evidence and that in giving their own evidence the witness will inevitably have to give such detail about their employment and experience as might make identification possible in any event.

I repeat that I express no view whatsoever in relation to this. It is a matter entirely for you to decide the matter on the basic and the principles I have set out. You may feel that this is an important matter which should be considered by you in camera and I state, as I said earlier, that under rule 48(2)(c) you should give the announcement of your determination in public.

That is my advice to the Panel.

Code A, do you have any observations on the advice just tendered?

Code A No, thank you.

Code A, do you have any observations on the advice just tendered?

Code A The Legal Assessor has quite properly reminded you of the terms of Rule 48(2)(a). The essential test is to discover whether any person – in this case it would be this witness – would suffer undue prejudice of a public hearing. Undue prejudice is not further defined, but I would venture to suggest that it is something which is more than the ordinary prejudice, as it were, of giving evidence, so something outside the normal course of events. You may think that with this particular witness one could properly say that this is more than the ordinary prejudice of giving evidence. I do not know if there is any comment to make about what "undue" means?

Code A Mr Chairman, I have no further comment to make. I should add that Mr Kark has properly referred to rule 48(2)(a). The principles I have outlined reflect 48(2)(a) and (b) as well. I have nothing further to add.

Code A Thank you. On that basis, the Panel will now go into camera to consider.

STRANGERS THEN, BY DIRECTION OF THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

The hearing continued in public

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 24 June 2009

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

Chairman:

Panel Members:

Legal Assessor:

Code A

CASE OF:

Code A

(DAY TWELVE)

Code A 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 Dr Barton, who was present.

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

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A

Code A

Good morning Code A

The next witness is Code A, please.

Code A, sworn

B (Following introductions by the Chairman)

Examined by Code A

Q Is your name Code A?
A It is.

C Q I am going to ask you first about you and your background and how you come to be involved in this case. Then I will ask you some general questions about how things worked on the ward that you worked on that concerns us. I will then move on to two particular patients who you had some dealings with. That is Code A and Code A
A That is fine.

Q First, about you. You qualified as a Registered General Nurse in 1998. Is that right?
D A That is correct.

Q In 1993 you worked as a bank nurse on all the wards at the Gosport War Memorial Hospital?
A That is correct.

Q You worked in the Redcliff annex?
E A That is correct.

Q Also Daedalus Ward and Sultan Ward.
A Yes.

Q After that you spent some time working at the QA Hospital. Is that right?
A Yes.

F

Q Then you returned to work at the Gosport War Memorial Hospital in 1995?
A That is correct.

Q That was on Dryad Ward?
A Yes.

G Q You worked as an Code A nurse. Is that right?
A Yes.

Q You continued to work on Dryad Ward through 1996 through until November or December?
A That is correct.

H

A Q At which point you took [redacted] leave. When you came back from [redacted] leave, you worked on Sultan Ward and is it right that in 1998 you were working on Sultan Ward?
A Yes, I was.

Q For the benefit of the members of the Panel it was in 1996 that you were working on Dryad Ward and you had some dealings with Code A and it was in 1998 on Sultan Ward that you had some dealings with Code A. Is that right?
B A That is correct.

Q Can you help us with what an Code A is and what an Code A did on Dryad Ward in 1996?
A An Code A was equivalent to Code A who was one grade below the Sister on the ward.

C Q The Sister on the ward was Code A Is that right?
A Yes, she was.

Q So your general responsibilities were general nursing care for the patients?
A Yes.

Q Was there any ward management involved?
D A Ward management in the absence of the sister.

Q Were you effectively second in command to the ward sister?
A Yes.

Q Would you also have dealings with maintaining notes, drug administration and dealings with patients' relatives?
E A That is correct, yes.

Q The Panel have heard a lot already about the kind of patients that were on Dryad Ward, but can you help us with your recollection with what sort of patients you dealt with?
A The patients that came to Dryad Ward at that time were in the main very frail, elderly patients who came to the ward for continuing care.

F Q What is your understanding of what continuing care means?
A Continuing care to me was to continue to look after those patients, nursing them, medically-wise to look after them from day to day, treat any signs and symptoms that may occur and to give good nursing care as to whatever they presented with.

Q Were these patients who were expected to leave hospital soon?
A No.
G

Q Was there a difference between continuing care and say palliative care or terminal care?
A Palliative care to me is a control of signs and symptoms of illness which could be incorporated with continuing care if they presented with the kind of symptoms that needed treatment.

H

A Q You have already mentioned Code A as being the ward Sister on Dryad Ward at the time. Can I ask you about her. How would you describe her in terms of her abilities as a nurse?
A Code A was a very good, caring nurse.

Q What do you mean by that?
A She cared very much for her patients and she gave excellent nursing care.

B Q Did you have any reservations about any aspects of her nursing knowledge?
A Nursing knowledge?

Q Yes.
A I think there was room for update. She had been the Sister on the ward for quite a while.

C Q Room for update in relation to what?
A Aspects of evidence based practice, wound care.

Q What does evidenced base practice means?
A Evidence based practice to me is researched nursing practice that is up to date.

D Q Can you help us with what aspects were not up to date?
A I would say in the main, for me, it was wound care.

Q What of her management style?
A Personally I felt that Code A s managerial style could have been improved. I found her to be at times quite authoritarian and felt that sometimes she did bully and belittle some of the nurses.

E Q In terms of who ran the ward, in terms of the nursing staff, who was it on Dryad Ward?
A Code A ultimately had responsibility as sister of the ward but, as to who ran the ward, it was depending who was more senior on the shift.

F Q Yes, I am sorry, but in terms of when Code A was on the ward, whose word was it that counted in terms of the decisions that were made or the care that was given?
A It was Code A 's ward and she did run the ward.

Q Was it easy for another nurse to challenge her view?
A I would not say at all times it was easy. Sometimes I felt myself that if things were challenged, then it was not met with a good reception.

G Q Code A was the Code A on the ward at that time. Is that right?
A She was.

Q What was her relationship like with Code A
A In my opinion they got on very well in the working relationship.

H Q How close was their relationship?
A They appeared to have a close working relationship.

Q What was your view in relation to what level of trust there was between them in terms of their working relationship?
A I think there was complete trust.

Q Moving on to some general aspects of the care, I want to ask particularly about syringe drivers on the ward. Before 1995 and the time when you arrived at Dryad Ward, did you have experience of how syringe drivers worked?
A I had experience from when I first started working at Gosport War Memorial which was in 1993.

Q Had you received training before 1996 on how to use them?
A Training at that time, as with other aspects of nursing, was very much – how can I put this – very much learning from your colleagues, no formal training as such.

Q You described it in your police statement as "on the job training".
A Yes.

Q You learned, simply, how it worked, how it operated, how to use it?
A Yes.

Q Did you also attend a course on palliative care in 1996?
A Yes. I was asked if I would like to go on the Care of the Dying and Their Family course in the Isle of Wight in 1996.

Q That is an English National Board course at the Hospital of Nursing at St Mary's in Newport in the Isle of Wight?
A That is correct.

Q Is that a course that ran from January to July 1996 for about a week each month.
A I believe so.

Q So you attended off and on for about a week a month each time?
A Yes.

Q Did you learn more about syringe drivers there?
A No, I think it was just continuing in the knowledge that I already had. I did not think learn anything new or learn that we were doing anything wrong. It was just continuing learning really.

Q Were you aware at that time in 1996 of the analgesic ladder?
A I was.

Q Was that also something covered by the course?
A Yes, it was.

Q Something you were aware of before?
A Yes.

A Q When you started working on Dryad Ward in 1995 and into 1996, how did the use of syringe drivers compare there to your previous experience of them?
A I would say we did use them more, but then the patients that were on Dryad Ward were very different to the patients that I worked with before. This was a continuing care ward. I previously worked on acute wards and theatres so the patients' needs were very different.

B Q I think when you were making your statements for the police you made clear that you were aware that there were benefits to syringe drives for certain patients?
A There are definitely benefits to syringe drivers.

Q Which are?
A To control signs and symptoms, to relieve pain, to relieve restlessness, to relieve breathlessness and syringe drivers are used for many other things.

C Q Did you have any concerns about the way that drugs, particularly for syringe drivers, were prescribed upon patients' arrival in the ward?
A No, I would not say I had concerns. If I had concerns, then I would have voiced them at the time. The way they were prescribed I had not seen before, but that did not mean to say it caused me concern.

D Q To be clear about this and in fairness to you, when you were dealing with the police and making your statements, you made clear that at no stage did you ever feel that any member of staff did anything to harm a patient?
A I still feel very strongly about that. I could say hand on heart that that still stands and will continue to do so.

E Q The Panel will be clear on that. Let me ask you about the way in which drugs were prescribed. You said you had not seen the way that they had been prescribed before. What was this way of prescribing when a person came into the ward?
A When a person, from my recollection – and I think it has to be made clear it was a long time ago, it was over a decade ago – but from what I can recollect at the moment is that when a patient came onto the ward, they were written up for their current medication but they were also written up in the main for the syringe driver if it was required. That did not mean to say every patient that came onto the ward went onto the syringe driver, and did not
F immediately go on to the syringe driver. It was there if it was required.

Q The drugs that would be prescribed in that way to go into the syringe driver, would that always include diamorphine?
A The diamorphine was written up, but it was not necessarily that that patient would require diamorphine; it very much depended on their symptoms.

G Q So we understand, we are just talking about what was written up at this point.
A Right.

Q What about midazolam?
A Midazolam was also written up.

H Q Whose decision would it then be about if and when a syringe driver would be commenced?

A A It tended to be a nurse's decision, because we were there looking after that patient 24 hours a day, so depending on how the patient presented and if they were in pain; but it was always a decision that was made with reference to Code A as well.

Q When you say "with reference to Code A" ---?
A She was always consulted.

B Q At what point?
A From what I recollect, before the syringe driver was administered.

Q We have obviously dealt with the starting of the syringe driver. In terms of subsequent increases or changes in the dose in the syringe driver, who would make this decision?
A I think that was – what I recollect, that was a decision that was made with nursing
C staff and Code A

Q We have already heard quite a lot of evidence about those ranges being prescribed for drugs like diamorphine or midazolam – for example, say, diamorphine 20 mg to 100, or 20 to 200, that sort of thing. Did you have experience of those sorts of prescriptions?
A I did.

D Q I appreciate that this may be going over a little bit of the ground we have just covered, but what would be the purpose of that sort of prescription on Dryad Ward?
A It would allow the administration of higher doses of diamorphine if it was required.

Q In terms of, say, increasing doses for a person who was already on the syringe driver, would a nurse need to talk to Code A before increasing such a dose?
A Not necessarily.
E

Q Not necessarily? You have already explained that you were aware of the analgesic ladder at the time. Was that the same for all the staff on the ward?
A I cannot comment on that; I do not know.

Q You do not know?
A No.
F

Q From your experience of how syringe drivers were used or the doses that were used, does that help you in terms of whether the analgesic ladder was always being applied on the ward?
A I do not quite understand what you are saying, sorry. Can you repeat it?

Q Yes, I am sorry. From your experience of syringe drivers being started and doses
G being increased, did that inform you about whether the analgesic ladder was being applied, or not?
A The analgesic ladder was not always appropriate for the type of patient. If the patient was bed-bound, not able to eat or drink, then to start from the bottom of the analgesic ladder was not appropriate. Also the levels of pain that some of the patients were in, it would not have been appropriate.

H

Q You have mentioned already in relation to syringe drivers that they can be helpful for people in pain and also people with agitation. In relation to opiates being used, whether that is diamorphine or in fact oral morphine, would that ever be used for anything other than pain relief – like agitation?
A Diamorphine?

Q Yes.
A No. Diamorphine can be used to help with breathlessness.

Q Breathlessness?
A Yes.

Q Agitation?
A No.

Q Also, just on a related point, once a person was started on a syringe driver, in your experience would they have received any hydration intravenously or subcutaneously after that?
A From what I can recollect – are you talking about oral hydration?

Q Oral hydration if conscious, or other means of hydration if unconscious.
A If they were conscious and able to have small sips of water, then that was done, they were not just left without anything. They were given excellent mouth care, if that was required.

Q Once unconscious from the syringe driver would there be any other means of hydration used?
A You could use sub-cut fluids.

Q Can you remember whether ---
A From what I can recollect – I cannot remember using that, but then that is not always appropriate. Sub-cut fluids in somebody that is dying is not always the best thing to do for the patient.

Q Because most of us in this room are not medically qualified, can you just help us with why it might not be in the patient's best interests to hydrate at that point?
A Can I take a little bit of time to think about that?

Q Of course.
A (After a short pause) There are other ways of keeping the patient comfortable in hydration, like I said before, with good mouth care, and I think sometimes that sub-cut fluids would be a comfort more to the relatives because they can see there is fluid going into their loved-one, rather than actually benefiting the patient.

Q So on Dryad Ward in 1996 are you able to remember whether it ever happened that people were hydrated once they were unconscious?
A With sub-cut fluids?

Q Yes.
A To be honest it is a long time ago, and I cannot remember.

Q Can I also just understand what it would mean for a patient to be commenced on a syringe driver on Dryad Ward at this time. What was the significance for the patient of going on to the driver?
A The significance of using a syringe driver was to relieve signs and symptoms that the patient presented with, and that was the only reason.

Q Certainly. Did it have, though, any significance ultimately for the patient in terms of what was going to happen?
A It depended very much on the individual patient. Because the patient was commenced on a syringe driver it did not mean to say that that syringe driver could not come down again; it did not mean to say that they had to stay on the syringe driver.

Q Did that actually happen ever, that a person was commenced on the syringe driver and then recovered?
A Not that I can recollect on Dryad Ward.

Q Those are the general questions that I wanted to ask about. Could I now move on to the first of the patients that I want to ask you about, and that is Code A You have a number of files next to you. Could you take out, please, the one marked A; that is our file of notes which deal with Code A I appreciate that you probably have not seen these notes for a long, long time, and a lot of them do not relate to you any way, so please take whatever time you need when I am referring you to them, to make sure that you understand.
A OK.

Q If we just remind ourselves of Code A and generally speaking what happened, you can see at the front there is a chronology.
A I can.

Q If you go to the second page, the second entry down, you can see that on 14 September 1995 he was admitted to the Gosport War Memorial Hospital for depression. Do you see that?
A I can.

Q Then he was subsequently discharged. Then over the page to page 3, at the top, on 13 December 1995 he was admitted to Mulberry Ward under Code A Mulberry Ward was a psychiatric ward?
A Yes, it was.

Q He was then referred on to Code A who was a consultant dealing with Dryad Ward, is that right?
A She was.

Q Then on page 4 we see that it was on 5 January 1996 that Code A was admitted to Dryad Ward, and then reviewed on the 10th by Code A another consultant who would sometimes deal with the ward – is that right?
A That is correct.

Q We can see over the page that there were certain prescriptions that were written up at around that time, for Oramorph, and other prescriptions that would have been given by the

A syringe driver. Then we see that it was on 15 January that the syringe driver started, and that was when diamorphine, hyoscine and midazolam were begun – right?
A Mm-hmm.

Q Then it was continued on the syringe driver, and on 24th, the last page, page 10, on 34 January Code A died. So I hope that gives you at least a brief introduction or reminder about Code A Could I ask you, please, to turn to page 196 in that bundle. There are
B different pages numbers on these pages, but the ones that we are using are the ones which are in the centre at the bottom with dashes either side, and in fact on page 196 there is only that pagination there. Do you have page 196?
A I believe so.

Q These are the clinical notes from Dryad Ward, and can you see that the first two entries are entries by Code A ?
C A They are.

Q The first being from 5 January, which is the day of the transfer to Dryad Ward – and the first line of that is:

"Transfer to Dryad Ward from Mulberry
Present problems –
D Immobility, depression" –

and the note goes on. OK?
A (The witness nodded)

Q There is another entry from 9 January, again by Code A , relating to the right hand, but also "increasing anxiety and agitation". There is a question mark, and "sufficient
E diazepam" – diazepam, for the benefit of the Panel, being a drug that could help with agitation?
A It could, yes.

Q A sedative sort of drug?
A Yes.

F Q Then a question mark, and "needs opiates". Then do we have an entry from 10 January – and is that Code A ? The initials at the bottom seem to be Code A
A They appear to be, but I could not say for definite that that is Code A 's handwriting.

Q Very well. That entry lists some factors – "depression, catheterised, superficial ulcers, Barthel zero, will eat and drink", and then it says "For TLC". Could you just help the Panel with what a note such as "For TLC" would mean on clinical notes on the ward?
G A TLC to me has been a term that has been around for many years in nursing, and it is even still used today. TLC means for no active treatment, in that the patient is to be made comfortable and signs and symptoms are to be treated.

Q So does it have significance in terms of an elderly patient on a ward like this, in terms of ultimate prognosis?
A Yes, I would say so.
H

A Q What does it mean?
A It means that the patient is obviously very ill, very frail, condition deteriorating, and the nursing and medical care needs to correspond with that.

Q Could we turn now to the nursing notes, please, and page 208. The note is yours from 15 January. Do you have that?
A I do.

B

Q We are starting here, just to see the first entry from the 15th; it is two lines up from the bottom. This I do not think is your note?
A No, I was going to say I do not recognise any of that writing to be mine.

Q This is just to see how the day began. 15 January. "Seen by Code A Has commenced syringe driver at 08.25" – so fairly early in the morning. Over the page, C "diamorphine 80 mg and midazolam 60 mg and hyoscine 400 mcg". But then the next entry is yours, I think – is that right?
A That is correct, yes.

Q It is timed at 19.00 hours, so 7 p.m. that evening, is that right?
A That is correct.

D Q On that same day, the 15th:

> Code A informed of Code A s deterioration during the afternoon. Now unresponsive, unable to take fluids and diet. Pulse strong and regular."

It is signed by you, is that correct?
A That is correct.

E

Q Are you able to help with what "deterioration" means there, whether it is from your recollection or just your understanding of what you would mean.
A It would be my understanding, as I have no real recollection of this man at all, unfortunately – deterioration would be that his condition had changed for the worse.

Q When you say "now unresponsive", what does "unresponsive" mean?
F A "Unresponsive" would mean that he would not be opening his eyes to speech, he may not be perceptive to pain, would not be able to eat and drink.

Q Does it have any different meaning from "unconscious"?
A (After a pause) A very similar state.

Q In terms of deterioration of someone who was unconscious on a syringe driver, who G was unresponsive on a syringe driver, how would one detect whether there had been a deterioration in such a patient?
A If when moving a patient, if they were still experiencing pain, seen by non-verbal communication, by their body language, then you would see that they were still in pain and needed further symptom control from their general physical being, by looking at the patient, treating the patient holistically from top to bottom.

H

Q Can you help from the note where it mentions the deterioration and says "Now unresponsive". Are you able to tell whether that is a change that had occurred after the start of the syringe driver?
A From looking at the notes here, the syringe driver is started in the morning.

Q Yes.
A And we had written at the end of our shift, or near the end of our shift, that his condition had deteriorated, but I think what you have to remember is this is a frail patient who may well deteriorate. It does not mean because the syringe driver was put up that his condition deteriorated because of the use of a syringe driver.

Q It is obviously a fair point. Just to return to the particular question of whether it appears from your note that the change, in terms of being "now unresponsive" seems to have occurred after the start of the syringe driver. Does that appear to be the case?
A It would appear to from what I have written, but it was not necessary because of.

Q There is another entry from you, I think, on the next page but let us just run down this page first so that we know what happens in between. Following your entry on the 15th, the night seems to be a comfortable night with the syringe driver replaced early in the morning at 07.05. Then, on the 16th, there is an entry from the evening, that,

"The condition remains very poor. Some agitation noticed when being attended to."

Then that night, the condition remains poorly. Care continued. All right?
A Yes.

Q Then going over the page – this is page 210 – we are now on the 17 January. Is it right, the top half of that page really is all in your handwriting?
A It is.

Q Just to read it through, the first entry relates to 0900:

"[Seen by] Code A medication increased 08.25 as patient remains tense and agitated, chest very 'bubbly'. Suction required frequently this morning. Patient bed bathed, mouthcare tolerated well. Skin marking easily despite hourly turning and use of Pegasus mattress, and remains distressed on turning."

That is the entry for 9 a.m.?
A That is correct.

Q Then there is an entry at 14.30, so early afternoon:

"[Seen by] Code A medication reviewed and altered. Syringe driver renewed at 15.35 (two drivers)..."

simply because of the amount of medication required and how it was administered.

"Code A informed of deterioration."

And it is signed by you?
A I did.

Q First of all to deal with the earlier entry at 9 a.m. When you have noted that the patient remains tense and agitated, could you just help the Panel with how that fits, or how that relates to a person who has been unresponsive? How is it possible to be both?
A From recollecting – and again, I need to stress that this was over a decade ago – this was probably seen "remains tense and agitated" from when the patient was being turned, from what I can recollect.

Q Your last entry for that time is "remains distressed on turning", so in a sense does that fit what you just said?
A It does.

Q Do you remember – please say if you do not – but do you remember, or does the note help you, with whether he was conscious or unresponsive generally at this point?
A I cannot remember.

Q For a patient who was unresponsive on the 15th on the syringe driver, and there had simply been a continuation of the same dose on the syringe driver, would you have an expectation about whether there would be a change, whether someone who had been unconscious would become conscious? Would that be unusual?
A Becoming conscious does not mean, from what I understand from what you are saying, the patient is not going to suddenly wake up. It would be a drastic change for the better in his condition. It may well be that he is unresponsive because his pain is controlled, his symptoms are controlled, his agitation is controlled. If there is a change in his pain level, or there is a pain in his agitation level, then he would have shown us that there was a change in his condition. That is how we would have seen that he was tense and agitated, because he was not getting the symptom control that he obviously needed.

Q If a patient had been unresponsive on the day that the syringe driver started and then improved so as to become responsive, would you expect a note to have been made of that? Would it be sufficiently significant for a note to be made?
A Can you repeat that again, please?

Q If a person was unresponsive on the 15th, as this patient was, and had improved to have been responsive, would you expect a note to be made?
A I think there is a note saying that he... It is not written as this patient is now responsive, but it is written that he is tense and agitated. That indicates to me that he does have a level of response.

Q Is there anything in the note for 9 a.m. that indicates anything to do with pain?
A It does not directly say there is pain, but you can become tense and agitated we have all experienced if you are in pain.

Q Was there any consideration given to other reasons for being tense and agitated?
A I do not know.

Q Just to follow through what then occurred, in terms of the medication change at 08.25 that you noted there –would you go to page 203, please. 203: I hope you have a page there from the drug chart?
A I do.

A

Q Three drugs detailed there – haloperidol, diamorphine and hyoscine. I think you have made entries for each of those on the 17th at either 8.25 or 8.30?
A That is correct.

Q We know that the diamorphine was previously being administered at 80 mg per 24 hours. Here, do we see that at 08.30 the syringe driver was recharged with 120?
B A We do.

Q And you have initialled that entry?
A I have.

Q The prescription looks like it is actually dated 18 January but your entry is for the 17th. Do you know – and please say if you do not – but do you know why the prescription
C has the 18th?
A No, I do not.

Q The hyoscine had been 400 mcg, and we see here that it has been increased to 600, and you have initialled that. Is that right?
A Yes.

D Q The hyoscine being for secretions?
A It is.

Q Does the fact that the patient was receiving hyoscine and needed increased levels, does that indicate anything about whether this was a patient who was – and say if you do not like the language – conscious or unconscious?
A Can you repeat that again?

E

Q Does the fact that the patient was receiving hyoscine at an increased dose here, does that tell you anything about whether this was a patient who was conscious or unconscious?
A No.

Q At this stage – and in fact we can just go to page 201 to confirm – the midazolam remained unchanged. Can we see that on page 201 midazolam is the second from bottom
F drug that is marked up there. Do you see it?
A I can, yes.

Q In the middle of the page there is an entry for the 17th of the 1st at 08.25, 60 mg with your initials?
A That is correct.

G Q So 60 continued to be administered then as before?
A It did.

Q I should have mentioned this before. The haloperidol, which was on page 203, we can see that that was increased from 5 to 10 mg?
A That is correct.

H Q Haloperidol being? Can you help us with what that is used ---?

A A It is a drug that can be used for agitation as well as an anti-emetic.

Q Would it be fair to say that here it was being used for agitation?
A One could presume that, yes.

Q At around this time, about 8.30, there has been an increased in the diamorphine from 80 to 120?
B A That is correct.

Q And increase in haloperidol from 5 mg to 10 mg?
A That is correct.

Q An increase in the hyoscine from 400 to 600 mcg?
A That is correct.
C

Q But the midazolam had stayed the same?
A Yes.

Q Can you say from your note – so this is going back to the note on page 210 at 09.00 – what it was that led to those changes in the drugs? First of all, was it information from you that would have had an input into that?
D A I would have had some input, yes.

Q What would your input have been?
A My input would have been reporting the condition of Code A as I found him at that time.

Q To?
E A Code A

Q Does the note tell us, or do you have a recollection – of whether Code A conducted any examination of her own?
A Code A was present every morning on the ward. She did ward round every morning so I presume, because I cannot recollect, she would have seen that patient that morning.
F

Q Again, say if you are simply unable to remember, but on the ward round one presume if a doctor was coming to see a patient, the patient would not be turned, with nursing care given, at that time?
A No, that is not correct. Code A could walk into the room while we were attending to a patient.

G Q Do you have any recollection of whether Code A conducted any examination of her own?
A No, I do not.

Q Moving on to the second part of the entry, 14.30 hours:

H ""[Seen by] Code A medication reviewed and altered."

A The syringe driver was renewed at 15.35 and the **Code A** informed of deterioration. Can you help with what the deterioration was?
A No.

Q If we just see what changed about the medication, and we go to page 190, there is a drug chart there. On page 190 we have prescriptions for diamorphine, midazolam, hyoscine, haloperidol and Nozinan. Can we see that running down the column for 17 January at 15.35,
B for each of the first four of those, there is an entry by you?
A Yes.

Q So that for diamorphine at 15.35, 120 mg?
A That is correct.

Q For midazolam, 80 mg?
C A Yes.

Q Hyoscine, 1200 mcg?
A Yes.

Q And haloperidol, 20 mg?
A Yes.
D

Q So this was recharging the syringe drivers. The diamorphine stayed the same from the morning on 120?
A It did.

Q It had been put up from 80 to 120 at the beginning of the morning but it now stayed the same. Yes?
E A Sorry. You are going a bit too fast. I am trying to look at the drug chart and what is written, and everything together.

Q Of course, and you must ---
A Just bear with me.

Q You must say, and I am sorry. We looked at the entry earlier for that morning for
F diamorphine?
A I am just looking at the times.

Q Yes.
A And trying to get my head round it all.

Q Of course. Let me just help.
G A Okay, that is fine. I am all right now.

Q Yes?
A Yes.

Q The diamorphine had been running at 80 mg the day before. That is on page 201.
A Thank you.
H

Q Right. On page 201, diamorphine is the first drug and there is an entry for the 16th of 80 mg?
A Yes.

Q And then we looked at how, on page 203, it had been increased to 120 at 08.30 that morning?
A Yes.

Q And then going back to page 190, it stayed on 120 now at 15.35?
A It did.

Q The midazolam, which had been at 60, was now raised to 80?
A That is correct.

Q The hyoscine, which had been 600 mcg, was now raised to 1200?
A That is correct.

Q And the haloperidol had been at 5 mg the previous day – that is on page 203 if you wanted to check?
A Yes.

Q It had been raised to 10 mg that morning and then now it was put up to 20 mg?
A That is correct.

Q All right. You have initialled that?
A Yes.

Q Going back to your note, then, please, at page 210, the note is "[Seen by] Code A medication reviewed and altered." Is there anything which helps us with why that change in medication took place?
A There is nothing documented from what I can see that would help.

Q Do you have any recollection now of what that would have been or what it was?
A I do not have any recollection, but there must have been a change in order for it to have been done.

Q If there was distress on turning, and please say if you can in relation to this patient, what was that put down to?
A I cannot recollect turning this patient.

Q What we have seen here about the changes in the afternoon, they are not an increase in pain relief, are they, because the diamorphine stayed the same from the morning?
A The diamorphine did from what is written, yes.

Q But it was increased, particularly the midazolam which is a sedative drug and the haloperidol also for agitation. Does that help you in any way with what change there was or deterioration there was, if any?
A It may, and I stress "may", indicate that this patient remains agitated and uncomfortable. His hyoscine was increased so that would indicate to me that he had more

A secretions on his chest and to have secretions on your chest is not a comfortable thing to have or see.

Q Can you help us with this. For a patient like this, Code A being on the syringe driver with the diamorphine at 120 mgs, the midazolam at 80 mgs and the hyoscine at 1200 mgs, what does that tell you about the sort of state he was in?
A That he was not a well man.

B

Q That is clear in one way but in another way it is not a very clear statement. What do you mean?
A I do not know how I can put it any differently. He was a very ill man that needed control of his symptoms at that time.

Q Can I refer you to a very limited number of other entries that feature in the records for
C Code A, really just to deal with the narrative of what happened in the next few days. If you turn to page 189, we are going to move on to 20 January. Just dealing with Nozinan, on page 189 we have a page from the drug chart which only features Nozinan on it. Have you written the entry relating to the second entry related to Nozinan there, "Nozinan 100 mgs subcutaneously in 24 hours"?
A At 18.00 hours, yes.

D Q It is dated 20 January and it says, "Verbal order, Code A 17.20" and you have written your name, Code A. Is that right?
A I have.

Q It has been subsequently countersigned by Code A next to your name. Is that right?
A It has.

E Q We can see also that you have signed off for administering the 100 mgs at 18.00 on the 20th?
A I have.

Q At the same time, if we turn to page 191, another page from the drug chart, we can see that same afternoon, on 20 January, relating to haloperidol, that it was omitted at Code A's request and this is in your hand as well?
F A That is correct.

Q I think when you made your statement for the police you pointed out that you thought the timing there, 15.30, must be wrong?
A I did.

Q That it must be 17.30 in order to fit with your contact with Code A that day. Is that
G right?
A That is correct.

Q Do we see here, effectively, Nozinan replacing haloperidol?
A It would appear so.

Q Haloperidol is used often for agitation in a patient?
H A That is correct.

Q Nozinan being a sedative drug often used for terminal agitation and restlessness?
A That is correct.

Q Did you talk yourself to Code A yourself that day?
A I would presume so. It would have been myself or the other nurse that had signed but I cannot remember whether it was actually me.

Q Why would Code A have been contacted?
A Code A would have been the doctor on call for Dryad at that time and, as nurses, if we felt that the patient was not getting adequate relief or needed a change in medication, then we would have discussed it with the duty doctor.

Q Are you able to remember now what change, if any, there was?
A I cannot remember.

Q If we go back to the nursing notes at page 211, on 20 January there is a note that after Code A and Code A had visited, says:

> "Code A contacted regards drug regime. Verbal order taken to double Nozinan and omit haloperidol. Syringe driver recharged at 18.00 hours. Appears comfortable at time of report."

That is not your entry.
A It is not, no.

Q It is a Code A
A Code A, yes.

Q It obviously fits with what you have been saying about the contact with Code A Does it help us with what change, if any, there had actually been?
A No, I cannot remember.

Q Looking at page 198 now, the clinical record, there is an entry for 20 January saying:

> "Has been unsettled on haloperidol in syringe driver, discontinue and changed to higher dose Nozinan. Increase Nozinan 50 mgs to 100 mgs (verbal order)."

That seems to be an entry by Code A
A It is not signed, so I cannot comment.

Q The entry below it for the 21st is then signed by Code A Is that right?
A That is correct.

Q Can you help at all with what "unsettled" might mean here?
A No, I cannot.

Q Just to follow it through, on page 190 relating to 20th January, can we see running down the page that for each of the drugs that were administered in the syringe driver, at 15.30 you have crossed out those entries?

A A I have.

Q Because of the change to the Nozinan which meant that the syringe driver had to be ---

A Had to be recharged as such and replaced.

Q Leaving out the haloperidol, under each of those crossings out you have written in the B new time of 18.00 drugs being administered.

A That is correct.

Q We have already seen on page 189 that the Nozinan at 100 mgs was also dealt with in that syringe driver. Is that right?

A That is correct.

C Q Thank you. Those are all the matters dealing with Code A, so we can close that file.

Code A we will take this opportunity to break. We will return at 11 o'clock. We are going to have a short break now. You will be taken somewhere where, hopefully, you can be given some coffee or other refreshment and brought back here at 11 o'clock and we will continue. Please do not discuss the case with anybody whilst you are D out of the room.

(The Panel adjourned for a short time)

Code A Welcome back everyone. Code A

Code A one general point before we come on to Code A E who was the second patient. Were you aware at the time, in 1996, of what the conversion rate was for a patient who had been on oral morphine going on to subcutaneous diamorphine. Where you aware at that stage of what the conversion rate would be to start it?

A I was aware there was a conversion rate, but to be honest, and even to this day, I always refer to the British National Formulary.

Q If that was done by the doctor, or anyone else, would you check that yourself with the F BNF or would that be someone else's responsibility?

A No, nurses have an obligation to query things if they feel that they are not right. You should be aware of dosages of drugs that you are giving anyway.

Q Was there ever a time when you challenged Code A in relation to any such?

A Any such patient?

G Q Yes, about the use of diamorphine or conversion rate or something like that?

A I have in the past questioned Code A on drugs that we used for a patient.

Q I am sorry for being slightly unclear about this. What I am asking about is conversion rate from oral morphine to diamorphine. Do you recall any instances where you challenged that change, that conversion, by Code A?

A No.

H

A Q To move on to Code A We have put file A back, if we could take the file for Code A which is file F. Your dealings with this patient were limited to the time when she was on Sultan Ward, where she was admitted just over a month before she suffered a fracture and ended up being admitted under Code A 's care. We can run through your entries reasonably quickly. Just to remind you and the Panel about Code A If we look on the first page of the chronology on 29 June 1998, she was admitted to hospital from home for treatment of leg ulcers. She was admitted to Sultan Ward at that time. That is the admission
B we are going to be looking at now. Over the page, it was on 5 August, a little over a month later, that she was admitted to the Haslar Hospital for a fractured left leg and femur. We are looking at the period from 29 June. To look at a few notes you made, if you could turn in those medical records to page 298. Do you have page 298?
A I do.

Q That is an assessment sheet in relation to Code A and a number of those entries in
C your handwriting?
A That is correct.

Q Your handwriting is the handwriting which is slightly neater than the other handwriting and slightly bolder?
A Slightly bolder, yes.

D Q Just to run through the assessment sheet, you have written in under "Patient's Understanding of Condition" under 29 June 1998, "To heal leg ulcers", which we have seen was the purpose of the admission?
A That is correct.

Q Her hearing was fair; sight fair with bifocals; speech good; bladder normal; bowel normal; under "Diet" is written in "normal diet"; appetite, initially is written "quite good" but
E you have written in "poor appetite"; and functional problems, you have written in "arthritis". Under "Pain", you have ticked the box for "Yes" for pain. There is an entry there about a swollen and very painful right hand and then someone has also ticked the box to say not controlled and takes coproxamol regularly. Coproxamol is an analgesic?
A It is.

Q A little more powerful than paracetamol?
F A That is correct.

Q We have a weight of 57.2 kilos, a little over 9 stone. Could you explain, when a box is marked to say the pain is not controlled, what does that mean?
A It means that the analgesia they are taking at that time is probably not effective and controlling their pain.

G Q Not effectively controlling their pain. Does it necessarily mean that a person is in agony or in obvious pain all the time or does it cover a range of possibilities?
A It covers a range of possibilities. It could mean that they are in agony, it could mean that they are in slight discomfort. It just basically means, if it is ticked, that the pain is not controlled and then whatever pain the individual has, which is an individual perception of pain, which we all have, is not controlled.

H

A Q There are then a number of other entries you made for this admission. On page 300, there is an entry by you just in the middle of the page for 29 June:

"Admitted for reassessment and dressings of leg ulcers (right) to see Code A in the clinic on Friday. Seen by Code A for swab on ulcers and bloods."

B Code A was a consultant dermatologist at the Gosport War Memorial Hospital. Is that right?
A That is correct.

Q And Code A is a GP?
A He is, or was.

C Q Is or was a GP, and Sultan was a GP ward, so it would be normal for a GP to have an input into the care?
A It would, yes.

Q You have also recorded there that there was a phone call from Code A on the 30th: the previous swab before hospital admission showed an infection that was sensitive to those antibiotics that are listed, and that you were awaiting the results from the more recent swabs that had been taken – right?
D A That is correct.

Q You also, just to run through, made certain entries on page 302, noting at the bottom of page 302 that the last four entries are by you – is that right?
A That is correct, yes.

Q And it indicates the medications that Code A was on at that time.
E A On admission to hospital.

Q On admission at that stage. Digoxin, which is?
A For her heart.

Q Heart condition. Aspirin – the same. Sorry – aspirin – help us, please, with what that might be used for.
F A Aspirin would be to thin her blood.

Q To thin the blood. Allopurinol?
A May have been used for gout.

Q May be used for gout. And co-proxamol, which is the analgesic we went through?
A Correct.
G

Q Will you excuse me for a moment. (Short pause) You have also made entries on page 306. Do you have that?
A I do.

Q You are the named nurse ---
A I am.
H

A Q --- on the nursing care plan. A named nurse – can you help us with the responsibilities of a named nurse?
A A named nurse would effectively have 24-hour responsibility for that patient, and to plan the care for that patient.

Q This is a nursing care plan which relates specifically to four small ulcers on the right leg, and there are various nursing action points that were listed to deal with that, including
B really the dressing of the wound and the cleaning – is that right?
A That is correct, yes.

Q On page 308, this is a nursing care plan note that deals with the arthritis that Ruby Lake suffered, and you filled that page in, is that right?
A I did.

C Q Making clear at the top that:

> **Code A** suffers with arthritis which causes pain therefore requires help with washing and dressing."

So this is all about managing that. The last point, (3), at the bottom of the page, is to give analgesia, monitor and report its effects"?
D A That is right.

Q You filled in the Barthel index, which is on page 314, is that right?
A That is correct.

Q We can see that it has been done for 26/9/95, and then secondly, the date we are concerned with, 29/6/98, the score there being 12.
E A That is correct.

Q You also filled in the next page, 316, the Waterlow pressure sore prevention/ treatment score, and a score on 29 June 1998 was 16 – which is just above the 15 mark for being high risk. You also filled in page 317, is that right?
A That is correct.

F Q In terms of lifting and handling risk for that day, with the score being 11; and if a person scores 10 or over they need a specific care plan about that. Under "Special risks" there you have indicated pain as being one of the special risks that applied to **Code A**, is that right?
A That is right.

Q You have also dealt, on the following pages, 318 and 319, with a nutritional
G assessment form. It is sometimes difficult to make out the headings, but the second of the main boxes is a box that deals with appetite, on page 318 – can you just about make that out?
A Yes, I believe it is.

Q Under "Appetite" you have written in "3", for "Reduced". And under the box which is second from bottom, "Ability to eat", you have marked "Needs help".
A That is right.
H

A Q Then lastly, on page 320, this is simply making clear what the patient's problems were assessed as being at that stage, "Index of patient's problems", and written in there, (1) right leg ulcer, and also arthritis and hygiene.
A That is correct.

Q Could I just have one moment, please. (Short pause) Thank you, we can put that file back in the boxes, because we are finished with that for the time being. I just wanted to ask
B you another general point before I finish. You explained a little bit about assessing pain on patients on the ward – and we were talking about your time on Dryad Ward in 1996. Before opiates were administered to a patient, what sort of pain assessment would take place?
A Unfortunately at that time there was no 'tool', in inverted commas, that was used to assess a patient for pain, so there was not anything that gave you a marker; but what you could do is do your own nursing assessment from your experience, and also you could ask the patient from nought to 10, 10 being the highest, how much pain they were in. A thorough
C nursing assessment, really.

Q And if the patient was not able to describe their own pain to you, what sort of methods would you be left with?
A You would be looking at the patient's non-verbal communication, their body language.

D Q Those are all my questions; thank you very much.
A Thank you.

Cross-examined by Code A

Q Code A I am obviously asking questions on behalf of Code A Just to follow on from that last point, was it the case with some patients that their non-verbal
E communication would be very clear?
A Yes, I would say in the majority of patients it was very clear. If it was not clear then you would not see that they were in pain.

Q Yes. Can I come back to the evidence that you gave at the start of the questions you were asked. You said of the patients on Dryad Ward from 1995 that in the main they were very frail, elderly patients.
F A That is correct.

Q You said, I think, of those the very frail, elderly patients, were not expected to leave hospital.
A No, they were not.

Q I think there were other patients who might come in for respite care?
G A There was. From what I recall, I think we had one respite bed where patients did come in and then go home.

Q Were there some patients who were stepping down from surgical units locally – the Queen Alexandra Hospital or the Haslar Hospital?
A I believe from what I can recollect of my time there, that had only just been introduced or was going to be introduced.
H

Q I understand. We know from other evidence that it was a changing picture, and you are confirming that, I think?
A Yes.

Q You told us about Code A – a very good caring nurse, who gave excellent nursing care – and you told us as well about her relationship with Code A
A I have.

Q Can I ask you about Code A
A You can.

Q What we know of her is that she would come and do a ward round every morning.
A She would.

Q That is what you told us – but that she was there for a very limited time during the day.
A She was.

Q When she arrived in the morning from Dryad there would be discussions between her and nursing staff as to how the patients were getting on.
A Yes, and she always went round with whoever was in charge that day and saw every patient. It was not just go in the office and talk about the patients; she actually went round and saw every single patient.

Q We know that if there had been investigations done on patients – there may be pathology reports, biochemistry reports coming back from the laboratories – would she see those as well in the morning as part of her process?
A She would se them at some time during the day; I cannot say for definite it was in the morning.

Q Should the Panel have a picture of Code A being busy when she was on the ward in the morning?
A Can you repeat that? Sorry.

Q Should the Panel have a picture of Code A being busy – receiving information, going to see the patients?
A Yes. It was the start of her working day.

Q After the ward round she would go off to work as a general practitioner?
A I think normally from us she would go to another ward to do her round.

Q That would be Daedalus Ward?
A Yes.

Q I understand. Was it your understanding that she would go through the same process with patients on that ward as well?
A Yes.

Q Can I put it in this way: that there was not a lot of standing around chatting and drinking cups of tea when Code A was there in the morning?

A A Definitely not.

Q Definitely not?
A Absolutely not.

Q She was businesslike, would that be fair?
A She was professional.

B

Q She was professional; I am grateful. You have told us that the professional relationship between her and Code A was one of trust.
A Yes.

Q It has to be?
A It has to be. In the job that we are in, it has to be; it cannot be any other way.

C

Q The nursing staff have to trust that the doctor can come in when needed?
A Yes.

Q That the doctor in that sense can be relied upon?
A Yes.

D Q And from the doctor's perspective, the doctor has to be able to rely on the information that she is receiving from the nursing staff?
A Yes; it is a two-way relationship.

Q She has to rely on the nursing staff being diligent, to monitor the patients and report back anything that the doctor needs to know?
A That is correct.

E

Q Was it clear as well that Code A was diligent?
A Yes.

Q She was concerned to do what was best for the patients?
A Most definitely, yes.

F Q From her position, she relied extremely heavily on feedback she was getting from nursing staff?
A She did.

Q That was essential because of the limited amount of time that she was on the ward?
A Yes.

G Q Now can you confirm for us that if there was a new patient admitted to the ward, Code A would come back, usually at lunchtime, to undertake an assessment and to clerk the patient in?
A Yes, she would.

Q If there were other issues concerning other patients that had arisen during the course of the morning, would she be available to deal with those?

H

A A She would. She would also be available in between times. If we had real concerns about the patients we could ring her at the surgery.

Q Again, she was wholly professional in being available?
A Yes.

Q Would Code A see relatives of the patients?
B A She would.

Q When would that happen, and what would cause it to happen?
A When the need arose, really. If there was a change that we wanted to discuss with the relatives, then Code A would see patients' relatives normally, I would say, with a member of the nursing staff.

C Q Was it ever difficult for relatives to find that there was not a doctor there when they visited?
A No, I never came across that situation. If a relative felt that they needed to speak to Dr Barton then we would explain how Code A worked, and that we would contact her and make a mutually available appointment for them to be seen.

Q Again, was it clear that Code A was perfectly happy to come in in her own time in
D the evenings ---
A She was.

Q --- to talk to patients and relatives?
A She was, yes.

Q What you have told us is that there was certainly one occasion when you queried a
E patient's medication with Code A
A That is correct.

Q How did she deal with it?
A I remember phoning her at home, so we even had access to her own personal life, really – and discussed some medication that was being given to a patient. She was very open to discussion, very willing to listen to what I said, and worked as a team, really, for the best
F interests of that patient.

Q I do not think it is either of the patients you have been asked about.
A No, it is not.

Q Were you querying the medication because it seemed that you had more information than might have been available to Code A?
G A Yes, and also it is my duty as a professional and a qualified nurse that I am accountable for my actions, and if I do not feel comfortable with doing something then I must challenge it, which I did.

Q The expression we have heard is that the nurse is the patient's advocate.
A Can be at times, yes.

H

A Q You told us about syringe drivers. You had worked in at least one other unit where syringe drivers were used.
A Yes.

Q Did you say that they were being used in a similar way in Dryad?
A Yes. Yes.

B Q But that the mix of patients was different ---
A Completely different.

Q --- from what you had seen before?
A Completely different.

Q I understand.
C A The patients had completely different needs.

Q Again, are you saying that the patients on syringe drivers that you may have dealt with on Dryad were at the end stage of their lives?
A They could be, yes.

Q You told us that you learned about syringe drivers by being shown by another nurse.
D A Yes, initially.

Q Was that the ideal way to be shown it, or would you have wished for courses?
A In retrospect perhaps courses could have been introduced earlier; but I must say from 'learning on the job', in inverted commas, I did not learn anything more from doing the course.

E Q Was it clear that there maybe some nurses, particularly the night staff, who may not have been shown how to use syringe drivers by other nurses?
A I think all nurses would have been educated.

Q Perhaps by 1995.
A Yes.

F Q I understand. We will hear from other witnesses at a later stage. Was it the management of the War Memorial Hospital that organised the course for you to go on, or did you have to organise that yourself?
A No, it was the management that organised it.

Q Again, you told us the course that you went to in the Isle of Wight was 1996?
A That is correct.
G

Q You told us that syringe drivers can definitely bring benefits and you gave three situations in which a syringe driver can be of benefit. You referred to pain and restlessness and breathlessness?
A Yes.

Q Clearly those are separate topics?
H A Yes.

Q Can I ask you about restlessness. Compare and contrast that with agitation. Is that the same thing? The Panel has heard the word "agitation" used a few times?
A Uh-hum.

Q I am wondering if that is the same topic as restlessness or whether it is something slightly different?
A It can be something slightly different, depending on the reason for the agitation and restlessness. You can be in pain, be agitated and be restless. You can mentally be agitated and restless.

Q Yes. Can I ask you about patients who may be in the terminal stages of their lives. Is there sometimes in patients an agitation or restlessness which is part of the dying process?
A Yes, there is a term called "terminal agitation," which can occur when somebody is dying.

Q What would you see if you were nursing such a patient?
A You may see them physically looking agitated, as in facial expression, body language; they would be moving round the bed, maybe thrashing limbs, depending on the level of agitation.

Q And that is part of the dying process?
A It can be, yes.

Q And in your experience have you seen patients at that stage of their lives who were frightened?
A Definitely. Definitely. Which can also make people agitated if they are frightened of facing death and dying.

Q How is that dealt with?
A The patient normally would be given some sedation to take that fear, anxiety, away, to relieve them of that anxiety and agitation.

Q Is it your experience that opiates, diamorphine, in cases where it is appropriate, cases can lift a patient out of that sense of agitation and fear?
A They can do, yes.

Q It brings a sense of well-being?
A A sense of euphoria, really. It can, yes.

Q And is it also your experience that with patients who are dying, that part of the process can lead them to drift in and out of consciousness?
A Yes.

Q Sleep for long periods?
A Sleep for long periods, maybe come round a little bit, go off to sleep again.

Q That is whatever drugs they may be on?
A Yes.

A Q And would it be fair to say that as somebody nursing a patient at that stage of their life, you would be very conscious, as you move the patient to change them or bath them or change dressings on them, you would be very conscious of how responsive the patient was?
A Yes.

Q Whether they are in discomfort or pain?
A Yes, yes.

B Q Again, it is the non-verbal communication that a nurse dealing with a patient would be witnessing?
A Yes. And I must say, the majority of nurses on Dryad were very experienced nurses.

Q You were asked some questions about the analgesic ladder and you said you were aware of it, but that it was not always appropriate. You gave an example, that if a patient was
C bed bound and could not eat or drink, you cannot start them on oral medication?
A No, you cannot. You cannot expect them to swallow a tablet.

Q And is it also your experience that some patients may not want to take tablets?
A Patients have refused to take tablets in the past.

Q Some patients who may be demented may not cooperate?
D A That is right.

Q And in those circumstances the staff have to find some other way?
A Some alternative way of administering their medication that they require.

Q Yes. You also said that the analgesic ladder may not be appropriate because of the level of pain that the patient is in?
E A That is correct.

Q Can I ask you to expand on that. If someone comes to you and they are clearly in pain, are you saying you would not start them off with a couple of paracetamol?
A Not necessarily. You know from the level of pain, depending on their medical condition, depending on the disease that they have, that paracetamol is not the drug of choice. It will not relieve them of their symptoms.

F Q Your role as part of a caring profession is to try and meet the pain?
A Definitely.

Q That the patient has?
A Definitely.

G Q And that means go in, if I can use that expression, at an appropriate level?
A That is right, yes.

Q And sometimes that may need to be adjusted?
A Yes.

Q Up or down?
H A Up or down, yes.

A

Q And was that something that happened on a regular basis?
A Yes.

Q People would review how the patient was doing?
A They were reviewed every day, if not twice a day.

B Q You were asked about a lot of forms, a lot of documents. Were there lots of documents to fill in?
A There was an awful lot of documentation, yes.

Q Did that take away from the time you could spend with the patients?
A It could do, but we tried to ensure that it did not.

C Q I understand. Might it be the case that sometimes the note is not as full as it could have been?
A The documentation?

Q Yes.
A Yes, definitely.

D Q Dealing with Code A as an example, you were asked about matters that occurred on 18 January 1996. Let me take you to the pages. There is a medical entry on page 198, an entry by Code A. It is folder A again. At the top of page 198 Code A has written:

"Further deterioration subcutaneous analgesia continues. Difficulty controlling symptoms"

E and she has written "Try Nozinan". Yes?
A Yes.

Q You were not referred to that, but you were referred to page 210, I think. You were asked about deterioration. You were asked why it might be that the medication was changed for that patient, as we know that it was. I do not think there is a nursing entry to explain the nature of the change?
F A There is not, no.

Q You told us with this patient that you cannot recall turning him. I wonder if I can just remind you about some of the documents that the Panel have. Would you turn to page 215, this is an assessment of the pressure sores that Code A had, showing a number of areas of the body with pressure sores. If we go to page 222, this is a nursing care plan dealing with the sacral area, with the pressure sore that is there. I think there are entries, if you turn over
G the page to 223, the last entry, saying that on that same day, 18 January he was turned hourly.
A Right.

Q Would you expect that to happen for a patient with those sort of bed sores?
A Yes.

Q We have an identical entry, I think, on page 218, to the effect that on 18 January the
H patient was turned hourly?

A

A That is correct.

Q "Marking on all pressure areas". Can you tell us what "marking" would be? What would that mean?
A "Marking" would be that there would be indentation in the skin of the patient.

Q Does that indicate the skin was in poor condition?
B A Yes, and that it was deteriorating, the body would be deteriorating.

Q If we look up to the 17th on that page 218, it is you turning the patient hourly, I think?
A It is.

Q If we go up a further line: "All pressure areas marking easily". Again, a further indication of Code A 's very poor condition at this point?
C A Yes.

Q Can I ask about hydration? You have told us that you could not remember whether subcutaneous fluid was being given at the time you were dealing with him?
A Yes. I cannot remember.

Q But you told us it is not always appropriate?
D A No.

Q And that if somebody is dying it may not be in the patient's best interest?
A No.

Q You said it may be a reassurance for the family?
A Yes.
E

Q But not necessarily for --?
A For the patient.

Q To the lay person, not to provide a patient with hydration may sound cruel?
A It may do.

F Q But you told us that excellent mouthcare would be given?
A That is right.

Q What were the reasons for not hydrating if that was not done? A dying patient. Why might hydration not be given?
A Because they were dying and it would be inappropriate.

G Code A : Thank you very much.

Re-examined by Code A

Q Code A , there are just a couple of things that I wanted to clarify with you as a result of the questions you have been asked.
A Okay.
H

Q You were asked a little bit about the occasion when you queried medication being given by Code A when you rang her at home. Please, I do not want to ask you the patient's name, but in relation to that patient, was that an elderly woman who suffered from dementia?
A It was.

Q And she would squeal, according to your recollection?
A Yes.

Q As a result of her dementia. What was it that Code A had prescribed that caused you to contact her?
A Without having that lady's notes I cannot say for definite what it was that was prescribed. From my recollection the lady had a fentanyl patch. She was on Oramorph and diazepam, I do believe.

Q You dealt with this in a statement that you made for the police on 9 October 2003. Would it help you to look at that statement, or be reminded about what you said in the statement?
A Yes.

Q What those drugs were. It may be, in fact, if I just read the sentence, it helps you. You said that she was elderly and suffered from dementia.

"She would squeal, and Code A prescribed diamorphine and a fentanyl patch. She was already on Oramorph. I did not think she should be on all these three drugs."

A Right.

Q Does that help in terms of what the drugs were that were prescribed?
A From what I have written there, that is what I could remember in 2003, but you have to appreciate that is another six years ago.

Q You mention there diamorphine rather than diazepam?
A Right.

Q Would you recollection in the statement be more reliable than your recollection now, do you think?
A It may well be.

Q So what did you do in relation to that prescription in terms of contacting Code A ?
A I would have contacted Code A to discuss it with her – not necessarily that that was not a right prescription for the lady to have but I had concerns, and I wanted to discuss it with her.

Q You mentioned in response to questions that you worked as a team for the best interest of the patient?
A That is correct.

Q What was Code A 's view about what drugs should be administered?

A A From what I would recollect at the time, Code A felt that those drugs are appropriate for the lady, but by no means – from what I can recollect of our discussion – was she hostile towards me. It was quite an open discussion as to what she felt was appropriate.

Q You were also asked about what diamorphine could be used for. Obviously pain relief was mentioned, but then you were also asked questions about whether diamorphine could also have an effect in removing anxiety and agitation?

B A Yes.

Q You agreed that it could do that. Was diamorphine used on Dryad ward for agitation and restlessness?

A Alone?

Q I will say "Yes", and then you may be able to explain more about it?

C A I would say "No," from what I can recollect. No. Not diamorphine alone.

Q Were there other drugs which were used for anxiety and restlessness?

A There are the other drugs that we have already talked about, as in haloperidol and Nozinan and midazolam.

Q Are those specifically designed to address such symptoms?

D A Of agitation and restlessness?

Q Yes.

A Yes.

Q Was diamorphine used in any way on Dryad ward for agitation and restlessness?

A It could be, in the sense that we have spoken; it can give a sense of euphoria but

E I cannot recollect diamorphine alone being in a syringe driver for agitation alone. I think you also have to remember that every patient is an individual and would respond to different drugs differently, so you have to assess that patient. It is not a standard treatment for all patients.

Q The final topic that I wanted to try to clarify relates to the questions about when the oral route for medication is not possible or appropriate. You were being asked about when a

F syringe driver might be needed and particularly in relation to a patient who might be demented, or refusing to take their oral medication.

A Uh-hum.

Q Were you meaning that patients who were demented and refusing to take their oral medication would be started on syringe drivers on Dryad ward in 1996?

A Was I meaning that?

G

Q Yes?

A Absolutely not.

Q Right. If a person who was refusing to take less powerful analgesia, like paracetamol, co-proxamol, something like that, if there was a patient who was refusing to take such medication, would it be appropriate for such a person to be started on a syringe driver simply

H because they were refusing to take their oral medication?

A A To relieve their pain?

Q Yes.
A Because they would not take their tablets?

Q Yes.
A No. I would say that was inappropriate.

B

Q Does the analgesic ladder have some significance to that kind of question about whether you can go from a less powerful to a more powerful analgesic in that way?
A It depends. It totally depends on that patient. It totally depends on the level of pain that they are presenting with, and it would change from day to day. You are asking me to make a very generalised statement when we are dealing with individual people.

C **Code A** Thank you. Those are all my questions.

Code A Thank you, **Code A** as I indicated earlier, a time would come when it would be the turn of the Panel to ask questions of you, if they had any. I am going to look now to see if there are questions.

I am receiving an indication that at least one member of the Panel would like first of all for
D there to be discuss amongst Panel members. That means that we are going to break now so that the Panel can conduct those discussions in camera. You will be taken somewhere, given refreshment and so on, until such time as we are able to call you back. We will break there, please, ladies and gentlemen.

(The Panel adjourned for a short time)

E **Code A** Welcome back. **Code A**, I have asked for the witness to be held back for the moment because there is a small matter that I need to raise with you. During the course of the break that has just finished it has been brought to my attention that a member of your team, I think it was paralegal, was observed speaking, apparently – it may not have been the case, but apparently – speaking to the witness. Given the warning that we traditionally give and the witness received earlier today, we need for transparency to hear why, if it did occur, and what was said. If you would like to make enquiry. (Short pause)

F

Code A It is a paralegal and she spoke to the witness about accommodation as she is perfectly entitled.

Code A It is simply a matter of appearance and it would be most unfortunate if, for example, the doctor or one of her representatives saw only that and had no understanding of what happened.

G

Code A We entirely take the point and we will try to avoid it in the future.

Code A It is just a matter of care please.

Code A Can I thank you for raising it, but I should add that I am entirely confident that nothing would ever happen in these circumstances that we would have cause to complain
H about.

Code A That is very generous of you. I share the sentiment, but once the matter has been brought to my attention I have to do something. The first thing I did was consult our Legal Assessor who, in my view, said, quite rightly, that this should not be allowed to hang over us, we should bring it out in the open and deal with it. That has happened to my satisfaction so we will move on.

(The witness resumed)

Questioned by THE PANEL

Code A As I was saying before the break, we have now reached the point at which Panel members are entitled to ask questions of you if they have any. We do have some questions from Code A to my left. Code A is a lay member of the Panel.

Code A As a lay person, excuse me if this sounds something I should know.

A Not at all.

Q Continuing care of an elderly person, so people are very frail and not in good health, lots of problems when they come into Dryad Ward. That in itself will not be the terminal illness, will it?

A No.

Q Old age may be when the body functions start to break down and the skin starts to disintegrate etc. Is that when people move into the terminal stages of old age or your continuing care. Have I asked that in a clumsy way and you do not understand it?

A I would not say it is a clumsy way.

Q I am trying to understand the decision making that occurs and what influences that decision as you move from continuing care to terminal care, because continuing care may in itself not be terminal care even with the elderly?

A Exactly, yes.

Q Talk me through that.

A When a person came to Dryad as a continuing care patient, their Barthel – which I do not know if it has been previously explained – tended to be less than 4, which indicated that they needed a lot of nursing care, they were very dependent patients for all activities of daily living, so those patients came to the ward. We had patients who had been in their continuing care bed for years and some of them did eventually die as a natural course of the life cycle if you like.

Q Is it often a natural progression from the continuing care to the terminal?

A Or something acute could happen. In somebody on continuing care, they may – I am not saying it did happen – they could, for instance, have a heart attack, a very dependent person have an acute episode and have a heart attack. It may not be appropriate for that patient to be transferred to an acute hospital for active treatment. it would not be morally and ethically right, but that would be a multidisciplinary decision. If that happened and the patient was not transferred, then you would be treating their symptoms, so you would not leave somebody who had had a heart attack with no pain relief for example.

Code A I am sorry to interrupt. Can I ask you to move the microphone a little further away, we are getting a lot of distortion.

Code A When we think about Code A is it the case that he moved in with continuing care needs, but then moved into a terminal stage?
A I do not know whether terminal is the correct word.

Q You help me to understand?
A I would say, from what I can recollect, Code A came to us on a continuing care basis. I was not aware that he was expected to be discharged. I may be wrong but from what I can recollect that is how I see it. His condition changed, for whatever reason I cannot remember why, so then his signs and symptoms were controlled. It does not necessarily mean he was terminal because terminal to me means that he was coming to the end of his life. He did eventually, but that was not why he came in.

Q What I am trying to understand is when somebody goes into unconsciousness and then they stop having any hydration, that is more or less the terminal stage?
A They are coming to the end of their life, yes.

Q When I look at the notes on page 208, if you can go to bundle A, if I look at 9 January, 10 January, 13 January and you go to the 15th, it seems to me that the syringe driver is connected with him moving into a different stage of care. I am looking to understand what was the decision making and what moved the treatment of this person, or the care of this person, into that stage. I cannot see the reference to pain and I cannot, other than on the 9th and then the 10th when the Oramorph is given, 4-hourly Oramorph, but I cannot see anything there which tells me about pain. All it tells me is that Code A is not taking medicine orally?
A I will have to read it. From reading that, and you have to understand that I am giving my opinion because that is not what I have written, from how I see it from a professional point of view from what is written is that this chap was eating a very small amount on the 9th. He was sweaty, he had generalised pain. He was seen by Code A and then on 10th he still remained in a poor state of health so they commenced him on Oramorph 4-hourly. From what I can see, he had a catheter in and he had problems with the catheter and was distressed. On the 15th, initially, it says that the diamorphine was set up and then I have written in the evening of 'Code A' that he was now unresponsive and to take fluids in diet. Where I have written 7 o'clock may not have been when he became unresponsive. That would have been, from my recollection, the time I have written that.

Q It might have been earlier?
A It may have been earlier in the afternoon that his condition had worsened.

Q It does not help. If I turn to page 223, for instance, and I look at the 13th, I can see that it is telling me, if I look at several of those notes, it is telling me that the skin is not so much disintegrating because there is improvement there, so the sacral area continues to improve on the 13th. So there the skin seems to be improving, albeit a little, it is a skin improvement. But once we increase this dosage of the analgesics and we go on to a syringe driver, the patient becomes unconscious, then he does not get hydrated so it is natural that the skin is going to break down even more. I am not getting that the skin is breaking down when I look at the 13th, but I am getting, once the analgesics have been increased and the unconsciousness is there and the non hydration is there, that the skin is obviously starting to

A break down. It seems to me, or I am trying to establish and get your view about this, is that the syringe driver and the increase in analgesics is a contributory factor to the deterioration of this patient?

A I can totally understand what you are saying and I think, personally, if there is one thing I will take away from this experience is what you write down, how important it is to document everything because, like you as a lay person, you have not got any nursing medical knowledge so it is difficult for you to decipher, so I think there are lessons to be learned in
B our documentation.

Q It does seem to me that also what you have said is that, when you move from one stage to another, there would be a thorough nursing assessment. You have said, "Yes, we would make a thorough nursing assessment", so would that be that when you are moving from a continuing care stage to more of a terminal stage, that I would have expected to have found that because I cannot find that?

C A I think it is documented that this patient's condition is deteriorating. To me, as a nursing professional, that is quite evident.

Q It is after the syringe driver and the going on to unconsciousness, but it is that decision making before moving to the syringe driver.

A Yes.

D Q You cannot help to throw any light on this because the nursing notes, to me, seem to say something different, that the patient was necessarily deteriorating?

A What I will say is that because the patient was so ill, it may have been that without the syringe driver he would have become unresponsive, unconscious. Hand on heart I would not say that it is the fact that he has gone on to the diamorphine that has made him deteriorate so much.

E **Code A**: Thank you.

Code A is a medical member of the Panel.

Code A You have file A?

A Yes.

F Q I will take you through one or two pages as well. I am going to talk about the opiates, how they were started and how they were changed; not in any great length but I want to put it into context that, if it is right that opiates were used only for pain in the way that **Code A** has touched on it - I want to make my mind clearer – what is the context of pain? If you look at page 196, remembering that Oramorph was started on the 10th, and the note in the middle of 196 is the 9th, the day before, **Code A** has written on the first line "painful right hand".

A Yes.

G Q If you flip those through to page 208 which is a nursing note.

A Yes.

Q It is not you, somebody has written "9/1/96" halfway down the page, the third line of that entry, "Has generalised pain".

A Yes.

H

A Q You did not write it, but can you help us, what does that mean. Does that have a general parlance in nursing, does it mean anything to a nurse that it would not mean to the rest of us, generalised pain, in this context. Can you tell anything from it?
A I do not know what context that has been written, because, as you said, it is not me that has written it, generalised pain. He has obviously been assessed by a nurse. It also does not say what time that was, so that would have been a factor.

B Q That statement does not mean anything particular to you reading it now?
A Generalised pain could mean different things to different people.

Q It could mean anything; that is fine. Let us look have a look at the prescriptions and how they are being given. The drug chart is page 200, Oramorph at the top?
A Yes.

C Q It is first given on 10 January at 10 o'clock at night?
A That is correct.

Q The dose is 5 mgs, it is 2.5 mls, 10 in 5. It is given again at 6 o'clock in the morning?
A Yes.

Q Help us with this, it is a side line here. We have heard from a witness yesterday that
D opiates cannot be written up PRN?
A Cannot be written up PRN?

Q Cannot be written up PRN. In your experience is that correct?
A No, that is incorrect.

Q On the 10th and the early morning of the 11th, we have two doses of Oramorph 5
E mgs. That is the 10th, moving on to the 11th. You need to move two pages on to page 202 and Oramorph is started. It is written up and it is being given four times a day, the two bottom prescriptions, and the upper one says, "Oramorph", again it is 5 mgs, it is 2.5 mls.
A Yes.

Q That is 5 mgs four times a day?
A Yes.
F

Q Plus double that dose at night 22.00.
A Yes.

Q That is 30 mgs in a day?
A Right.

G Q Just hold that in your mind, 30 mg, because I am going to pursue 30 mg.
A OK.

Q That is continued for four days, give or take a dose – 30 mg. We are not going to look at those notes any more.
A Right.

H

Q Could you go to the big bundle, number 1 – it does not have a letter on, but a number. You mentioned the *BNF* is somewhere you would go to find information. Why would you go to the *BNF*, by the way?
A Why?

Q To help the Panel, why the *BNF*?
A Because I consider it to be the bible of all drugs, to be honest.

Q Thank you. The *BNF* is behind the tab on the side number 3. If you go then to page 11, the bottom right-hand corner ---
A Page 11?

Q Page 11, the bottom right-hand corner is the number of the page.
A Yes.

Q No, I am sorry. Before we go there, just thinking again about an elderly person in pain, and you are putting them on Oramorph.
A Yes.

Q What dose would you normally start at?
A Depends on the patient.

Q Depends on the level of – what?
A Pain.

Q Pain. For moderate pain in a little old lady – this is not a little old lady, this is **Code A** – what kind of dose might you think of starting at?
A I am not a doctor.

Q No, I know you are not.
A I am a nurse!

Q You are a nurse ---
A An experienced nurse.

Q An experienced nurse.
A Yes.

Q And you said you have a responsibility to the patient.
A You may see 5 mg, you may see 10 mg; you may see more than that.

Q May you see less?
A Not very often.

Q Not 2.5 mg?
A No.

Q I am sorry, I have misled you, but I do not think we need to go back, because it is pretty clear that from that 30 mg of Oramorph a day, we go to a pump with 80 mg of diamorphine in, a day. Do you want to check that?

A A Yes.

Q Let us check that, then. It is page 201.
A Right.

Q It is important to check it in case I get my facts wrong. Yes?
A Yes.

B

Q Have you got it?
A Yes.

Q By the way – I had not noticed this before – it says "As required prescription".
A Where does it say that?

C Q Just above "Diamorphine".
A Right.

Q Is that unusual?
A It may be that it should not have been written in that particular place. It may have been better written as a permanent ---

D Q But the starting dose is 80 mg – sorry – the width of dosage is 80 to 120, and we can tell in the third column going along rightwards – the first column is the date, the second column is the time, and the third column is 80 mg – still on page 201.
A Yes.

Q So that kind of establishes pretty firmly that 80 mg was started.
A On the 15th, yes.

E

Q On the 15th.
A Yes.

Q Can you just go back to that other bundle, bundle 1, and look at page 5. This table is at the bottom half of page 5, and this is what we heard before, equivalences, how you convert one drug to another so that you get the dose right.

F A Yes.

Q We have established that for five days, give or take a dose, Code A was on 30 mg of Oramorph, so that is the left-hand column, 30 mg.
A Yes.

Q If we travel right across at the same level to the far right, that is subcutaneous

G diamorphine, and the equivalent dose would be 60 mg.

Code A I think one has to be cautious, because the far left column is every four hours – but the far right is 24.

Code A I apologise. I am going slowly because I realise the complexities of these tables.

H

(To the witness) Let us start again. Look at the columns again. We do not need to go back in there, we have established doses.
A Would you mind if I just double-check something on here, please? (Indicating bundle A).

Q Of course.
A OK.

Q I am very sorry about that.
A No, that is fine. I am not as quick as you.

Q It is bound to throw you. Look at that column again, and if you take the top of the far left column, that is where I should have started. 5 mg every four hours is 30 mg a day.
A It is.

Q So that is our equivalent dose for five days, give or take a dose?
A That is correct, yes.

Q If we travel right across to the right-hand side, the equivalent dose of diamorphine subcutaneously would be 15 ---
A Milligrams.

Q Milligrams.
A According to the *BNF*.

Q According to the *BNF*?
A Yes.

Q Can you explain why you say that.
A Because – that is a guide. Yes? Then it is up to the prescribing doctor and the patient's condition. Looking at **Code A** 's notes, he was also on Arthrotec, which is an anti-inflammatory, pain relief. It seems to have been omitted that he was taken off this. So his level of pain would have altered; he is now not having that anti-inflammatory.

Q For the Panel could you just explain what Arthrotec is used for – what kind of thing?
A It is for arthritic type pain.

Q Yes.
A I have noted that he has been taken off that, so his level of pain is going to alter.

Q Again, for the Panel – the rest of the Panel are not doctors.
A Sorry.

Q What does Arthrotec equate to in terms of the drugs that we have come to think of as the ladder – paracetamol, paracetamol plus something, co-codamol ---
A No idea, to be honest.

Q No?
A No idea. It is an anti-inflammatory.

Q An anti-inflammatory?
A Yes.

Q It is not an opiate?
A It is not an opiate, no, but it is quite – or it was, it is not prescribed very often any more – but it was quiet an effective pain relief for an arthritic type of pain. So he has been taken off this, so my assumption is that his pain is going to alter. Also, from the notes, his pain is not controlled, he is in generalised pain, so to give 15 mg when he is still in pain, he has been taken off a previous painkiller, I would say in my professional opinion it is still going to leave this chap in pain.

Q Fine. Let us just go back a step, though.
A Right.

Q You are not saying that you do not accept that the equivalent dose is 15 mg a day?
A Am I not saying? Sorry, say that again.

Q If you look at the table, do you agree that the equivalent dose to 30 mg a day of Oramorph is 15 mg a day of subcutaneous diamorphine?
A As written down in the *BNF*, yes.

Q As written.
A I agree.

Q But you suggest that it might not be the appropriate dose any more. You might in the circumstances want to increase the dose?
A Yes.

Q So if you wanted to increase a dose of an opiate, because the pain was not controlled, to what degree would you normally – talking about your experience as a nurse – what would you expect the degree of increase to be?
A Generally you half it again.

Q Half it again?
A Yes.

Q And that would be 20 to 25 mg?
A Yes.

Q If you put that against 80 mg started, there is obviously a big difference, is there not?
A There is, yes.

Q I am conscious that we are not allowed to surmise, but in your opinion why should there be – why might there have been – do you see anything that we have gone through this morning that might lead you to understand why the dose has increased five-fold?
A It was a long time ago. From what I see, I was not present when that decision was made, so I am afraid I cannot comment.

Q Can you comment on this, then: bearing in mind that if we looked at another page of the *BNF* it would suggest that you more or less halve the dose of opiates in the elderly ---

A A Right. Where does it say that? Sorry, can I read that?

Q I can take you to that. Page 7. It says "Guidelines", does it not, half-way down the left-hand column?
A Yes.

Q It says "Limit range" and then it says "Reduce dose":

B

"Dosage should generally be substantially than for younger patients and it is common to start with about 50% of the adult dose."

Do you agree that is what it says?
A Sorry? Whereabouts? We are on page 7 where it says "Guidelines", yes?

C Q Yes. The last heading on that side ---
A Where it says "Reduce dose"?

Q Where it says "Reduce dose", and it suggests you halve the dose for elderly patients.
A Sorry, I cannot –

"Dosage should generally be substantially than for younger patients" ---

D

Q "and it is common to start with about 50% of the adult dose."
A Where does it mention – oh, "Elderly" at the top. Sorry, that is where I am getting confused.

Q It is this confusion of calling – elderly people apparently are not adults, and that is the confusion.

E A And what do you term as "elderly"?

Q We will not go into that. That just puts a flavour in, it is a guideline.
A Yes.

Q It is a guideline, it is not a tramline. It is not a trick question; I am trying to understand, if you can help us, from what is here, as to why the dose went up in such a big

F step. And you cannot; I think you cannot.
A I cannot, particularly. I can see on page 200 that the diamorphine then was written up 40 to 80.

Q But it was never given.
A No, and I do not know why.

G Q I think that is all. Thank you very much.
A Thank you.

Code A Thank you very much, doctor.
(To the witness) It is now me. The other two Panel members do not have questions, but I just have a couple of things. Picking up on the matter you have just been discussing with Code A on the paper, on the written records alone, coming in fresh, if you had been, as

H someone who had not been connected with the case, there would appear to be an anomaly

A there, in that you would have expected the dose to be lower. Would that be the sort of occasion, had it occurred on your watch, when you would have contacted the doctor, expressing your concern and asking for reassurance or information?
A It may well have been, depending on the patient, how the patient was.

Q I think you told us that there was one occasion where you did have concern, and you contacted the doctor to discuss that concern with her. You may have said, but I did not get a
B note of it – you told us that she was very receptive and open to discussion.
A Yes.

Q What was the result of the discussion? Was there a change made in the prescription or dose?
A From what I recollect – and it is very hard to remember – as I have written in my police statement, I think Code A wanted to continue with the drugs that she prescribed.
C

Q Thank you. Just some general questions, no specifics. You told us that people, elderly, as they are coming towards the end of their lives, may simply die, and as part of that natural process there would be times when they would be sleeping for longer, and drifting in and out of sleep, drifting in and out of unconsciousness, even if they were not receiving any opiates or perhaps any medication at all – is that right?
A That is correct, yes.
D

Q Somebody who is in that position, just naturally coming to the end of a good and long life, drifting in and out of sleep, is such a person going to be rousable? Say they have gone into a period of sleep, if you were to come to them and try to wake them, would you in the absence of any drugs expect to be able to do so, or not?
A Not necessarily, no.

E Q Not necessarily?
A No.

Q Can you tell me a little more about that?
A Just reflecting back and thinking about one particular patient, he was dying, very near to the end of death (sic), 'asleep', in inverted commas, eyes shut. When you turned him, did not respond at all – was that close to death, really. And people did die on Dryad without the
F use of the syringe drivers.

Q I have understood that. This particular gentleman you are remembering, how soon after that moment of unresponsiveness, unrousability, was death, do you recall?
A I do not know. It was not immediate, but I do not recall exactly how long it was. It may have been a couple of days. I know it was not immediate.

G Q Is there any way – as a layman definitely not – but as an experienced nurse, is there any way that you would be able to distinguish between a patient who was unrousable because they were taking drugs, and a patient who was not taking any? Would there be any difference in the way they would present in that unconscious state?
A No. You may, if you looked at their pupils, you may see a change in their pupil size; but no, apart from that, no.

H

Q That is very helpful. As you will have gathered, and I should have told you earlier, I am also a lay member of the Panel, so it is very helpful to clarify for me.
A Right.

Q You have also told the Panel that where a patient will not cooperate in taking pills or perhaps cannot swallow staff would have to find other ways of administering and you have given us your view on the appropriateness of doing so, of putting somebody onto a syringe driver when they are refusing medication. In a situation where a patient is not refusing because they do not want to take it, they simply cannot swallow, is a driver the only way of administering the drugs that they are unable to swallow, or is there another way?
A No. You could give it subdermally through a patch, transdermally through a patch, a fentanyl patch.

Q Or even straightforward manual injection?
A You could but if a patient was requiring regular injections, that is not something that we encourage when we have the use of syringe drivers.

Q And the reason for that would be?
A To use a syringe driver rather than an injection?

Q Or to not encourage manual injection, for example?
A Because it would hurt every four hours to come along with a big needle, and to have the syringe driver with a much finer needle that can stay in place for up to three days is a much more humane way, I think.

Q Thank you. That is very helpful too. You talk about patients being reviewed every day. A patient who is on a syringe driver which is loaded – and I choose my words carefully – with a mixture or combination of opiates such as those mixtures or combinations we have been looking at, are you able to recall any occasion when such a review of such a patient resulted in a reduction in the dosage that was in the driver?
A Yes.

Q Was that a common thing or an uncommon thing?
A It did not happen very often.

Q Can you tell me the circumstances in which it did happen in your recollection?
A It was a particular lady who was showing side effects of morphine; therefore her dose was reduced.

Q And who was it who gave the order to reduce that dose?
A From what I can remember, it was a consultant.

Q It is not something that a nurse would be able to do. Is that right? To order a reduction?
A Not without consultation with the medical staff.

Q So it would have to be either the regular doctor on their rounds or the consultant on his or her slightly less regular round?
A Yes.

Q Thank you. That is helpful. Just a response you made to a question from Mr Jenkins. Again, I apologise if it is an obvious answer. He was asking you about the rehydration of patients, or the hydration of patients, and you said it would be inappropriate to hydrate a dying patient.
A Could be.

Q Ah, could be. Would you like to give me a short tutorial then in why it might be inappropriate to hydrate a dying patient?
A There is a lot of research on this. There are a lot of papers out there. There is a lot for, and there is a lot against. From my understanding of reading things, when you are hydrating somebody subcutaneously because we could not give it intravenously in the hospital environment where we were – we were not an acute hospital so we did not have the facilities to provide that – to give somebody fluid subcutaneously, you are very limited to the amount of fluids that you can give because of the absorption. Also, giving, say, a litre of water over 24 hours of normal saline, what are you going to hope to achieve for that patient? What is the patient going to benefit from? That is what you have to think of.

Q It would not affect the comfort of a patient?
A No. I think there is research out there that is showing that if you give good oral mouth care, the patient can be as comfortable.

Q As if they had ---
A As if, yes.

Q --- been hydrated?
A Then you get the complications of putting up subcut fluids; the injection site swells; it becomes red; the patient may be in pain because of that; there is another needle in the patient.

Q I think I am beginning to get a clearer understanding of that ---
A I am not saying that it never happened.

Q No, I understand. Thank you very much indeed. That concludes the question from the Panel. There is just one little bit still to go.
A Okay.

Code A When the Panel have asked questions, we then turn to the barristers to see if they have any questions which arise out of the questions asked by the Panel. I am going to ask Code A if he has any such questions.

Code A I have some, but not very many.

Further cross-examined by Code A

Q If the patient's skin condition is very poor, sticking in another needle may cause further problems?
A You would be limited to where you could put that needle, and may cause further trauma.

Q Can I just come back to Patient A, Code A and just look at one or two entries to draw some threads together. We are looking at a time, January 1996, when he may have had a number of complaints. I want to take you, if I may, to page 218. Most of these are not entries that you have ever made.
A Right.

Q And we just have to take them at face value for the moment. All right?
A Yes.

Q Looking at 9 January, this is before he is seen by Code A and Code A and commenced on Oramorph, but on 9 January on this document he is given a bed bath. His scrotum is very sore. Something under the skin of the penis. There is discharge present from around the catheter. The sacrum. There is a small sore area above the anus and there is something else removed from the area on the left hip. Yes?
A Yes.

Q We can see that those areas were treated. We can jump on down that page to a time after the diamorphine was started on the syringe driver but on 16 January, started the syringe driver first thing in the morning of the 15th, but on the 16th his right ear is referred to. It was very blistered and swollen. Yes?
A Yes.

Q If we go on to page 225, again another element of the nursing plan – there are many plans for different things. On 13 January there is reference to the catheter by-passing twice. That is leakage from the penis ---
A From around the catheter.

Q From around the catheter?
A Yes.

Q "Patient appears distressed." That was at a time when he had been on Oramorph for a number of days. I do not need to take you to anything else there. Can I take you on to 227. Your entry, obviously, on the 17th, but this is part of a nursing care plan to deal with dietary and food intake. You see it was started in the preceding page, on the 11th. Not many entries have been made on the subsequent days, but it is clear that on the 11th his food intake was very poor and taking half a cup of tea at a time. If his food intake was very poor, might that be an indication of the general poorness of his condition?
A Definitely, yes.

Q We have looked a number of times at page 208. It starts on 5 January, when he is transferred in, and we have seen references in there to "scrotum sore" and matters of that nature. We have dealt with the 9th. He is in generalised pain. "Very sweaty this evening but apyrexial", meaning no temperature, sweaty?
A That is correct, yes.

Q "Small amount of diet taken" then, on the 9th, and we know that he is commenced on Oramorph the following day, on the 10th, when seen by the consultant, Code A and also by Code A. Can we just look at the bottom of that page, just to remind ourselves that Code A was started on the syringe driver first thing on the morning of the 15th?
A Yes.

A

Q And he appears to have been in distress on the 13th, just looking up on that same page, 208. I just want to concentrate on the entries that may deal with his level of consciousness after the syringe driver was started. Right?
A Yes.

Q On 209 there is your entry?
B A Yes.

Q In the evening. You say it may not have been at 7 p.m. – 19.00 hours – that you wrote it?
A Yes.

Q But it is clear that you measured his pulse?
C A Yes.

Q You were keeping an eye on Code A, quite clearly?
A Definitely, yes.

Q What is the significance of the pulse being strong and regular after he has been on a syringe driver for 11 hours?
D A What is the significance?

Q Yes.
A That his heart was still going strong.

Q Yes. I think if we look down that page again, not your entry, but for the 16th:

E "Condition remains very poor. Some agitation was noticed when being attended to."

Not unconscious?
A No.

Q If we turn to the 17th and look at page 210, reference to Code A at the top of the page – "medication increased as patient remains tense and agitated…". Not unconscious.
F Further down the page, the same entry:

"Skin marking easily, hourly turning, use of Pegasus mattress, and remains distressed on turning."

That means two things: one, that he is not unconscious when nurses are dealing with him, but it also means, does it, that the level of medication for pain relief was not lifting him out of
G the distress?
A It was not adequate, yes.

Q So we see for 14.30 hours:

"[Seen by] Code A

H

who had come back into the hospital for some reason, but certainly deals with Code A whilst she is there.

"Medication reviewed and altered. Syringe driver renewed."

We then have the medical note that I asked you to look at some time ago on page 198, but the following day, 18 January,

"Further deterioration

...

Difficulty controlling symptoms"

Code A has written.

A Correct.

Code A Thank you very much.

Code A Thank you, Code A Any questions arising out of those asked by the Panel.

Code A Just two, very briefly, if I may.

Further re-examined by Code A

Q The first is just to try to clarify a point that has just been raised. The references in the notes that you have been referred to where there are the words "tense and agitated" after your reference to being unresponsive - do those actually show that Code A was conscious, not unconscious?

A Yes, I would say so. He is showing the signs that he has receptors to pain or agitation.

Q Do we have anything more there about any other ways in which he was responsive or conscious?

A What page are we on again? Sorry. 210?

Q We have just been looking at 209 and 210.

A Do we have any other ways of ---?

Q Any other signs of consciousness or responsiveness?

A There are references to him being agitated and tense – yes?

Q Those are the ones though. Those are the ones you have been referred to.

A Right. You are asking if there are any more?

Q Otherwise.

A What? By myself?

Q Or anyone.

A There is another entry saying "some agitation noticed".

Q Yes.

A A On the 16th.

Q Those are the ones you have just been taken through.
A No. These are by somebody else, not myself.

Q That is right, but you have just been taken through these pages.
A Right?

B

Q Referred to entries relating to being tense or agitated.
A Right, right.

Q And you confirmed, as I suggested to you, not unconscious ---
A Yes.

C Q --- at those times?
A Yes.

Q And I am just asking whether there is anything else there in these notes giving you any information about this man being conscious?
A No.

D Q Thank you very much. The only other thing then is when you were answering to the Panel, you mentioned the medication Arthrotec?
A Yes.

Q Which is shown on page 199 of those notes of Patient A. It might be just sensible to look at that briefly. On page 199 Arthrotec is the drug at the bottom of the page. Is that right?

E A That is correct.

Q On that drug chart?
A Yes.

Q Is Arthrotec a form of a painkiller that is also known as diclofenac?
A No.

F

Q It is not?
A It is not the same drug as diclofenac. It might be related, but it is not diclofenac.

Q Right. It may be that we will need to talk to our expert about that point. Can we see form page 199, then, that the last time that is administered is on 10 January at 9 a.m?
A Yes.

G

Q That day, 10 January, is the day that Oramorph is started. If you look over the page to 200 Oramorph is at the top of the page, first administered on the 10th at 22.00. Yes?
A Yes.

Q There is also an administration the next morning on that prescription, and then it continues on page 202. On 202, the bottom entry there is Oramorph, continuing on from the

H 11th?

A A Yes.

Q So on the 10th, the Arthrotec stops and the Oramorph starts?
A Yes.

Code A Thank you very much. Those are my questions.

B Code A Thank you, Code A you have made it. That is the end of all of the questions. Thank you so much for coming along to assist us. Panels such as this really do rely enormously on the presence of live witnesses to enable them to build up a clear and accurate picture of events and circumstances that very often took place many years before. We are extremely grateful to you for your assistance in helping us to do just that. Your testimony is at an end, and you are free to leave. Thank you.

C THE WITNESS: Thank you very much

(The witness withdrew)

Code A We will break there, ladies and gentlemen, and return at ten minutes past two, please.

D (The luncheon adjournment)

Code A I call Code A

Code A, sworn

(Following introductions by the Chairman)

E Examined by Code A

Q Is your name Code A?
A Yes, it is.

Q Code A, I am going to ask you questions first. I am going to ask you, first, about
F yourself and how you fit into this case and then I will ask you about some general points, particularly about syringe drivers back on Dryad Ward in the 1990s. I am then going to ask you about a number of particular patients who you had dealings with on Dryad Ward. We will go through their records and see where you featured. First off, in relation to you, Code A you worked as a Code A on Dryad Ward at the Gosport War Memorial Hospital from 1992. Is that right?
A In 1992 I was a Code A

G Q In 1992 Code A and then by the time you got to working in Dryad Ward?
A I was Code A

Q Code A
A Yes.

H Q That means a Code A

A A Yes.

Q In terms of the hierarchy, above that would be a Code A
A Yes, Code A yes, and then G would be the ward Sister.

Q You worked as a Staff Nurse on Dryad Ward between, apart from other dates, between 1996 and 1999?
B A Yes.

Q At which time the ward Sister was Code A ?
A That is true.

Q The clinical assistant for the ward was Code A
A Yes.
C

Q We have heard about Dryad Ward already, the kind of patients that were cared for on that ward. How would you describe the kind of patients you received, dealing with that time, 1996 to 1999?
A The patients were varied, all over 65. We had a mix of continuing care, palliative care, terminal care. We also had some patients in for respite care whether it was for a period of two weeks, home for four or six weeks and then back in for two weeks.
D

Q What were the shifts that you would generally work?
A I worked 7.30 to 1.30 if I was on an early shift.

Q That is 7.30 am to 1.30?
A Am, yes, and then 2.15 to 8.30 pm.

E Q You would not work nights?
A No, I did not work nights.

Q Would you ever be involved with ward rounds with Code A ?
A Yes.

Q When would it be that you would be accompanying Code A ?
F A If the ward Sister or the Senior Staff Nurse was not on, or if I was the only trained nurse on duty, then I would go round with her.

Q Would there be occasions when you were on duty when you were the senior nurse present?
A Yes.

G Q What was the atmosphere like on Dryad Ward at this time?
A I think it was relatively happy. The staff all got on quite well, a good rapport with the patients, with the relatives, with other staff, with other people who came into the ward.

Q How was your relationship with Code A ?
A Fine.

H Q Your relationship with Code A ?

A A I had no problems with Code A.

Q In terms of the relationship that existed between Code A, the clinical assistant, and Code A how would you describe that relationship for us?
A As far as I am aware, professional, they each respected each other's roles.

Q Was it a relationship where there was trust between them?
B A I believe so.

Q Would you have patients who arrived on Dryad Ward who were there for the purpose of rehabilitation?
A We were not a rehabilitation ward. Any rehabilitation would have been very, very slow. Rehabilitation, we did not have designated physiotherapy time so it would really be up to the nurses to do as much as you could with the patients – encourage them if they were able
C to walk, to feed themselves – but it was not an actual rehabilitation ward.

Q Did you feel there were any difficulties that arose if people expected rehabilitation?
A At times, yes.

Q Can you explain why that was?
A It is difficult. It is such a long time ago I cannot think of anything specific.
D

Q Was there any difficulty in terms of how relatives perceived the care which should have been received by their loved ones?
A At the time I was working there, no, I was not aware of anything like that, no.

Q Was there ever any difficulty that you saw of people coming to the ward and expecting there to be a rehabilitation when in fact there was not?
E A I cannot recall anyone coming to me specifically and saying that.

Q Did you perceive that at all?
A I am not sure what you ---

Q I have asked you a little already about whether there was any difficulty in terms of patients coming to the Gosport War Memorial Hospital onto Dryad Ward for rehabilitation
F when in fact that was not what was going to happen. There was a point where I think you were saying "Yes, it was a problem", and I am just trying to find out if you can help us any more with why that was a problem or what the problem was, and if in fact it was not, then ---
A I think I am getting a bit mixed up because reading the statements I have read, and there appears to have been a problem since then, people have come and said they expected their relative to be rehabilitated, but at that time no-one actually came to me and said, "I am expecting", if that makes sense.
G

Q Did you have many dealings with the relatives of patients?
A At times, yes.

Q What sort of thing would be discussed?
A If I was on duty when a patient was admitted, I would explain to the relatives what the ward was, what the visiting hours were, what they needed to bring in for their relative, if
H there was anything specific that they knew that the relative liked, what they liked to be called.

Q What about the treatment, the medical treatment, the patient was going to receive, would that be discussed?
A You would say that they would be seen by the doctor, that they would be assessed regarding what their needs were and take it from there.

Q Can you help us with whether the treatment that the patient was going to receive was always discussed with the family or not?
A As far as I am aware, yes.

Q Were you involved in those discussions?
A As I say, I would explain to the relative what we would be doing. We would assess the patient, see what they were able to do, what they were not able to do and we would do the best we could for them.

Q Would it ever be more specific than that?
A I am not sure.

Q Moving on to syringe drivers, when you were being spoken to by the police and making statements for them in 2003, you said that you never had any concerns about the use of syringe drivers at the hospital and they were always used correctly and when necessary. Diamorphine was also used when necessary and correctly, and your only concern at that stage was that you felt the use of syringe drivers and diamorphine was not enough. That is the statement of 12 June 2003. Your meaning, in terms of the use of diamorphine not being enough, was a concern that people who were in pain might not then be receiving the pain relief that you thought they required?
A That is correct, yes.

Q Does that remain your general view?
A I no longer work on the ward so I do not deal with the patients.

Q In terms of the use that was made of syringe drivers and diamorphine in the period that we are talking about in 1996 to 1999, has your view changed at all or does that remain your view?
A That remains my view.

Q Do you remember, in your experience at the time, any concerns being raised by any other members of the nursing staff at the time?
A No.

Q You personally were involved in the administration of syringe drivers and drugs through them?
A Yes.

Q I think you made the point in your statements that you would not have done that if you did not think it was necessary?
A That is right.

Q Some questions about the detail of how they would be used. The Panel has heard evidence about **Code A** prescribing medication to be given through a syringe driver in a

variable dose, a dose range of between an amount and another amount. Were you aware of that at the time?
A Yes.

Q Who would it be, once such a prescription was written up, who would decide to start the syringe driver?
A It would be in discussion with the doctor and the rest of the team on the ward. If the patient had deteriorated, then it was not just one person that would say, "I will go and do that", it was discussed.

Q Would it always be with the express knowledge of the doctor or the doctor saying so, or could it ever be done just by the nursing staff?
A It occasionally may have been done by the nursing staff if the doctor was not there, but the doctor was aware that the patient had deteriorated.

Q To clarify that, the doctor could be aware of the deterioration but may not actually have been spoken to about the driver being set up?
A If the doctor had been in that morning and seen the patient and the patient was poorly and we felt they had deteriorated and we had already discussed with the doctor, it may have been started. I cannot give you the exact dates or anyone in particular, but it may have.

Q When a syringe driver was commenced, who would decide the starting dose of the medication to go within it?
A It would be started at the lowest dose or the equivalent to whatever other pain relief they had been on.

Q Either the lowest dose within the prescribed range?
A Yes.

Q Or simply an equivalent dose to what they were already having orally?
A Yes.

Q Would that mean that it would be unnecessary to consult the doctor about the starting dose or would the doctor have an input into it?
A The doctor would have an input.

Q All the time?
A I would say probably yes.

Q Except, I suppose, presumably those times when, as you described before, it was just the nurses who had decided to institute the syringe driver?
A Yes.

Q Once a syringe driver was up and running and the dose of medication within it was increased, who could make that decision? Would that need **Code A** or another doctor to say so, or could that be done just by the nurses?
A You would normally discuss it with the doctor, if the doctor was available; but discussing it with the team, if you felt the patient was not comfortable, or still distressed or in pain, then it would be increased and doctor would be informed.

A Q So if the doctor was not immediately available, you are saying that it might be done without the say-so, but only subsequently telling the doctor?
A Yes.

Q If a patient was on the syringe driver with diamorphine for pain relief, and that dose was going to be increased, how much would it be increased by? Were there any particular rules or guidelines that you worked to about that?
B A Normally you would go by the *BNF*. The *BNF* had a guideline on it. I could not do it now, because it is a long time since I have ---

Q Very well. The Panel actually have copies, and we can look at it if necessary, but it may short-cut matters if I help that there are references to stepping up ---
A Yes.

C Q --- of 30 to 50 per cent incrementally.
A Yes.

Q Does that ring any bells with you?
A Yes.

Q But it would be by reference to that that the amount would be increased?
D A Yes.

Q In your experience on Dryad Ward, once a syringe driver was started, and started with diamorphine, did you have experience of those doses being decreased, or was it more the case that once it had started, that would not happen?
A I really cannot remember.

E Q Did you know at the time of what is called the analgesic ladder?
A Yes.

Q Did you apply it personally, in terms of giving pain relief?
A I think so. I cannot remember that far back.

Q Can I just ask you about this as well, about hydration for patients who were on a
F syringe driver. In your experience would patients on Dryad Ward who were on syringe drivers receive any other hydration, if they were unable to drink orally?
A If they were unable to drink they would be given frequent mouth-care, and I think some may have had subcutaneous fluids, but we did not do intravenous fluids.

Q Do you remember personally being involved with any patients who had subcutaneous hydration?
G A I cannot remember, no.

Q Can you help with this, and say if you cannot, but the significance on the ward at this point of commencing on a syringe driver, in your experience what did it mean for a patient in terms of their prognosis?
A Basically their prognosis was very poor – they were dying. The patient was dying. We were trying to make sure that they were comfortable, pain free, not distressed.
H

A Q I have already asked you about whether you were aware of any other of the staff members' concerns about syringe drivers, and I think you said no, you were not.
A That is right.

Q Specifically, can I ask you to clarify whether you were aware of any concerns that **Code A** had about syringe drivers?
A No.
B

Q You certainly did not share any such concerns?
A No.

Q One last general point, which is in relation to a note that the Panel have seen on occasion within the clinical notes, which would be the words "I am happy for nursing staff to confirm death".
C A Yes.

Q That was something which you would see in the medical notes?
A Yes.

Q In your experience, first of all, why would that be written for patients on Dryad Ward?
D A Because there was not a doctor there all the time, and if the patient was – you would only do that if the patient was expected to die, if their condition had deteriorated or if it was during the night or out of surgery hours, then at that time we would do it. It has happened. I have worked in nursing homes and it is the same policy there.

Q I am sorry, I am being asked to clarify. Did you say that those words would only be written on the notes if the patient was expected to die, and therefore this was making
E provision for the nursing staff to confirm death?
A I did not say that, no.

Q I am so sorry.
A You said that.

Q It is a good thing I clarified it, then, because I do not want there to be any
F misunderstanding. What would be the purpose of writing those words?
A To allow the nurses to verify that the patient had died.

Q Right. And that would be necessary for the doctor to write that, because otherwise the doctor would have to be called out to do the job?
A The doctor would have to be called out.

G Q Did it signify anything to you as a nurse about a patient's prognosis, if you saw that note in the records?
A I suppose it would signify that their prognosis was not good, and it was there so that if they did die, then I would be – myself and other trained members of staff would be able to verify the death.

Q Was it written for every patient on Dryad Ward?
H A I cannot remember.

Q Thank you very much. That deals with the general topics. Can I move on now to the first of the particular patients that I want to ask you about, and that is Code A You will see that next to you there are some files, and can I ask you please to take out file A. That is a file that contains notes relating to this patient, Code A In fact, Code A I can tell you immediately that all we are going to be doing in relation to this patient is just identifying the notes you made, rather than any particular issues surrounding him, so this should be reasonably quick. So if I can just remind you about Code A, because I think you made clear in your statement that you did not remember anything about this patient. There is a chronology at the front of that folder which tells a little bit about Code A. On the second page, he was admitted to the Gosport War Memorial Hospital suffering from depression, 14 September 1995.

A Yes.

Q If we go over the page to page 3, at the top of the page, in December 1995 he was admitted to Mulberry Ward under Code A?

A Yes.

Q Referred to Code A Then on the next page, page 4, you can see that on 5 January 1996 he was admitted to Dryad Ward.

A Yes.

Q Then there is a review by Code A that you can see, and then we have notes of the drugs that were administered; then on the last page we can see that unfortunately Code A died on 24 January – right?

A Yes.

Q Just to orientate you slightly about the patient. Now if we can just look at the notes that you made – page 207 of the file, please. You will see at the bottom of this page there is only one page number. When we look at other pages you will see that there are a number of different paginations. We are always going to be concerned with the one in the bottom centre with the dashes either side. This is a handwritten note; is that your handwriting?

A I think so, yes.

Q In fact if we just go back to the page before, 206, we see this is one page of this form "General Information" which is filled in on admission to Dryad – is that right?

A Yes.

Q Your note at page 207 would seem to be written on the back. Does it appear to be some information relating to Code A that had been noted on admission?

A The front page, yes.

Q Sorry, 207 is also information recorded on admission?

A Yes.

Q Just reading it together:

"Past history: long term psychiatric problems (Depression). Has been in Hazeldene rest home for past 7 months. His wife unable to cope with decreasing mobility. Has

had recent falls due to decreasing mobility. Reluctant at times to eat and drink. Catheterised on 23.12.95 due to fluid retention."

That is your note?
A I think so, yes; it looks like my handwriting – a lot better then.

Q If we go over the page to 208 do we see that you have made the first entry there on the nursing notes ---
A Yes.

Q --- for the day of admission, 5 January. You have written:

"Transferred from Mulberry Ward at lunchtime. Appears to have settled well. Wife and daughter visited this afternoon. Has had a sore on right buttock which has Granuflex on – same left" –

So the left buttock?
A "Same left intact".

Q "Left buttock dressing removed and Granuflex applied. Scrotum sore and broken, felt dry. Has taken a small amount of puree as reluctant to eat sandwiches. Needs to be encouraged with diet – fluids. Catheter bag changed – dated."

A Yes.

Q And it is signed by you? You also included a number of entries on the various nursing care plans for Code A firstly on page 218 – and I am just going to run through these very briefly, just to identify your entries. On that page it is your entry that is dated 15 January 1996, is that right?
A Yes.

Q In relation to giving the bed bath and applying liquid paraffin. You have also made an entry on 19 January, again bed bath, cleaning, mouth care and paraffin – is that right?
A Yes.

Q There is also a hygiene care plan on page 217. That was written by Code A, is that right?
A That is correct, yes.

Q There is information about the pressure sores that Code A had, on page 215, those sores being identified on the locations in the middle of the page – is that right?
A Yes.

Q Sacrum, left hip, left foot and the right ear. You also have further care plans from page 224 – there is a catheter care plan ---
A 215 is not my writing.

Q No. In fact from page 224 was it Code A who was completing these care plans?
A I am not sure who it is because it has not been signed on the front.

A

Q Very well. There is a catheter care plan, there is a dietary care plan at 226, to encourage adequate diet and fluids. That seems to be signed by Code A ?
A Yes.

Q There is also a sleeping care plan at page 228. But you were asked to check the drug charts for this patient, and you confirmed when you did that that you did not administer any
B drugs to this patient. In fact that deals with Code A from our point of view for the moment.

Can I ask you then to turn to Patient G, please, and you could put that file back.
A G?

Q Yes. Patient G is a man called Code A , and I think when you were
C making your statements you could vaguely remember him a little?
A And that was?

Q I am so sorry. Is it the case that you do not remember at all now?
A Sorry.

Q Very well. We will look at the notes to see whether you can help on any particular
D points. Just to remind you or help you now with Code A 's history, if you look at the chronology, please, on page 3, you see that on 21 September 1998 he was reviewed by Code A in respect of his sacral ulcer and admitted to Dryad Ward that day, and reviewed by Code A . So that is 21 September 1998. Over the page, prescribed that day Oramorph initially, and then diamorphine, midazolam and hyoscine, which was started – apart from the hyoscine, that is. Medication continued, and on page 6 we see that it was on Code A that Code A passed away. All right?
E A Yes.

Q Turning to your dealings with Code A you were, I think, the named nurse for him. Do you recollect that?
A I do not recollect. I have read the statement and seen my name and what is written, but I do not remember now.

F Q Could you just help us with what the role of a named nurse is?
A The named nurse was the person responsible for the day to day care of the patient. You would be responsible for writing the care plans if you were on duty. If you were not duty, you have seen whoever was on duty would initiate the care plan. You would ensure that what was in the care plan was followed through as best you could. If the relatives were there, you were the point of contact - again, if you were on duty. If you were not on duty, then one of the other staff nurses or sister would speak to the relatives.

G

Q We know that he was admitted then on 21 September 1998. Can we turn, please, to page 865, quite near to the end of the bundle. Page 865 is the first page of an assessment sheet?
A Yes.

Q Is this the sort of assessment sheet that would deal with a patient upon, or soon after,
H their admission to hospital, to Dryad ward?

A A Yes, at that time. I am not sure if they still use that.

Q If you just look briefly over the page, is that the second page of it?
A Yes.

Q Does it have your signature at the bottom?
A Yes.

B

Q And it is dated 22 September?
A Yes.

Q Which is actually the day after admission. Are you able to help with whether this would have been filled in on the day of admission, or is the date correct?
A Possibly the date is correct. All the paperwork may not have been concluded the day
C that the patient was admitted, depending on staffing levels and the workload.

Q Just to look at page 865 of the assessment sheet, under "Patient's understanding of condition", you have put "Unaware". "Communication: Hearing – no problem; Sight – no problems; Speech – coherent." Would that be based on your own dealings with the patient?
A Possibly mine. Possibly what I had also been told about the patient from their handover, coming on shift or the other nurses who had been dealing with them.

D

Q Are you able to actually say which of the two it was, or combination?
A I have no idea. I cannot remember. Sorry.

Q You have ticked the box to show that he had a urethral catheter?
A Yes.

E Q And under "Nutrition: Diet" is marked up as "Soft; Appetite – Fair;" you have also highlighted Parkinson's disease and dentures that he had. Under the box for pain, you have ticked "yes" for pain and "yes" for controlled. Again, is it the same situation, that you do no recall whether that was based on your own assessment?
A No. I have no recollection.

Q If we just remind ourselves of the medication that was being administered from the
F 21st, so the day of admission could I ask you, please, to look at page 758. Do you have a drug chart there?
A Yes.

Q Which is marked at the top "Daily review prescriptions"?
A Yes.

G Q The first drug that is dealt with is diamorphine?
A Yes.

Q With a dose range of 20-200 mg in 24 hours?
A Yes.

Q Can we see that from 23.10 on the 21st, 20 mg of diamorphine was being administered
H by syringe driver?

A A The 21st of the 9th?

Q Yes.
A Yes.

Q And also at the same time, the same day, the midazolam was started with 20 mg?
A Yes.

B

Q On the 22nd it looks like it is around 20.20, so twenty minutes past eight in the evening?
A Yes.

Q Again, 20 mg of diamorphine and 20 mg of midazolam was being administered?
A Yes.

C

Q All right?
A Yes.

Q Do you remember going, back to your entries on the assessment sheet on 865, whether you were assessing Code A on the syringe driver and how he was at that time, or whether this is based on previous information?
D A I do not know.

Q You cannot say. If we move on in the notes that were made – these were the initial assessments – would you go to page 867, please. That is a Barthel score?
A Yes.

Q It is dated also 22nd of the 9th, so the day after admission. That is something that you
E filled in?
A I have no idea. It is not signed.

Q When you made your statement to the police you thought that that was your handwriting. Does that help at all?
A I am really not sure.

F Q All right.
A I cannot tell just by the date there.

Q It is obvious, just running down the page that there is a zero score on all of these entries including, for example, feeding?
A Yes.

G Q A zero, which means "unable to feed himself", and transfer and mobility, also zero. Does that fit with what is on the assessment sheet in terms of speech being coherent and appetite being fair?
A No.

Q No? Could you just explain – and I appreciate it may be obvious – but can you just explain what you mean?
H A I have no idea. I do not know. I do not know. I cannot remember it.

A

Q A Barthel score where every one of the entries is zero, you are saying that does not really fit with the other information?
A The feeding part, I am surmising. I do not know. I cannot remember. But the feeding is "unable". He may have been fed by someone.

Q Someone else?
B A Someone else, so he may have been taking some diet if he was fed. I do not know. I am surmising.

Q If we see a score like this, where a person has zero for every entry on the Barthel, what does it say about the kind of condition the patient was in?
A It means the patient is totally dependent.

C Q Does it say anything about whether they are conscious or unconscious?
A That does not always relate whether they are conscious or unconscious. It could be that they are totally dependent, unable to feed themselves, unable to wash themselves.

Q So it does not necessarily mean unconscious?
A It does not necessarily mean, no.

D Q If we go over the page to 868, that is a page marked "Abbreviated Mental Study"?
A Yes.

Q It does not seem to have been filled in?
A No.

Q Does that tell us anything about whether he was in a condition to be assessed?
E A It might have been that we never got round to filling it in, or it might have been that a patient was not able to communicate to do it. I do not know. I cannot remember.

Q All right. Then, moving over the page to 869, is there a page of nursing care plan where we can see under "Named nurse" at the top of the page, it is your name?
A Yes.

F Q That appears to indicate that you were the named nurse?
A Yes.

Q This has been filled in on the 21st of the 9th, it seems. Is this your handwriting?
A No, it is not my handwriting.

Q That relates to requiring assistance to settle for the night?
G A Which is normally filled in by the night staff.

Q Going over the page to page 870, it is a continuation of the nursing care plan. It may be helpful for you to look at the first entry there, for the 21st of the 9th, so the day of admission. It says the driver was commenced at 23.10. We have already seen that.

"... containing diamorphine 20 mg and midazolam 20mg. Slept soundly following.
H BS ---"

A Blood sugar.

Q "[Blood sugar] at 2320..."

And there is a measurement of that. Then it says:

B "Two glasses of milk taken when awake. Much calmer this a.m. Sacral sore oozing but left exposed as requested."

It seems from that note that overnight he was able to have a couple of glasses of milk when he was awake, and then he was calm in the morning. Over the page to 871, that is a Waterlow Pressure Sore assessment?

C A Yes.

Q For the 22nd of the 9th. Is that your handwriting or you are not sure?
A I do not think so. No, that is not mine and I certainly have not written the name.

Q We can see that the score there is 20, which is high. Over the page to page 872 is a "Lifting/Handling Risk Calculator". It has not been filled in. Does that tell us anything about
D this patient's condition?
A No.

Q Would it sometimes be that it just was not filled in?
A Yes.

Q On page 873 a further "Nursing Care Plan" dealing with the sacral sore. Do you have
E that? The first entry, I think, is yours?
A Yes.

Q You have pointed out on the 21st of the 9th, there was a large sacral sore present on admission, and that the desired outcome there was:

F "To aim to promote healing and prevent further breakdown."

Cleaning and so on, dressing appropriately. Over the page, on 874, we can see that there is an entry in relation to that for the 21st of the 9th from a nurse, I think called "Collins"?
A Yes.

Q About a dressing being applied to buttock at 18.30, and some cream being applied to the necrotic area. "Very agitated at 17.30." Oramorph was given, 10 mg, at twenty past
G eight, and then it says:

"Pulled off dressing to sacrum".

Then it is signed by that nurse. So there is some information there about Code A 's condition on the evening of the 21st, and the administration of Oramorph then. Were you aware of the purpose of the admission to Dryad ward? Are you able to remember?

H

A A From what I recall, reading the statement, because of his pressure sore I think was one of the reasons that he was admitted.

Q Right, and that is what appears on the care plan in relation to the sore, an aim of promoting healing and preventing further breakdown. We have also seen, though, that on the day of the admission a syringe driver was started that evening. For you as a named nurse, how would those two fit together? Did that mark a change in terms of the syringe driver
B being started? That marked a changed, really, in the kind of treatment that was being given to the patient?
A I am not with you at the moment. I am sorry.

Q You have already said, quite fairly, that a purpose of admission was to deal with the pressure sores that this patient was suffering?
A From what little I remember.
C

Q If it is helpful there is correspondence in the file from Code A which confirms that. Would you like to look at page 458? Do you have that?
A Yes.

Q It is a letter from Code A to Code A. It is dated 23 September. It was dictated on the 21st, so that is the day of the admission to Dryad ward. You can see that the first line of
D the letter points out:

"Code A ... has a large necrotic sacral ulcer which was extremely offensive."

Then she points out that

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

The second half of the letter goes on:

"I have taken the liberty of admitting him to Dryad Ward ... with a view to more aggressive treatment on the sacral ulcer as I feel that this will now need Aserbine in the first instance. The social worker is being contacted so that his place at the Thalassa nursing home can be kept open for the next three weeks. Code A
F has agreed to the admission. We shall let you know how he gets on."

When you said a purpose of the admission was to deal with the sacral ulcer, yes, that appears to be right. The question that I am asking is, in fact on that night of his admission he was started on a syringe driver, as we have seen from the notes. For you as a nurse working there at the time, and dealing with him, would that seem to you to mark a change in the way this man was being treated.
G A I would say it was a change in his condition. I cannot comment any further because I do not remember and I obviously was not there when – that is why I cannot comment on what the patient was like.

Q To go back to the care plans, I am not going to ask you anything about them, I want to confirm where we see your handwriting, page 875. That is part of the nursing care plan dealing with a blister on the heel and that is signed by you.
H A Yes.

Q Moving over to 877, that is a nursing care plan to do with personal hygiene, again signed by you?
A Yes.

Q That he needed assistance with it due to the Parkinson's disease and you also dealt with a catheterisation, or a catheter care plan at 879. That is also your note?
A Yes.

Q If we go back to page 831, this is the last entry that I am going to refer you to where we see your name or your initials, page 831, that is another page of the drug charts.
A Yes.

Q We can see featuring there diamorphine, hyoscine and midazolam. The entries relating to 25 September, this is the day before Code A passed away, can we see diamorphine 60 mgs administered from 10.15?
A Yes.

Q Are those your initials just below that?
A Yes.

Q Hyoscine 1200 mcg, slightly difficult to read but I think it must be 1200, administered at the same time, and midazolam at 80 mgs?
A Yes.

Q So effectively we see this was the syringe driver that you prepared at that stage?
A Yes.

Q Diamorphine 60, hyoscine 1200, midazolam 80 mgs. If we turn to page 863, the top of the page deals with the day before and we run on to the middle of the page to that day when you recharged the syringe driver in that way. Looking to see what changed, on the 24th there is an entry from Code A Is that right?
A Yes.

Q Saying that:

> "Report from the night staff that Code A was in pain when being attended to, also in pain with day staff especially his knees. Syringe driver was recharged at 10.55 with diamorphine at 40 mgs, midazolam 80 mgs and hyoscine 800 mcg."

Comparing that with what happened the next day, at that stage the diamorphine was 40 and then, when you came to recharge it on the 25th it was with 60 mgs, so there had been an increase in diamorphine, also hyoscine had gone up from 800 to 1200, but the midazolam stayed the same. Is that right?
A Yes.

Q Continuing reading:

> "The dressing was renewed this afternoon – see care plan. Code A seen by Code A this afternoon, fully aware of Code A's condition."

Later that day there is an entry about Code A telephoning. An entry about being aware of being moved and sounding chesty in the morning. That must be the morning of the 25th and the entry for the 25th makes it clear that at 10.15 the syringe driver was recharged with the amounts we have already been through -- diamorphine 60 mgs, midazolam 80, hyoscine 1200.

In light of the fact that you were the person who administered the drugs on the 25th, can you help with why there was that increase in diamorphine. Is there anything from your recollection or from the notes which helps with why the diamorphine was increased?

A From the notes I would say because he appeared not to be pain free.

Q Where do we get that from?

A I was reading it from the 24th, he still appeared to be in pain. It is not clear in the notes, it could have been passed over by the night staff, I do not know. It is a possibility.

Q It is a possibility?

A Yes, it is a possibility.

Q We do not see that reflected in the notes.

A No.

Q Do you have any recollection of that?

A No, it is a long time ago.

Q I appreciate that. Do you have any recollection, or is there anything which helps us, with whose decision it was to increase the diamorphine?

A No.

Code A Thank you. Those are all the questions about that patient, we can put that away for the time being.

Code A the patient witness has been on the stand for an hour so we will break at this point. We will take a break and we will return at 3.35 pm. (To the witness) In the time that you are out of this room, you are in the middle of your evidence, so you are technically still on oath. I must ask you not to discuss any aspect of this case with any person while you are out of this room. Thank you.

(The Panel adjourned for a short time)

Code A Welcome back. Code A

Code A, the next patient is one we can deal with reasonably quickly. It is Code A file H. The summary in relation to Code A, from the chronology at the front, on that first page, 21 September 1998 Code A went to Accident & Emergency at the QAH after falling and fracturing his left humerus bone. He was admitted and then over the page at the bottom, on page 2, it was on 14 October that he was transferred to Dryad Ward and reviewed by Code A there. Going over the page, at the top of the page we can see that Code A prescribed some paracetamol but that was not administered. Over the next page, at page 4, in that first box Oramorph was prescribed and indeed administered on

14 October, and Oramorph was prescribed again on 15 October. Subsequent to that, a syringe driver was commenced from the 16th and it was on the 18th that Code A died.

Turning to what involvement you had, it was limited to the 14 and 15 October, so the day that Code A came to Dryad Ward and the following day. If we turn to page 266 we have some nursing notes.

Code A Is it A or B?

Code A It is the same but one is a better copy.

Code A There is some additional notation on one.

Code A For our purposes it does not matter, but you are absolutely right. I am looking at 266A. Looking at the top two entries, the first one is an entry by Code A for the 14th and then the second for the 15th is you. Is that right?

A (Witness nodded)

Q The 14th says:

"Received as a transfer from Dickens Ward QAH. History of left humerus fracture. Arm in collar and cuff. Long history of heavy drinking. LVF, [left ventricular failure] chronic oedematous legs. Seen by Code A, Oramorph 10 mgs given. Continent of urine - uses bottles."

That is the 14th. Going back a couple of pages to page 263, at the top of the page we can see the Oramorph that is administered that day. We see that we have 10 mgs administered at 14.45 and administered again at 23.45, so it looks like another dose was given after the nursing note was made, so two doses of 10 mgs given that day. Going back to the nursing note, you then noted on 15th:

"Commenced Oramorph 10 mgs."

Can you make out what that next word says?

A 10 mgs and 5 mls 4-hourly.

Q Four hourly, thank you.

"... for pain in left arm. Code A seen by Code A who explained Code A's condition is poor. Please call day or night if any deterioration."

Two doses of 10 mgs have been given on the 14th and on the 15th it was commenced at 10 mgs every 4 hours. Looking back to where we see that, on the drug charts page 262?

A Yes.

Q We have Oramorph 10 mgs every four hours and then below that Oramorph 20 mgs nocte, so 10 mgs four times a day, being 40 mgs, then 20 mgs at night, so that would be a total of 60 mgs in the day. Have I read that right?

A Yes.

A Q Again, please say if you do not remember or you cannot help, we know and it is recorded in the notes that before the admission to Dryad Ward, this was patient who was receiving paracetamol and codeine for pain relief. On admission on the 14th we have those two administrations of Oramorph and then on the 15th the prescriptions we have just seen. Can you help with why it was that there was the change to use of opiate analgesic?
A I do not recall the patient or doing the medicines, but I would assume that perhaps his pain was not controlled.

B Q Is there anything in the notes that we have looked at which helps with that or is it an assumption?
A Partly an assumption and partly by what I have written that the wife had been seen by Code A who explained that Code A's condition was poor so I would assume that he had deteriorated.

C Q You have written that the Oramorph 10 mgs 4-hourly for pain in the arm. Do you have any further recollection of the nature of that?
A No.

Q You can put that file back. Turn to file I, file I deals with the patient Code A
A I do not have file I. (Same handed)

D Q If we can just again do the same process with this patient, from the chronology we can see on the first page that she was admitted to the Royal Haslar Hospital on 19 March 1999, after falling and suffering a fractured femur. She received medication there and had surgery, and there was a period of time that she went on the ward there. Then on page 4 we can see that on 26 March 1999 she was transferred to the Dryad Ward and reviewed by Code A, and Oramorph was prescribed and administered. Moving on, continued prescriptions over the days, co-dydramol being used – that is another analgesic, is that right?
E A Yes.

Q Then from 31 March, which is on page 6, we see MST being prescribed. MST is a slow release morphine tablet, and that seems to replace the Oramorph from that time on. That continues over a number of pages, until on the 12th – which is the last page, page 10 – on 12 April is the start of the syringe driver, and then on the 13th, just in the very early hours of the Code A Code A passed away. OK?
F A Yes.

Q So again just turning to the entries where you may be able to help us, could we go, please, to page 132. Again this is one where it is easy to become confused by the pagination. If you remember, it is the pagination in the bottom middle with the dashes either side.
A Yes.

G Q So that should be a summary of significant events from the nursing notes. Do you have that?
A Yes.

Q For example, the entry just a few lines down from the top relates to the admission on 26 March saying "Admitted to Dryad Ward for rehabilitation and gentle mobilisation" – OK?
A Yes.
H

A Q Moving down the page to the bottom, an entry for 6 April 1999, so we are now dealing with a time when Code A had been back on the ward for a little time, certainly over a week – a week and a half or so. This seems to be an entry by you, is that right?
A It is my writing, yes.

Q It is your writing. Let us just read it, please.

B "Seen by Code A MST increased to 20 mgs." –

So that is a reference to the slow-release morphine tablet.

"Code A has visited, if necessary once Code A is discharged home (as she is adamant about not going to a nursing home) he will employ someone to live in. Code A has been incontinent of urine a few times over the weekend. I have spoken to her about a
C catheter and she is going to think about it or using pad & pants."

That has been signed by you?
A Yes.

Q There is also a note there where the day may have been cut off slightly. It is in fact the 7th, if everybody else's is cut off as well. It is an entry for 7 April, the next day, another
D note by you saying:

"Fracture site red & inflamed seen by Code A to commence Metronidazole 400 mgs and" –

I think it is –

E "Ciprox 500 mgs BD" –

which is twice daily. And you sign that as well.

Code A, do you have any questions regarding these? We seem to be directing the witness to clear notes that we have already looked at before, and there are no questions forthcoming, so I am wondering what the value of the exercise is.

F

Code A Yes, I am so sorry. There is a question coming, if it assists.

Code A OK, I will bear with you.

Code A That is very kind, but it is a helpful reminder that I will do what I can to try to avoid anything like that, and I apologise that I missed that.
G (To the witness) The first point is this: your note for 6 April relates to being seen by Code A and the MST, the slow-release morphine dose, being increased to 20 mg. Is there anything there that helps us with why that increase took place?
A No.

Q Do you have any recollection of this patient that could assist with you with that?
A No, sorry.

H

A Q Is there anything helps us with whether there was any examination by Code A of the patient?
A When I have wrote "Fracture side red & inflamed seen by Code A".

Q Does that tell us that she saw that?
A Yes.

B Q It seems that the entry for the 7th relates to the commencement of drugs which are antibiotics, is that right?
A Yes.

Q Would that related to possible infection on the site of that fracture site?
A Yes.

C Q You administered MST on a number of occasions from 31 March, I think, and if we go to the drug chart on page 178 we can see that. Do you have page 178?
A Yes.

Q We can see in the middle of the page "morphine MST" being prescribed, initially at 10 mg twice a day.
A Yes.

D Q And then from the 6th, a cross-reference to your last entry, it goes up to 20 mg twice a day – yes?
A Yes.

Q We can see your initial, for example, on the 7th at eight in the morning, administering that; and then the next day, the 8th, at eight in the evening you administer it. Right? So for
E these subsequent days running up through April we then have 20 mg being administered twice a day, so 40 mg of MST.

There came a time, though, that you were involved in the administration of the syringe driver. Do you remember that?
A No.

F Q If we look to page 174, which is just a page back in these records, can we see here the prescription for diamorphine, hyoscine and midazolam, where the diamorphine and the midazolam have been started on the 12th?
A Yes.

Q Can you see that?
A Yes, sorry.

G Q Is it your signature that appears in relation to both, with 80 mg of diamorphine being administered at 08.00?
A Yes.

Q And 20 mg of midazolam being administered at the same time?
A Yes.

H

A Q Then those doses were both discarded, with the driver being recharged subsequently at 16.40, with a larger dose of midazolam – yes?
A Yes.

Q But in terms of your administration of the drugs then, diamorphine at 80 mg that morning, and midazolam at 20. What we have seen from the previous page was that up until that moment the analgesia that the patient was receiving was the MST 40 mg a day – yes?
B A Yes.

Q There is one other point that we should not miss, because also on the 11th there is a little bit of Oramorph that is administered – if you go to page 160. Do you have that?
A Yes.

Q Can you see on page 160, Oramorph, which had been prescribed PRN – as required –
C on the morning of the 11th, 5 mg of that was also given?
A Yes.

Q So on the 11th a total of 45 mg of oral morphine was given. Then on the 12th, when the syringe driver was started, it was with diamorphine 80 mg.
A (The witness nodded).

D Q Can you help at this stage with whose decision it was to commence the syringe driver?
A I have no idea.

Q Could it have been commenced at either **Code A**'s direction or just by the nurses?
A I have got no recollection of this at all.

E Q Were you aware at the time of how an equivalent dose would be worked out from an oral dose to a subcutaneous dose?
A Yes.

Q What was your understanding – it is not supposed to be a test, but what was your understanding – about how you would convert and make an equivalent dose from oral morphine to subcutaneous morphine?
F A In the *BNF* there was a table which was a guideline which as I recall we would follow.

Q Right. When you were answering questions on the general topics you told us that if a syringe driver was started, then the equivalent dose would be found to what the patient was receiving orally. Can you help us – and I apologise if this is repeating a question at all – but can you help us with how it was that the patient went from 40 mg, 45 mg or oral morphine to
G 80 mg subcutaneously?
A No.

Q Can you help at all with why midazolam would also have been required?
A If the patient was agitated, to keep them comfortable.

Q This was obviously, as we have seen, a dose that you administered yourself. Can you
H remember whether this was anything that you challenged, or ---

A A I cannot remember anything about it, I am sorry.

Q Very well. Let us move on then please to the final patient that we are going to deal with, so we are on the home strait, and this is going to be Patient K, please. This is Code A Code A Is that someone that you do remember?
A I remember from reading my witness statements.

B Q Has that helped you at all in your recollection, or do you have any recollection beyond what is there?
A I have also read statements that I have said back when I was part of an independent inquiry.

Q Right.
A It is very difficult to remember.

C

Q Very well. A quick reminder, then about Code A from the chronology. If we go to page 3, at the top, she was admitted to the Queen Alexandra Hospital with an episode of acute confusion on 9 October 1999. Then over the page, it was on 21 October that she was transferred to Dryad Ward and reviewed there. If we go to page 7, she spent some time on the ward there – at the bottom of page 7 you can see that on 18 November, reviewed by Code A then over the page, it was on that day that a fentanyl patch was administered. We
D will look at that in a moment. Then the next day, the 19th, was the day that the syringe driver was started in relation to her, and then finally, on page 9, it was on 21 November that that patient had died.

Do you remember now how Code A was and how she was behaving when she arrived on the ward?
A I do not remember the patient coming on the ward. I can remember what I have read
E in my statements.

Q Can you help us with that now?
A Very vaguely, I think I remember the statement, going back to 1999 – I cannot remember when I wrote the statement. She was confused, she was not my patient, I did not really have an awful lot to do with her.

F Q Very well. We looked a moment ago at the entry on the chronology for the fentanyl patch being administered to her on 18 November. If I just show you the controlled drug record for that day, it may be that you can just confirm that you signed there as being the witnessing nurse for that. (Handed) If you look down the page, it is round about the centre of the page – you may see Code A 's name?
A Yes.

G Q Does that relate to the administration of the fentanyl patch?
A Yes, it does.

Q And does it show that you were the witnessing nurse for that?
A Yes.

H

A Q Thank you very much. We can probably take that back. (Documents returned to counsel) Can you help us from your recollection, as far as you have it, of that patient? Can you recollect why it was that the fentanyl patch was started?
A I do not remember... I do not even remember signing. I do not remember that incidence at all.

B Q Could we then move, please, to page 223 of the records and the nursing notes. We are moving now to the following day, 19 November. At the bottom of page 223 is an entry which has been written by Code A Can you see that?
A Yes.

Q It says:

C "Marked deterioration over last 24 hours. Extremely aggressive this a.m. Refusing all help from all staff. Chlorpromazine 60 mgms given I.M. at 08.30 – takes 2 staff to special."

What does that mean? Can you help me with what that means?
A She needed two staff to be with her.

D Q "Syringe driver commenced at 09.25. Diamorphine 50 mgms. Midazolam 40 mgms. Fentanyl patch removed. Code A seen by Code A at 13.00 and situation explained to him. He will contact his sister Code A and inform her of Code A's poor condition. He will visit later."

Then the next entry is an entry by you. Is that right?
A Yes.

E Q This is at 20.00 hours, so eight o'clock in the evening.

"Code A has visited – seen by Code A"

The Code A – that was Code A. Is that right?
A Yes.

F Q "All care given to Code A Has not passed urine."

Can I ask about the visit by Code A that evening, please. Do you remember Code A coming that evening?
A I remember what I have read in my statements. I do not actually remember the evening as such. I remember what I have written in my... Well, some bits.

G Q Was what was written in your statement correct?
A It is what I have said.

Q Yes. When you made our statements to the police, were you recording what you remembered at the time?

H

A I think some of it was from memory, and some of it was from reading a statement that I had from the Independent Inquiry – I think.

Q Were you trying to be accurate when you made your statements?
A I was trying to be accurate, yes.

Q Would it help your recollection for me to remind you of what you said in the
B statements?
A Yes.

Q What you said was that this was the first time that you had met Code A 's Code A – in the evening of 19 November. You believed she had been in London as Code A was seriously ill. Code A was very poorly. Her condition had deteriorated and she had been placed on a syringe driver. You said that you were in charge of
C the ward that day. Do you remember that?
A Yes. Vaguely, yes.

Q And you had been told that Code A had been informed and was coming, and it was normal practice for somebody who was very ill at that time, that the doctor would attend and speak to the family personally. You said that when the family arrived you called Code A and informed her, and Code A said she would come to the hospital after the
D surgery. When Code A arrived, you said you took Code A into a quiet room. I just want to ask you at this stage whether you are able to remember yourself the conversation that took place between Code A ?
A No.

Q With my learned friend's consent, I will remind you of what you said. Then you can see if you agree with it or not. You said in your statement:
E

> "I cannot remember if Code A were both present. I remained in the room while Code A spoke to Code A I cannot recall the exact words Code A used but she explained to Code A that Code A 's condition had deteriorated, the prognosis was not good but we would do everything possible to make her mother comfortable.
>
> F I then took Code A back to Code A . I cannot remember what I said to Code A Code A but my normal practice would be to say words to the effect of, 'Is everything okay and did you understand everything that the doctor said?'
>
> From memory I think Code A said she understood what she had been told and just wished to sit with Code A "

G Having been reminded of that, does that help you?
A It is what I would imagine I would say as I cannot remember. It is a long time ago.

Q In terms of the conversation that took place between Code A .
Does it help you or is it the case that you still just cannot remember?
A I cannot remember but I would imagine she would have explained that Code A had deteriorated.
H

Q If I ask you whether there was any mention of myeloma, are you able to help us?
A No. I cannot recall the conversation.

Q Similarly, are you able to help with whether there was any mention of fentanyl?
A No.

Q Or a syringe driver?
A A syringe driver, because it says here it had been commenced, it would have been discussed with her.

Q Do you remember whether the syringe driver was discussed or not?
A I do not remember, no.

Code A Very well, thank you, Code A Those are all the question I am going to ask you, so thank you very much.

Cross-examined by Code A

Q Code A I am not going to be very long. I am asking you questions, obviously, on behalf of Code A I think it would be fair to say that your recollection of patients now after all this time is not very good?
A Not very good at all. My memory of last week is not very good, never mind....

Q I am not going to ask you about last week either! What you told us was that at Dryad ward, when you were there, you said, "We weren't a rehabilitation ward. Any rehabilitation would have been very, very slow"?
A Yes.

Q You told us you did not have dedicated physiotherapists. I think there were physiotherapists in the hospital but you had very little of there time?
A That is true.

Q An hour a week?
A I could not state this specifically but probably round about.

Q But they were not on the ward every day?
A They were not on the ward every day, no

Q Dealing with patients. If a patient needed help to mobilise, it would be nurses?
A Nursing staff.

Q I understand. I think there were other aspects of Dryad ward that are relevant. There was obviously no permanent doctor?
A No.

Q There was a doctor there for a short period of time in the morning, Code A ?
A Code A came in every morning and went round all the patients, said good morning. If there was anything we had, were concerned about, then that individual patient would be seen, examined.

Q We have heard that if patients were admitted a doctor, usually Code A would come in and assess them?
A Yes.

Q And that would usually happen around lunch time?
A Yes.

Q If patients arrived shortly before then?
A After morning surgery.

Q There was a consultant always for the ward, and the consultant would do a ward round on a Monday?
A Yes.

Q I think. Would that be every Monday?
A I cannot remember if it was every week or fortnight. Fortnightly or weekly.

Q I think Code A would be there for a ward round every two weeks?
A Yes.

Q Not every week?
A I was confusing...

Q I think there was no crash team. If a patient collapsed and had a cardiac event, you could not give defibrillation ---
A No.

Q --- with electric paddles?
A No. Nothing.

Q You did not have any equipment?
A We did not have anything.

Q There were not doctors running around, as one sees on the television, to deal with a cardiac arrest?
A No.

Q But you told us that the staff got on quite well. It was a relatively happy ward?
A As far as I was aware, yes. I was happy.

Q And what would you say of the standard of nursing care that was being given to the patients who were admitted?
A I would like to think it was very high.

Q You were asked about Code A. You were asked about her relationship with the Code A You described it as a professional relationship, and they both respected each other?
A As far as I was aware, yes.

Q You said it was clear there was trust between them. Would you say there was clearly trust between all the nursing staff and Code A?
A Yes.

Q And trust between Code A and all the nurses was a two-way thing. Would that be fair?
A I would hope so, yes.

Q Would you say that Code A, from everything you saw of her, was a very dedicated doctor?
A I felt she cared about the patients. She was supportive to myself when I required it, so yes.

Q Was it obvious that she wanted what was best for the patients?
A As we all did. I would think so, yes.

Q Were there occasionally times when relations between members of staff were not the best?
A I personally cannot recall anything.

Q You were asked specifically about Code A I think you said in your statement that you did not really work with her very often?
A I did not work with her a lot, no – perhaps being opposite shift. She would work opposite the sister, so I was not always on with either of them, depending on how the shifts went.

Q And how did you get on with Code A?
A She was a colleague.

Q That is not answer – or it may not be a complete answer.
A As I say, I did not work with her very often.

Q All right. I am not going to press you on that. You told us that you were not a rehabilitation ward. Was it nonetheless the case that some patients were admitted onto the ward by consultants for the purpose of rehabilitation?
A I do believe in some of the notes it would have said "Dryad for rehabilitation".

Q Why do you think that was happening?
A I do not know.

Q Were you aware of a bed shortage locally, and that the Gosport War Memorial Hospital was receiving patients that perhaps it should not have done?
A I think at times we did receive patients that were not appropriate. We did get a lot of patients who were very poorly when they came to us.

Q Yes. And when you say sometimes you received patients that were not appropriate, what do you mean by that? What sort of patients were they?
A They were very poorly, and perhaps sometimes in my opinion should not have perhaps been transferred.

Q Sometimes patients are too ill to transfer?
A I suppose the answer is yes, and transferred. When they have been transferred, it takes them a while to recover from that as well.

Q Can that cause a downturn in your experience in the patient's condition? Just transferring them from one place to another?
A I think so, yes.

Q That was your experience. You said in your statement for the GMC – I will be corrected if I get it wrong. It is the last page of the statement you made in February 2008:

> "The problem was that some relatives were told that the patients were coming to the Gosport War Memorial Hospital for rehabilitation but that was not the reason why they were coming to the hospital."

Shall I read that again?
A No. I read that myself last night. I do not know if those are the exact words that I used. Patients' relatives were told that they were coming for rehabilitation. They were not told that we were not a rehabilitation ward.

Q Did that lead to concerns on your part?
A I think the concerns, trying to think back, would be that the patients were not suitable for rehabilitation. That is the only answer I can...

Q Yes. Because part of the problem may be that the relatives had the wrong impression of what is going to happen at the War Memorial Hospital, and therefore that their expectations might not be met. Would you agree with that?
A That could be true. I did not have any relatives come to me and say that – that I can recall.

Q Can I come to the question that you were asked about: it would sometimes be put on the medical records that the doctor "was happy for the nursing staff to confirm death"?
A Yes.

Q And you told us that that was pretty standard in nursing homes and other community hospitals?
A Not so much on the notes in nursing homes because you did not have... Excuse me.

Q You do not have doctors' records at nursing homes?
A Exactly.

Q But that was the understanding?
A Yes.

Q And I think if a patient were to die on the ward, until death has been confirmed, the patient has to remain on the ward?
A No. They would not remain on the ward. They would be transferred down to the mortuary.

Q Does that happen before a nurse has confirmed death?

A A No, no.

Q When are they transferred down the mortuary?
A After the nurses verified.

Q "Verified." I am using the wrong word. If a patient dies, the nursing staff can verify the death?
B A Yes.

Q And then the patient can be taken to the mortuary?
A Yes.

Q If that does not happen, if the nursing staff do not verify death, the patient will remain on the ward. Would that be right – until a doctor comes to confirm death?
C A Yes, yes.

Q And just take us through that. We know that there were some four-bedded units ---?
A Yes.

Q --- on Dryad, and some single rooms?
A Yes.
D

Q Would it be appropriate to leave a patient who had died in a room with other patients?
A No. If we had the room, if we knew someone was very poorly and their prognosis was poor and we had a single room, we would try to move the patient so that they had some dignity and privacy with their relatives.

Q I think dignity was at the forefront of everything you did – dignity for the patients?
E A I would like to think so.

Q Can I take you to two patients, very briefly. The first is Patient I, Code A

Code A 12f1mt
F1 Take over from Code A at 16.25 --

F Q I am afraid you will have to get the records out again. Patient I, Code A I am going to ask you to turn to page 96. This is a lady who fractured her hip. She had been in a lot of pain during the month of March and the nursing care plan on page 96, starting on 26 March, said just that, that Code A was experiencing a lot of pain?
A Yes.

G Q The nursing action, two-thirds of the way down the page, would be to prescribe analgesia and monitor its effect?
A Yes.

Q That would be standard, to monitor the effect of analgesia?
A Yes.

H Q It appears that at the bottom of the page, 27th and 28th March, that the patient was receiving regular Oramorph but was still in pain and had been vomiting with Oramorph.

Dr Barton, it would seem, advised that the Oramorph should stop and the patient should have some other form of pain relief. I do not know whether it was something you recall, but would that be typical of the way in which Code A would deal with pain relief if something was not working as it should be?
A Yes, it would be changed to something that was more suitable.

Q Can I take you to pages 91 and 94. We are moving on in time. I am going towards the bottom of page 91, do you have an entry for 10 April 1999?
A Yes.

Q That, I am going to suggest and I will be corrected if I am wrong, was a Saturday and the entry suggests that Code A had had a very poor night and "appears to be leaning to the left":

"Does not appear to be as well and experiencing difficulty in swallowing".

There is reference to a stitch line inflamed and hard and she was complaining of pain on movement and around the stitch line?
A Yes.

Q Over the page, for 11 April, a Sunday, this lady was described as:

"Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way."

We know that Code A would have been in on the Monday morning, 12 April.
A Yes.

Q What the Panel has had referred to them is the entry on page 174 which is a prescription sheet that you have already looked at. You have been through the exercise in the questions you have already been asked in seeing how this lady was changed from one type of medication, the Oramorph, over to a syringe driver. On that Monday, the 12th, Code A would have been in, I suggest?
A In the morning.

Q The entry we have for the diamorphine is that it was prescribed at a range of 20 to 200 mgs subcutaneously over 24 hours. Does it say at 8 o'clock in the morning?
A Yes 08.00.

Q And 80 mgs was given?
A Yes.

Q You were asked, if you recall, how that dose was selected and you said, effectively, you do not recall?
A I do not remember, no.

Q I think it was you and Code A who were responsible for dealing with the drugs that day. I do not know if you are able to help us with that or not?
A I do not remember.

A Q I want to read you one line or two from your police statements. For those that have it, it is page 5 of 6 of a statement that you made on 6 December 2005. You say:

"I can confirm I have made an entry on page 131 of the records."

I think you are looking at the same page, just looking at the different numbering, under the heading "diamorphine", and you give the details of the prescription. You said:

B "I have administered diamorphine 80 mgs at..."

09.00 is what is said in your statement. That may or may not be right as to the time, but can you help us with what the entry says?
A I think it may be 09.00.

C Q Under the heading "midazolam", you give the details of the prescription that we have on page 174/131, and you say:

"I have administered midazolam 20 mgs at 09.00 on 12/4/1999."

A Yes.

D Q You go on to say:

"I cannot remember whether it was Code A 's calculations or whether the dosage rate administered to Code A was worked out by Code A and I."

A Yes.

E Q

"The calculation would have been based on the previous morphine tablets that the patient had have been given on the preceding days."

A Yes.

F Q Does that remain the position, you cannot remember the patient let alone one administration of medication?
A No, I am sorry.

Q The Panel will know that the dose was reduced for that patient later in the day. I want to remind them, if they want to cross refer it and they have not already done so in their notes, it is page 27 which is the 12 April 1999. It is a note that has been identified as that of

G Code A did a ward round in the afternoons, on Mondays sometimes. Would that be right?
A I think so, yes.

Q I want to turn to Code A Go back to file K if you still have it. You were looking and had your attention drawn to page 224 in that file. There is an entry of yours at 20.00 hours, so 8 pm in the evening where you have written:

H

A Code A has visited. Seen by Code A All clear given."

Can you read the next bit?
A "Has not passed urine."

Q "All care given to Code A Has not passed urine."

B If your entry is timed at 20.00 hours, at 8 pm, are you able to help us now as to when that conversation was?
A I would assume I wrote that up prior to the end of that shift and that Code A came out after surgery.

Q Would that typically be when Code A came, after surgery at about seven in the
C evening?
A Roughly, yes.

Q You have told us, and we have heard from your statement, that this was the first time you had met Code A We have heard it read out from your statement that you believed she had been in London because Code A was seriously ill and you were in charge of the ward that day?
D A Yes.

Q You said that Code A was asked to come because the Code A was there?
A Yes.

Q Do you recall that the Code A visited regularly?
E A I believe so.

Q Let me read what is in your statement, on page 4 of 5 for those who have it, halfway down the page. You say:

"That was the one and only time I met Code A As Code A was not one of my patients I did not have a lot to do with her or her family. I was aware that
F Code A visited regularly, but had not spoken to him. All the nurses where aware that Code A was in London with Code A "

A Yes.

Q Of the conversation that you describe, we have heard the description, you cannot recall the exact words:
G

"Code A explained to Code A that Code A 's condition had deteriorated, the prognosis was not good and we would do everything possible to make Code A comfortable."

A Yes.

H Q That is what is in the statement but you do not recall it now?

A A I do not remember it, but that is what I remember reading.

Q Would you have seen Code A giving advice, explanations to relatives on other occasions?
A Yes.

Q Was that something she did regularly?
B A Yes.

Q Would she certainly explain the condition of the patient, their treatment, the prognosis?
A Yes.

Q How did she do it, did you have a view as to how well she was able to give that
C information?
A Code A was always very straight with the relatives and she basically did not beat about the bush. She told them what we were doing, how the patient was and what any plans were for their future care. If they were very poorly, she told the relative the patient was poorly and that we would do our best to keep them comfortable and keep them informed of what was going on.

D Q The Panel has heard from Code A, that she, Code A, did not like the way that was said. I want to ask, you do not recall that conversation, but from your observations of Code A having that type of conversation with relatives, how did you feel she gave the news and explanations?
A As I said already, she was very straight, she was not rude, but she did not like be all too, perhaps not too sensitive, but that is, you know, the way, her manner. She did always explain things and clearly as far as I can recall and straight.
E

Q She made sure that they had the information they needed to know?
A Yes.

Q She was not holding anything back?
A No.

F Code A Thank you.

Code A Thank you Code A

Code A I do not have any further questions, thank you.

Quite right. It has been a long week, not just a long day. I should have
G turned to Code A to give him an opportunity to ask any questions in re-examination. I failed to do so for which I apologise, but, fortunately, he did not have any. We have now reached the point at which members of the Panel would have an opportunity to ask questions of you. I am just going to look around now to see what their views are. (Short pause) It seems that at this stage there is a question from our medical member, Code A who is seated to my right.

H

Questioned by THE PANEL

Code A Hello, Code A Can I go back to the discussion about the statement that was written on admission in some patients' notes, "I am happy for the nurses to verify death".
A Yes.

Q You said that that would be made because there was not a doctor there every day, every night. I am just thinking, Code A was there every day, Monday to Friday. She came at 7.30-ish, is that correct?
A (The witness nodded.)

Q If a patient came from another hospital for rehabilitation, albeit you were not a rehabilitation ward, or if you knew that they were able to look after themselves with a reasonable Barthel score, for instance, and it was a weekday – an early weekday, Monday, Tuesday – why would it be written on the first day of admission?
A I do not know. I cannot answer that.

Q It would not have any implications?
A I am not really sure how to answer that.

Q Just to clarify, did you say that it would be written if the patient was expected to deteriorate? – because there was some – I think Code A went back and asked you what you meant.
A I think possibly – I cannot remember if it was always written when someone came in, regardless of their condition or if they were expected to deteriorate.

Code A Thank you very much. That is all.

Code A That is it for questions from the Panel. I am now going to turn to Code A to ask if there are any questions arising out of those questions from Code A

Further cross-examined by Code A

Q Just one. Would it alter your nursing care at all?
A No.

Code A

Code A No.

(To the witness) I am pleased to be able to tell you that that completes your testimony. Thank you very much indeed for coming to assist us today. It really is of enormous help for Panels such as this, looking back on events that occurred so long ago, to have live testimony from witnesses such as yourself, and we are most grateful to you for taking the time to come to help us, and also for being so patient during the course of today. Thank you so much; you are free to go.
A Thank you.

(The witness withdrew)

Code A Sir, can I just take you back to the schedule of witnesses, just to indicate that you will have seen that there are a number of witnesses who we were expecting to read today, and will possibly read tomorrow; but the next witness that we have coming to give evidence is Code A We are obviously going to start with live evidence and see how we do tomorrow. If we finish her in good time then we may use the spare time to read statements. But there is no particular importance in reading those statements in order, so, frankly, we can fit them in when it suits.

Code A That seems very sensible, Code A.

Code A I presume that that is all that you want us to do today, unless you want us to start reading statements?

Code A Do not tempt me, Code A Yes, I think that is enough for today. As I said earlier, it has been a very intense, intensive and long week for all of us, and probably going 15 minutes earlier than normal would be welcomed by all. So thank you very much indeed, and we will resume tomorrow at 9.30, please.

(The Panel adjourned to Thursday 25 June 2009 at 9.30 a.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 25 June 2009

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

Chairman:

Panel Members:

Legal Assessor:

Code A

CASE OF:

Code A

(DAY THIRTEEN)

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: Code A)

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Code A Good morning, Code A

Code A May I call Code A

Code A sworn

(Following introductions by the Chairman)

Code A We do understand that answering questions can be a very gruelling experience for witnesses. I will say now that throughout your evidence, if at any time you feel the need for a break, you merely need to say so and I will stop the proceedings and give you that break. If I do not hear anything from you, I will attempt to break about once every hour, so that you and, indeed the advocates and the Panel, can take a break. We do not like to have a witness having to answer questions for more than an hour at a go, but you do not have to go on even that long if you are finding it is becoming difficult. Is that all clear?

A Thank you very much.

Code A I will pass you to Code A

Examined by Code A

Q Is it Code A?

A Yes, it is.

Q Is it Code A

A Yes, it is.

Q I want to start by asking about your professional background. I think in due course you came to work as a nurse at the Gosport War Memorial Hospital. Is that right?

A Yes, it is.

Q I want to ask about your training before that and your experiences before that. When did you qualify as a nurse.

Code A

Q Prior to your getting to the Gosport War Memorial Hospital, which you did in January 1998, what had been your previous experience of working for the elderly?

A A Before I got there, I think every field the nurse works in these days, unless you are actually on a children's ward, you have a mixture of elderly people. We had – I would say about 50 per cent of the ward I worked in, in Southampton was elderly. That was in acute medicine. Before I left there I actually completed the Care of the Elderly Course, the EMB 998, sorry, the 941 – I am sorry, it is the EMB 941 – with a view to going into elderly care. From there I went to Code A which was the rehabilitation unit for elderly people.

B Q Where was that based?

A Code A

Q What experience, if any, had you had of palliative care?

A Not specifically, up until that time, none, not specifically. I had had people who were terminally ill on acute wards but not in a specific unit.

C Q Obviously working with the elderly, you would have come across patients who were being treated in a palliative manner?

A Yes.

Q What I understand you are saying is that you had not worked specifically on a palliative care ward or in a hospice or anything like that?

D A That is correct.

Q In January 1998 you go to the Gosport War Memorial Hospital. What was your grade as a nurse at that stage?

A I was employed as an Code A which was the Code A the deputy ward manager.

E Q By that time you would have been in nursing for over 25 years?

A Yes.

Q The ward that you went on to, I think, was Dryad Ward?

A Yes, it was.

F Q We have heard that the Ward Sister on that ward at that time would have been Code A Code A?

A Yes, it was.

Q Or should we call her Code A?

A Yes.

G Q If you were a deputy ward manager or a senior staff nurse, would that put you one below Code A?

A Yes, it did.

Q Was there anybody else on Dryad Ward on the same level as you?

A No.

H Q Does that mean that there were occasions, if Code A was not available, when you would deputise for her?

A A Yes.

Q Did you have specific shifts that you would perform or did you have a rota. How did it work?
A The off duty was done by various people. It changed hands several times while I was there as to who would complete the off duty. It was not a specific rota. We had specific shifts, but people would work different days depending on if they had made special requests
B or people were on annual leave.

Q We know obviously that there were night shifts at Dryad Ward and there were day shifts.
A Yes.

Q Did you ---
C A I was on the day shift.

Q That would mean what, from when to when?
A I believe it was 7.30 until, I think it was, 4.15 and from 12 until 8.15, 8.30.

Q Do those times include the handover time when there would be a handover to the nursing shift?
D A Yes, they did.

Q I want to ask you, first, about your impression of Dryad Ward when you arrived there. You had been in numerous hospitals before you got to the Gosport War Memorial Hospital. What were your first impressions of Dryad Ward and how it was run?
A When I very first got there I was impressed with it. It was very clean. Although everyone was very elderly, there were no odours to the ward. Everybody appeared to be well
E looked after.

Q Did that mean that patients were therefore being looked after in terms of their hygiene and their bodily care?
A Yes.

Q We have heard quite a lot about Code A in this case, as you will appreciate, but,
F again, when you first arrived, how did you regard her as a manager of that ward?
A When I first arrived, as a good manager. I did not have any concerns.

Q Her nursing?
A No concerns when I arrived on the ward.

Q You met, presumably, Code A?
G A Yes, I did.

Q Obviously we have heard quite a bit about her role on this ward and on another ward, Daedalus Ward. Did you ever work on Daedalus Ward?
A No, I did not.

Q You can tell us a little about Code A's role on Dryad Ward. How often would you
H see her?

A A If I was on the morning shift, we would see her daily, Monday to Friday. She would come in approximately about 7.15 to 7.20.

Q What would she do?
A It would depend on who was on duty. If Code A was on duty, she would come in early and she would get a quick handover from the night staff and do a doctor's round with Code A

B

Q Code A would?
A Yes. If I came in I did not come in until half past seven and Code A would be waiting to do a ward round, which sometimes she was in a hurry and wanted to get on, but I would have to wait until I had handover from the night staff because I did not know if there were any changes, so I could not do a ward round until I had done that. She would go into all the patients, Monday to Friday, and see them all.

C

Q At the time when you worked there, 1998/1999, approximately how many patients did you have on Dryad Ward, what was the average?
A Average about 16/17.

Q There were a few more beds, I think, than that, so that means you were not at full capacity?
D A No, we were not, we had empty beds.

Q When you arrived, did you have an impression of how Code A worked with Code A Code A?
A Yes, very closely.

Q Was there an appearance of trust between them?
E A Yes.

Q I want to ask about your knowledge of the use of morphine with the elderly prior to your getting to the GWMH. You told us that you had worked with the elderly, you told us you had worked with some patients who were on palliative care?
A Yes.

F Q Does it follow from that, that you would have had some experience of the use of morphine?
A Yes, I had.

Q Whether as Oramorph or diamorphine – morphine in its very various guises.
A Yes.

G Q Had you, yourself, administered morphine to patients who were in need of it?
A Yes, I had.

Q Did there come a time when you, yourself, had any concern about the use of morphine on Dryad Ward?
A Yes, I did.

H Q Tell us what those concerns were?

A I was concerned that often I would go home on an early shift at about 4 o'clock and we would not have any patients on a syringe driver. I could come back on a late the next day and somebody who would be on a syringe driver and it could be somebody that I had not expected to be because the previous day they would have been eating and drinking et cetera. On a couple of occasions I asked my ward manager why that patient was on a syringe driver.

Q That would be?
B A Code A and more than often I would just get "because" and she would walk away from me and I never had an explanation. It became such an issue that I actually went home and, not discussing the individual patients, but I used to discuss it with my parents who lived in the next road to myself and tell them my concerns.

Q It was a concern to you sufficient that you would go home and worry about it?
A Yes. My mother actually wrote it in her diary.
C
Q I am going to stop you, because what your mother did – you have to stick to what you saw and what you did?
A That is fine.

Q You said that when you raised this with Code A "more often than not", were the words you used, she would simply say "because". Did you try and pursue that any further
D with her on those occasions?
A No, because I felt I was really dismissed and it was just "because" and she would actually walk away from me.

Q To put this into context, I think there came a point much later on when there was effectively a grievance procedure. Is that right?
A Yes.
E
Q You complained of harassment?
A Yes, I did.

Q Who were you complaining about?
A Code A

F Q When did that arise, just so we understand the chronologies?
A I believe it was in 1999.

Q We will come to that in due course and how that arose. You told us there were occasions when a patient who had been eating and drinking one day would be found on a syringe driver the next.
A Yes.
G
Q When you found a patient on a syringe driver, and I appreciate that this may be a generalisation, did you find that they were generally able to eat and drink once they were on a syringe driver?
A Not usually. Usually they became progressively worse and they became more sleepy and more sedated.

H

Q While you were working on Dryad Ward, did you ever see anybody who had been put on a syringe driver come off the syringe driver and leave the ward?
A No.

Q Did you ever see anybody who was put on a syringe driver and lived through as it were?
A No.

Q Did you have, prior to coming to the Gosport War Memorial Hospital, any moral objection to the use of syringe drivers or morphine?
A None at all.

Q Had you used them yourself?
A Yes, I had.

Q Tell us, please, about how they came to be initiated on Dryad ward with any particular patient. I am not asking you at the moment to focus on one patient, but your understanding about the authorisation for their use. How did a syringe driver begin, as it were, with a patient?
A Every patient that was admitted to Dryad had a syringe driver, had morphine and midazolam written up for them on admission on the PRN side of the drug, which is "to give as necessary". If it was thought that a patient needed that analgesia, then the prescription was there for the nurses to initiate the use of.

Q Who wrote up those prescriptions on admission?
A **Code A**

Q Is that a practice that you had ever come across before?
A No.

Q Or since?
A No.

Q Once the prescription was written up who could make the decision to initiate a syringe driver?
A **Code A** or any of the nursing staff that were on duty.

Q Could you keep your voice up?
A **Code A** herself or any of the nursing staff that were on duty.

Q Or any of the nursing staff who were on duty?
A Yes.

Q Did you ever initiate the use of a syringe driver with a patient without consulting **Code A**?
A I think I possibly may have done. I cannot state any particular patient.

Q What about the dosages that were put into the syringe driver. Who would decide on the dose to initiate the patient, as it were, onto the syringe driver?

A A It could feasibly have been left to the nurses. I obviously cannot speak for other people, but I do not believe that I have ever set one up without having initiation from Code A as to how much I could start it with.

Q Certainly, you say, when you did it you would discuss the dose with Code A ?
A Yes, because I just did not feel it was a decision I would want to make on my own really.

B

Q You have told us of Code A 's reaction to you when you raised these issues with her. How did your relationship with Code A continue?
A Very badly. Deteriorated.

Q And in what sense did it deteriorate?
A I think when I first started, Code A .. I am sorry. I do not know how far you
C want me to go back. Do you want me to ---

Q Tell us about your relationship with Code A ?
A Code A did not want an Code A on Dryad ward. She had made it very clear to the hospital manager that she did not want an Code A on Dryad ward.

Q That was your grade?
D A Yes. Code A

Q Right?
A She had been persuaded by Code A who was the Code A at that time, to actually appoint someone to the role. I did not feel it was personal to me. I think it just probably ---

E Q The grade?
A --- would have been anybody who would have been appointed to the role. She had quite a firm hand on the ward and unless she was actually absent, I felt really that I was actually without a role because the sister ran the ward, and all the Code A staff nurses would have their allocated patients, and I was left in a limbo area really. But the situation declined, because Code A had quite extensive leave and I acted up into the manager's role.

F Q That is what I was going to ask about, so let us just pause for a moment. I think there came a time when Code A had some time off?
A Yes, she did.

Q Would that be because she was ill?
A Yes, she was.

G Q Can you remember how long she was off for approximately?
A I believe there was a period of four months at one time when she was off.

Q When was that? In which year?
A I think it must have been 1999.

Q So you had started in January 1998?
H A Yes.

Q You had worked all the way through 1998?
A Yes.

Q During that period had you relationship with Code A already been deteriorating?
A Yes.

Q Then we get to 1999 and at some point in 1999 Code A has four months off, or approximately four months off. Can you remember when in 1999?
A No, I really cannot.

Q During that period when she was off, what happened on the ward? Who took over her role?
A I did.

Q How did you work with Code A during that period when Code A was not there?
A I can only say it was all right, because Code A and Code A I felt had a very good working relationship and I did not feel I quite had that working relationship with Code A that she did.

Q And to be fair, Code A had been working there for a very long time?
A Yes, she had.

Q Before your arrival?
A Yes, she had. A long time.

Q Were there on occasions during that period discussions between you and Code A about whether any particular patient should go onto a syringe driver?
A I honestly cannot remember.

Q Was there a period when you had to transfer to another hospital for a while?
A Yes. I had been quite unhappy on Dryad ward for a long time and mentioned on several occasions that I might like to move back up to the acute hospital at Queen Alexandra. I was offered to go up there for a month to help out of their winter crisis.

Q Their winter crisis?
A Yes.

Q Is that an annual event?
A Yes, it is. It is when people go down with the flu and wards are short-staffed and big pressure on beds. So I had gone up there for a month to help on one of their acute wards.

Q Was that with a mind possibly eventually to transferring to –
A Yes. I was quite undecided.

Q Tell us about your return to the Dryad ward. Did you have any conversations with anybody?

A Yes, I did. It would be with Code A and with Code A about the possibility of moving, the prospects of moving.

Q Right. Specifically did you speak to Code A? I want to ask you about your conversation with Code A
A I did speak to her about the possible move. I cannot remember any of the conversations. All I know is I had spoken to her about it.

B

Q Was there some suggestion of having upset somebody?
A Yes, there was. Code A said to me that I had upset Code A and she said to me, "But I don't want you to talk to her about it." I cannot leave things like that; I cannot work like that. So I spoke to Code A in our treatment room one day when we were on our own, and I said, "I believe I have upset you, and if I have I am sorry." And she said, "Oh no, it is not that, but you do not understand what we do here." That was really the
C end of the conversation.

Q Were you two alone?
A Yes.

Q This was in 1999?
A Yes.

D

Q And this was upon your return after the month off at the Queen Alexandra?
A Yes.

Q When you asked if you had upset her, she said, "It is not that. You do not understand what we do here."
A That is right.

E

Q What did you understand by that?
A I assumed at the time that it was regarding the syringe drivers. The use of the syringe drivers.

Q Did you take her up on it and say, "Hold on. What are you actually saying?"
A No, not at that time I did not.

F

Q And when you came away from that conversation how did you feel about it?
A The same as I always did: very unsatisfied – dissatisfied – that I did not have an answer.

Q You had worked previously with patients on palliative care. Have you worked since with patients on palliative care?
G A Yes. I have actually worked in specialised palliative units since then.

Q You told us a bit about your concerns about the use of syringe drivers?
A Yes.

Q What about the quantities of morphine that was being put into them. Did you have any views either way about the quantities of morphine that were being used on Dryad ward?
H A I think the quantities were too large to actually start off with.

Q So they were starting off, you thought, on too high a dose?
A Too high of a dose.

Q Did you challenge any of the doses at the time you were there?
A Yes, I did.

Q Who did you speak to?
A I spoke to my Code A when I was in the acting up role as a Code A

Q I am going to stop you about the conversation.
A Sorry.

Q It is difficult to hear you. You are dropping your voice.
A Sorry.

Q It is all right. It is very tempting for you and me to have a conversation, as it were.
A Sorry.

Q It is very important that everybody else hears it.
A Sorry.

Q Okay. You said that you spoke to your Code A ?
A When I was in the acting up role as the Code A I used to have clinical supervision with Code A Supervision is a meeting between yourself and another person that you are confident in, and they help. You discuss issues of nursing and things. That is when I brought it up.

Q We do not want to know what she said back to you, as it were.
A No. That is fine.

Q But did anything change as a result of that conversation?
A No.

Q You have told us that the amount of morphine used as the initial dose was, in your view, on occasions too high. What about the increases in dosage?
A I thought they were too high as well. I thought they were increased too quickly and by too large an amount.

Q We have heard in this case about the Wessex protocol, and some nurses have heard of it and some nurses have not. Did you know about the Wessex protocol?
A Not as such. Is that like the analgesic ladder?

Q That is the next question I was going to ask you. What most nurses have heard of is the analgesic ladder. You are nodding. Is that a "Yes"? You have heard of it?
A Yes. I know the analgesic ladder.

Q The concept of the analgesic ladder I think we all know fairly well now, which is that you start at the lowest dose ---

A A Yes.

Q --- capable of dealing with the pain that the patient is suffering?
A Yes.

Q Is that a concept that you understood?
A Yes.

B

Q Did you have an understanding of how the doses were meant to be increased? If a patient was still suffering from pain, did you have an understanding about the incremental dosage increase?
A Yes. When a patient was on a syringe driver, if what they were on was not controlling their pain we would have – we called it – a top-up dose. It was a dose to be given as necessary in between to help their pain. Then the next day, when it was reviewed, it would C be looked at how much top-up they had needed, then the dose adjusted accordingly.

Q Is this your experience on Dryad ward, or is this your experience elsewhere?
A Elsewhere.

Q If there had to be an increase in the morphine on a syringe driver, did you know what the maximum was, the guideline was, for the maximum increase?
D A No.

Q How did you find that it actually worked on Dryad ward when a patient did apparently have an increase in morphine?
A I am sorry? When you say "how did it work", do you mean how do we decide how much?

E Q On Dryad ward, when a patient's morphine was increased ---
A Yes?

Q How was it done? I do not mean physically how is it done, but how much was the increase by, in general terms?
A There was not a set guideline as to how much it should go up by.

F Q Was there a method of deciding how much it should go up by? You just explained in other places where you have worked you would use a top-up dose, as it were ---
A That is right.

Q --- for what is called break-through pain?
A No, there was not.

G Q There was no system?
A No.

Q You have told us about **Code A** writing up prescriptions in advance?
A Yes.

Q And we have seen, and you know, that she would write up a range of, say,
H diamorphine or midazolam?

A A Yes.

Q Did you know why that was being done? Was that ever explained to you?
A Yes. Some of Code A 's colleagues were very reluctant to actually prescribe syringe drivers and it was done so that if the patient needed something and she was not actually on duty or was not there that we had cover, so that the patients could have pain relief without having to go through trying to get somebody in, to actually prescribe one.

B

Q Was that your experience that it was difficult to get somebody else in to write up such a prescription, or was that as it was when you arrived?
A That is how it was when I arrived. Because they written up, I never had to call anybody in to write one.

Q If Code A was not available, what would happen?
C A Sorry? In what regard?

Q You told us that the prescriptions were written up in advance?
A That is correct.

Q That your understanding was it had been difficult to get other doctors to initiate syringe drivers in the same way?
D A Yes.

Q So if Code A was not there, what was your experience of how nurses would deal with increase? What would they do?
A To say it was hit and miss is all I can say. It was up to us to actually just look at it and see how much pain we thought the patient was in and to increase it accordingly to what we thought.

E

Q You have just mentioned assessing pain?
A Yes.

Q I expect all members of the Panel have heard, and no doubt you have, of pain charts?
A Yes.

F Q It is a tool that is just an assessment system?
A Yes.

Q Did you have any such assessment system on Dryad ward?
A Not that I recall.

Q And apart from being used to control pain, was diamorphine ever used for any other
G purpose that you can remember when you were on Dryad?
A No.

Q So your recollection is, it would only be used if the nurse thought the patient was in pain?
A Yes.

H Q I want to turn to the issue of hydration.

A A Right.

Q Again, we have heard quite a bit about it. Were there hydration kits available?
A No.

Q Can you just describe what a hydration kit would be? What is a hydration kit?
A Giving somebody fluids, usually subcutaneously, just under the skin via a needle, to
B keep them hydrated.

Q We have heard of the difference between subcutaneous and intravenous?
A Yes.

Q Can we focus on the latter first, the intravenous. Have you ever put a patient on an intravenous drip, or is that something that has to be done by a doctor?
C A No. The doctor does it at the moment.

Q But have you dealt with patients who have been on intravenous drips?
A Yes, I have.

Q Have you dealt with patients who have been on intravenous drips and syringe drivers?
A Yes.
D

Q So the syringe driver is being used to control their pain.
A Yes.

Q And the intravenous drip is being used to hydrate them.
A Yes.

E Q We have heard a little bit about this, but I am going to ask you. The difference between an intravenous drip and a subcutaneous drip – I understand one goes under the skin and one presumably goes into a vein, does it?
A Yes.

Q But in terms of how the subcutaneous drip works and how much you can get into a patient, what is the difference?
F A It is not always effective putting it in subcutaneously. If the patient is not very well or they are not absorbing fluid, sometimes the fluid in a subcutaneous can actually collect under the skin. It depends what the condition of the patient is.

Q To your recollection on Dryad ward, did you use any subcutaneous hydration?
A No.

G Q To your recollection when you were on Dryad ward, did patients continue to eat and drink after they had been put on a syringe driver in general terms?
A No.

Q So if a patient was on a syringe driver, what would happen about their hydration on Dryad ward?
A They were not given any.
H

Q What effect in general terms would that have upon the patient?
A Do you want factually or what my understanding is?

Q Factually would be best.
A It is different, because I actually did some research on it for a project. Actually, it was recommended that hydration can actually make a patient more uncomfortable, because fluid can collect in their lungs and everything and if they are dehydrated they are actually more settled and more comfortable.

Q So this is for the patient who is on a syringe driver, but presumably unconscious.
A Yes.

Q I am sorry. I led you on that. Let me just correct that. Are there occasions when a person is on a syringe driver but not unconscious generally? Have you found that in other hospitals?
A Yes.

Q If they are on a syringe driver but conscious, would they on occasions still be able to eat and drink?
A Yes.

Q Because the syringe driver is simply there to control their pain.
A Yes.

Q If a patient is unconscious, it hardly needs you to say it, but can they eat and drink?
A No.

Q So the only system of hydrating them would be either subcutaneous or intravenous.
A Yes.

Q Once a patient is on a syringe driver and not being hydrated, would the patient deteriorate?
A Yes.

Q On another issue – and I do not need for the moment need to take you to an example, because we all know them very well and I think you will recognise the phrase as well without having to see it in the note – do you remember seeing the phrase, "Happy for nursing staff to confirm death"?
A Yes.

Q Was that something that was written into the notes of some patients by Code A ?
A Yes.

Q Did you have an understanding of why that was put into the notes?
A Yes. Because we were GP led and we obviously did not have doctors present in the hospital who would know the patient, it was so that we could actually verify the patient's death and the patient could then go to the hospital mortuary and then the doctor who had seen the patient last and who knew their condition could then come in at a later date and actually certify the death.

Q Is it a phrase or something similar which you have seen elsewhere other than on Dryad ward?
A Yes.

Q The same or not quite those words?
A No. Exactly the same.

Q Could you tell us – we may look at some examples in due course – what the frequency was of Code A writing that into the patient's notes on their arrival at Dryad ward? Was it any more or any less than elsewhere?
A I really do not remember ever seeing it with a patient arrived on Dryad. I know it was when they were on a syringe driver.

Q We may look at that in due course. I am going to turn to deal with some of the patients who I think you dealt with, but before I do, can you just tell us what the back end of all of this was? How did you come to leave the Gosport War Memorial Hospital and in what circumstances?
A Well, I had put a grievance in about Code A and I Code A.

Q The nature of your grievance was what?
A I felt at the time that they would be more than happy for me to actually go, but there was also – do you want to know what was in the grievance or – because there is something quite relevant, but I do not know whether you want to hear it or not.

Q I think I am going to let Code A explore this if he wants to. There was a grievance procedure. It went through an internal Trust procedure, did it?
A Yes, it did.

Q And you left the hospital?
A Yes. The outcome was that there was going to be some liaison between Code A and myself and I felt that no matter how much liaison there was, it was an unworkable situation and so I applied elsewhere.

Q Is it fair to say that this was not entirely about the use of syringe drivers and diamorphine, that there were other issues as well?
A There were other issues as well, yes.

Code A Please do not lead, is my request to my learned friend. It was not about syringe drivers at all. Perhaps the question could be rephrased.

Code A I do not have details of the grievance.

Code A If you would ask the witness perhaps.

Code A I will. If Code A wants it explored, I am happy to do so. (To the witness) Tell us what the grievance was.
A It was mainly the personality between myself and Code A and Code A I do not feel that we worked well together. Syringe drivers were a small part of it. They were not the main part, but they were a small part of it.

A Q When you talk about not working well with Code A and Code A what was the background to that?
A It was about the medication, because we had quite a bit of disagreement over it.

Q I am going to move on to deal with some of the patients that you actually dealt with. The first one I am going to ask you about is a lady called Code A This is our file F. If you would look to your left, you will see a file which has a big F on it. I am not going to B spend very long on this patient, because certainly I think in your statement you indicate that you had no recollection of her. Is that right?
A Yes. I do not remember the lady.

Q At the beginning of that file, if you open it, you will see that there is a chronology. I am not going to run through the whole chronology, but effectively she came to your hospital because back in the beginning of August, 5 August, she had a fall and she fractured her left C femur at the neck. She had been admitted to the Royal Hospital Haslar on 5 August and then she eventually came to you on 18 August. When a patient came over to your ward, can you give any assistance as to what sort of documentation they would arrive with?
A They should have come with their hospital notes.

Q Were there occasions when they did not?
A Yes.
D

Q Can you give us any idea of the frequency of that happening?
A No, I am sorry, I cannot.

Q Could you turn to page 394? We can see that there is an entry about halfway down the page. You were not this lady's designated nurse, I do not think. If we go back to page 391, we can see that Code A was the nurse. Have you made any entries on this page?
E A Yes, I have.

Q There is just one that I want to ask you about in particular and that is the entry on 19 August. Is that yours?
A Yes, it is.

Q Can you just read it through for us, please?
F A It says:

> "11.50 [complained of] chest pain. Not radiating down the arm – no worse on exertion. Pulse 96. Grey around the mouth. Oramorph 10 mg/5ml given. Doctor notified."

G And I have signed it. Then I have gone on to say:

> "Pain only relieved for a short period – very anxious. Diamorphine 20 mg, midazolam 20 mg commenced in a syringe driver."

And I have signed it again.

H Q You made that note. Who directed the commencement of that syringe driver? Are you able to tell, or not?

A No, I am not. I said that I have notified the doctor, so I assume I would have discussed it, but that is only an assumption.

Q If you could keep a finger there, please, but also go back to page 368e, is that a prescription for diamorphine written by Code A ?
A Yes, it is.

B Q It is for a variable dose of between 20 and 200 mg of diamorphine.
A That is right.

Q Could you turn also to page 368b? We can see there a prescription for Oramorph, 10 mg in 5 mls.
A Yes.

C Q That has been administered on 18 August at 1415. So that is on the day of this lady's arrival at your hospital I think.
A Yes.

Q Then twice the following day: in the very early hours of the morning, quarter past midnight, and at 11.50.
A Yes.

D Q Neither of those I think are your administration.
A No, they are not.

Q On 19 August, this patient had 20 mg of Oramorph and it follows that that would have been ingested orally.
A Yes.

E Q Did you know anything about the conversion rates between oral morphine and subcutaneous morphine in the form of diamorphine?
A Yes.

Q What was your understanding of what the conversion should be?
A That the whole dosage would be added up and then divided by three, and that would
F arrive at the amount of diamorphine that should be given.

Q That would be the equivalent dose.
A Yes.

Q Going back to page 368e, we can see that in fact this patient was started on 20 mg.
A Yes.

G Q On the basis of what you have just said, does that follow the guideline indicated?
A I think it could well do on this one, because 20 divided by three would be six point something and obviously if this lady was still having pain, it would have had to have been increased a bit, but also the minimum prescription we had was 20.

Q I understand that. I am not disputing that. The minimum prescription is in fact
H 20 mg.

A A Yes.

Q So that is, on this prescription, the lowest that you could start, or could you go lower than the prescription?
A No, because that would be myself prescribing and I am not authorised to prescribe.

Q I wholly understand that the lowest dose that you are allowed within this prescription
B to start at is 20 mg.
A Yes.

Q But if you were applying the guideline that you have just told us about, would you have started on 20 mg?
A On this one, possibly, yes.

C Q Tell us why.
A Because the lady had had 20 mg of Oramorph and obviously it was not enough; she was still in pain. So therefore an increase was indicated. So I would not have been unhappy giving it. Well, I was not unhappy, I started it.

Q You told us earlier that you – I do not think you were able to furnish us with the specifics of how an increased dose was meant to work; what the increment was meant to be.
D A But I had not increased that, because this was what the prescription was on here.

Q I understand. You are doing what the prescription tells you to do.
A Yes.

Q Your note, going back to page 394, was that the patient was complaining of chest pain, which was not radiating down the arm and was no worse on exertion.
E A Yes.

Q What is the significance of those words, please?
A Because if somebody was complaining of chest pain, I would want to try and assess whether I thought they had some cardiac involvement.

Q Does this appear at least to be a cardiac problem or not?
F A No. Having said that, it is not always – elderly patients can have silent heart attacks, where there are no indications at all. So this was only doing a preliminary, trying to assess what I thought was wrong.

Q On the face of the note, is that ---
A It did not look as if this indicated that she had any cardiac involvement.

G Q You have noted – this is at 11.50 – that Oramorph was given because of the patient's pain.
A Yes.

Q How quickly would you expect Oramorph to work?
A Half an hour or 40 minutes.

H

Q We know that the syringe driver was commenced at 1600 hours: four o'clock in the afternoon.
A Yes.

Q Can we take it from what you have said that this was not an occasion when you challenged the use of a syringe driver?
A No, obviously not.

Q Can you help us as to whether this would have been an occasion when you spoke to Code A first?
A That is what is indicated by the notes. It says the doctor was notified.

Q I just want to follow that up, because "doctor notified" follows from the Oramorph note.
A Yes.

Q Then after that, you have written:

"Pain only relieved for a short period – very anxious. Diamorphine 20 mg, midazolam 20 mg commenced in a syringe driver."

A Yes.

Q In terms of the starting of the syringe driver, can you help us as to whether you would have had a conversation with Code A first?
A I would assume from that, yes, I had. But that is only an assumption, because I have not written it.

Q The next note I do not think is yours?
A No.

Q We can see the note has been made:

"Condition appears to have deteriorated overnight."

Are you able to tell from your note whether the patient was conscious, first at 11.50 and, secondly, once the syringe driver had been commenced?
A The patient was obviously conscious when I wrote "very anxious".

Q Thereafter? Once that level of diamorphine kicks in, as it were, would you expect the patient to remain conscious or not?
A Not initially. Initially the patient would be very sleepy if it had just been diamorphine, but as patients get used to it, they do get used to it and they stay awake, but it would have been, I think, the midazolam that had made the patient sleep.

Q If we go back to the prescription sheet, page 368E, have you signed off on any of these drugs at the top, the diamorphine? It is quite difficult to read these.
A No, I have not.

Q You have not?

A A No.

Q Do you see that on the 20th the prescription continues so far as the diamorphine is concerned?
A Yes.

Q You may need to get the original of this if there is any issue about it, but the
B midazolam, if you look two entries below, on the 20th increases to 40. It is quite difficult to see it, but can you see, I think it is three boxes up from the very bottom?
A I cannot really make it out to be honest because there is a line through it.

Q It has been crossed through unfortunately and destroyed?
A I think that is Code A 's initials over the top of it.

C Q So far as the word "destroyed" is concerned, when a syringe driver came to the end of its life or in terms of the drugs being finished or a prescription was changed, and I suppose decreased or increased, you would have to get rid of the old syringe driver contents and start afresh?
A Yes. We would write in the back of the controlled drugs book that it was destroyed and two people would sign it.

D Q That is what happened apparently on 20 August. On the 21st we can see that the diamorphine is increased three-fold. Did you have anything to do with that increase?
A No, I have not signed anywhere, I have not signed that and there is nothing in the notes to say that I have increased that.

Q As we can see below, the midazolam is also increased to 80. We can take it from your previous answer that you had nothing to do with that.
E A No.

Q Before we move on from this patient, and it may be we give you a break once we have, could I ask you to go back to page 78 but also have a finger in page 373. Page 373, perhaps we could start with that first, is 18 August 1998?
A Yes.

F Q That is the day of this patient's admission to your ward?
A Yes.

Code A We have become well used to reading these Barthel ADL indexes and if we have a look at this, her feeding ability is 2, transfer is 1, which means she needs major help, but her mobility is that she can walk with the help of one person and she needs a bit of help with dressing and toilet. She is independent on her grooming, so her total score there is 9.
G

Code A I am sorry, I hesitate to interrupt, but it sounds as if my learned friend is going to be asking this witness about the notes with which she had nothing to do, did not see at the time and played no part in.

Code A I have to say that that is not uncommon in the way that this case has been progressing, with questions from both sides of the room. We have had notes put to
H people who had no particular part in them and they were being put to them, I have

understood, on the basis that they were, nevertheless, familiar with the customs and procedures of that particular ward at that particular time and they were being asked whether they could comment on them.

Code A That is absolutely right. There has been a reason, in terms of setting context and so on, but I do object if this witness is being asked to make a comment about an entry made by somebody else, in this case **Code A** She was not involved in the admission of the patient in any way at all and my learned friend is seeking to make a point which he can make perfectly properly with other witnesses who did have dealings with this in due course. To ask this witness to give an opinion in respect of a matter where she was not present and is unable to give an opinion as to why somebody would have written something, I do object.

Code A Can I deal with that. If the Panel are against me, they are against me. I was not going to ask the witness's opinion, I was going to ask her about her experience because she has told us – and the note I was going to come to is the very last note **Code A** made, "I am happy for nursing staff to confirm death" – that that is something she has read often, not only at this hospital but many other hospitals and it is not an uncommon note to be made. It was in that context I wanted to ask her whether, in her experience, that is the sort of note she has seen with this sort of patient previously.

Code A Within that context, that would appear to be absolutely in keeping with the tenor of questions we have had from both sides of the room.

Code A In the form my learned friend has put it, with respect, I agree.

Very well, keep within that context.

Code A (To the witness) Let us move on from the lawyer's squabble. You see that note **Code A** has made at the bottom, "I am happy for nursing staff to confirm death", you have told us that is a note you have seen elsewhere in those terms?

A Yes.

Q Have you seen that sort of note in relation to this patient with a Barthel score like that?

A Yes, in a patient who had a known terminal illness, yes.

Q In a patient with a terminal illness you have seen that before?

A Yes.

Q Let us imagine for a moment that this broken neck of femur is not a terminal illness, have you seen that sort of note being made for this sort of patient?

A No.

Code A Sir, would that be a convenient moment to break.

Code A We are going to take a break now. May I remind you that you are still on oath and we are simply interjecting into your testimony. Whilst that happens, please do not discuss this case with anybody. Thank you very much. I think the Panel assistant will take you now and hopefully get you some refreshment. We will be back just before 11 am.

(The Panel adjourned for a short time).

Code A

MR KARK: Could I ask you to put away the F file and take out the G file. That is the file for Code A Again, I ought to start by asking you whether you have any independent recollection of this patient at all. Does that name, Code A mean anything to you?

A Nothing at all, no.

Q You have dealt with a vast number of patients and there is no criticism of you for that. I want to see if you can help us about this patient for whom I think you cared. Would you turn to page 861. This gentleman came over to your hospital on 21 September, so that is the day shown at the top of this piece of paper. He had been seen at the Dolphin Day Hospital.

A Yes, I do.

Q Tell us about that?

A It is a day hospital where the patients go and they are medically assessed and they can have physiotherapy.

Q Where is it?

A It is at the Gosport War Memorial.

Q It is the GWH?

A Yes, it is.

Q On the same campus?

A Yes, it is, same building.

Q I think you have made the first note. Is that right?

A Yes, I have.

Q Can you take us through it.

A I have:

"Admitted from DDH..."

which is Dolphin Day Hospital.

"...with history of Parkinson's, dementia and diabetes. Diet controlled diabetic. Catheterised on previous admission for retention of urine. Large necrotic sore on sacrum. Seen by Code A ?"

I have signed it and it carries on:

"Dropped left foot. Back pain from old spinal injury."

I have initialled that.

"14.50 Oramorph 5mg given prior to wound dressing."

A

I have initialled that.

Q I entirely appreciate that you cannot remember the individual patient, so I am not going to ask you about this. A large necrotic sore on the sacrum, would that be something that is likely to give the patient a degree of pain?
A Yes, it is.

B

Q So far as changing the dressing is concerned, we can see that Oramorph was given?
A Yes.

Q It is difficult to read, but it is "prior to the dressing being changed"?
A Yes.

C

Q It may be obvious, but can you tell us why would that be done and would the wound dressing itself cause pain to the patient?
A Yes, it would because it is the actual cleaning of the wound and dislodging the dressing is actually quite painful, and it is quite common practice to give analgesia before doing a dressing of that type.

Q If we look at the following entry, I appreciate it is not yours, but we can see there is a
D note that the patient remained agitated until 20.30 and we know that a syringe driver was commenced at 23.10?
A Yes.

Q That was not your decision?
A No.

E

Q You had no role to play in it?
A No.

Q I led you on that. Did you have any role to play in that decision?
A Not to my knowledge, no. It depends, I do not know what shift I was on but it is not – no, it says here commenced at 23.00, that is at night and I would not have been there then, no.

F

Q If a syringe driver is commenced that late in the evening, would you be able to assist us as to upon what authority that would be done, or is that something outside your knowledge?
A I really do not know.

Q You did not do nights?
A There was a night sister on who would cover our ward at night so that would be her
G decision.

Q If we go to the next page – you are also at the bottom of this page, are you not?
A Yes.

H

A Q The bottom of page 861, we are now the day after admission and the patient is already on a syringe driver. Can you tell us your note?
A I put:

> Code A has telephoned. Explained that a syringe driver containing diamorphine and midazolam was commenced yesterday evening for pain relief and to allay his anxiety following an episode when Code A tried to wipe sputum on a nurse saying he
B had HIV and was going to give it to her. He also tried to remove his catheter and empty the bag and removed his sacral dressing throwing it across the room. Finally he took off his covers and exposed himself."

And I have signed it.

C Q That is your note. Is that something that you had witnessed personally or is that something being relayed to you by the night staff?
A I would have witnessed that because if the night staff had, I would not ever write something that the night staff had related, the night staff would write their own notes.

Q If he was removing his catheter, that would be his urinary catheter?
A Yes, it would.

D Q Does that bring this incident back to mind at all?
A No, not at all. I really do not remember this gentleman.

Q At the top it says:

> Code A has telephoned. Explained that..."

E Then the note continues.

Who would be having that conversation with Code A
A I would assume that I had because I made the entry.

Q Can we go over the page to 862. We can see at the top of the page that the syringe driver is continuing and then do you make a note on 23 September?
F A Yes.

Q

> "Seen by Code A has become chesty overnight. To have hyoscine added to the driver. Code A contacted and informed of deterioration. Code A asked if this was due to the commencement of the syringe driver and informed that Code A was on a small dosage which he needed. To phone him if any
G further deterioration."

A Yes.

Q Is that a conversation you were having with Code A
A Yes, I must have done.

H

Q I have not asked you about hyoscine. We have heard a lot about hyoscine. Is that a drug that was fairly frequently used?
A If a patient came chesty, it would help dry out the secretions on their chest to make them more comfortable.

Q In your experience, once a patient was on a syringe driver, is that something the patient sometimes suffered from?
A Not necessarily. Patients can walk around with syringe drivers up, it depends what is in there.

Q You are quite right and I am using a syringe driver in a certain way. What I mean is, if a patient is flat on their back and diamorphine is going into their system, does it sometimes happen at least that they cannot get rid of their secretions?
A Yes.

Q Rather than continuously trying to suction them out?
A You cannot always suction, it depends. If it is low down you would not be able to reach it anyway and suction is quite distressing.

Q Do you have experience of patients then getting chest problems?
A Yes.

Q As a result of the secretions?
A Yes.

Q Hyoscine is a useful drug?
A Yes, it is.

Q Because it minimises or lessens the secretions?
A That is right.

Q The next note I think is that of Code A Is that right?
A Yes, it is.

Q Just, please, for your confirmation, could you go back to the drug chart at page 758?
A Yes, I have that.

Q Can you help us as to whether you administered any of these drugs?
A No, none of them.

Q Does it follow from that that when we see the increase in diamorphine which we see on the 24 September, to the right hand side of the page, two increases in fact, of 40 mg, I think, and then 60 mg, that those would not have been your decision?
A No, they are not mine.

Q Just back to the nursing notes, please, page 863: again, I am afraid this is not a particularly good copy, but I do not think your writing appears on that page, does it?
A No. None of that is mine.

A Q And the following note is the end of the notes in that, and we can see that is not you either.
A No.

Q We put that file away, please. Pick up the next, which is your file H, and that is our Code A : again I have to ask you – do you have any independent recollection of this patient whatever?
B A I do not remember this gentleman either.

Q This is a gentleman who we know had alcohol problems. I think he had had, apparently, alcohol liver disease. May I just ask you this. Were you aware of any particular issues in relation to the use of morphine with somebody who had previously been an alcoholic? Or was that not something within your learning?
A No. I know we are careful... I know in patients that are up and mobilising we are
C very careful what they have if they are an alcoholic but if a patient is a palliative patient it would not make any difference at that stage if you are going to give palliative drugs to somebody.

Q You just used the expression, "If a patient is a palliative patient"?
A Uh-hum.

D Q How is that decision made, and who makes it, that a patient is destined for palliative care rather the curative care or rehabilitation?
A It should be a joint decision. Usually it should be a joint decision. It should be after a conversation with the doctor and the patient if they are able, and the relatives and the staff.

Q Right.
A So everyone can come to an agreement.
E

Q And how did it work in Dryad ward – do you remember?
A Code A did used to speak to the patient's relatives.

Q If palliative care was ---
A I do know that she did speak to the relatives. I do not know if she spoke to all of them because obviously I cannot speak on her behalf but I am aware that she did speak to relatives.
F

Q At other places where you have worked, where a decision is made to begin treating a patient palliatively – and I am using that in a sense of not trying to cure the problem, not trying to rehabilitate. Is that the right way of looking at it or... You help us. What does palliative care mean to you?
A It means that a patient has a disease that they are not going to recover from, that will only worsen. If the patient is capable, it is their decision.
G

Q Yes. It is obvious perhaps: when you talk about a disease that "they are not going to recover from," in other words it is an end of life ---
A Yes.

Q --- issue?
A Yes.
H

Q Again, in other places where you have worked, what sort of note would you expect to be made, if any, about that sort of decision, that a patient is now for palliative care?
A When I worked in palliative care, the doctor would speak to the patient themselves if they were capable and/or the relatives and then would document the conversation that she had had and what the outcome was.

Q So there would be, you have seen in the past have you, specific notes relating to the decision?
A Yes.

Q We have heard in this case, and I just want to ask you very briefly about it, about various notes that are made on a patient's records. For instance, let me just give you an example, "Not for 555" and "Not for resuscitation". You understand those terms, do you?
A Yes.

Q We have also heard the term "For TLC"?
A Yes.

Q "For tending loving care"?
A Yes.

Q Does that have any particular relevance in terms of palliative care? Is that an expression you have seen before in that context?
A Yes, it is.

Q And if you see TLC on a patient's note, what would you understand that to mean in relation to that patient, in normal circumstances?
A That there is not to be any active treatment that would actually prolong life, but for example if a patient was for tender loving care and they actually maybe developed a chest infection that was quite distressing to them, I would still expect that to be treated. It is to relieve symptoms rather than to actually lengthen life.

Q So you would not want the patient to be suffering from distressing symptoms?
A No.

Q You would do what you can to relieve the patient of the symptoms, but you would not be curing the patient?
A That is right.

Q The words, "Please make comfortable": we have seen that on frequent occasions in these notes. What would your understanding of that be?
A I would keep the patient pain-free.

Q Would that have any significance in terms of a decision for palliative care or not?
A This is all one and the same.

Q They are one and the same?
A Yes, I think so. If a patient is for TLC, it means really they are not for active treatment.

A Q Yes?
A But doctors express what they mean in different ways, so that is how I have always accepted that, but they are not for active treatment, as I said, to prolong life, but it would be relieving any symptoms that they had.

Q So, "Please make comfortable" is the same as "TLC"?
A Yes.

B Q Finally – and this is an expression we have already dealt with but I just want to know whether it has any significance in relation to the matters that we have been discussing: "Happy for nursing staff to confirm death." Does that have any significance in relation to any decision that the patient is destined for palliative care?
A Sorry. Could you say that again?

C Q Yes.
A Sorry.

Q The note that we looked at earlier, or discussed earlier: "Happy for nursing staff to confirm death."
A Right.

D Q Which you say you have seen elsewhere?
A Yes.

Q And you must have seen on Dryad ward?
A Yes.

E Q Does that any significance in terms of the decision to treat a patient palliatively or not?
A No, I do not think so. I think the "Happy to confirm death"... It could be somebody who maybe had a heart attack and were not going to resuscitate for various reasons. But no, no.

F Q In what circumstances would you expect to see that note? Would you see it for every patient who comes onto Dryad ward or not?
A No. If a patient was expected to die.

Q I got diverted. We were dealing with Code A Could I ask you, please, just to turn up page 266A.
A Right.

G Q This gentleman had come over to you, as we can see, from Dickens Ward at QAH. He had on occasion had morphine. More frequently he had had something called codeine phosphate?
A Yes.

Q Is that a drug you are familiar with?
A Yes.

H

Q But in the days prior to him coming to your hospital, he had been on paracetamol and on occasion codeine phosphate. All right?
A Right.

Q If we look at page 266A, do we see an entry by you right at the beginning?
A Yes.

Q Again, can you just take us through this please?
A

"Received as a transfer from Dickens Ward at QAH.
History of left humerus fracture. Arm in collar & cuff. Long history of heavy drinking. LVF."

That is left ventricular failure .

"Chronic oedematous legs. [Seen by] Dr Barton. Oramorph 10mg/5ml given. Continent of urine – uses bottles."

And I have signed it.

Q And who would have given that Oramorph? I appreciate **Code A** prescribes it?
A With a (inaudible). If the prescription sheet is there it will say.

Q Would you go back to page 263. We have all inserted the better version now.
A Yes, I have signed it. I gave it.

Q Would you have known at this stage what the patient had been on previously?
A Yes, we would have had the prescription chart.

Q And he is now being put on 10 mg diamorphine, which is given to him ---
A No. Oramorph.

Q I beg your pardon. You are quite right. Oramorph. I am looking at Oramorph and I am reading diamorphine. Oramorph. 10 mg of Oramorph, which he is given twice, I think, on the day of his arrival, one by you and one by another nurse?
A Yes.

Q Can you tell us why he was put on Oramorph?
A I have no idea except for the fact that he has got left ventricular failure so it is very possible that he was in a degree of heart failure when he came in, and Oramorph can help that. But I would not know the reasoning at this time.

Q And this is a prescription of 10 mg in 5 ml. Underneath that we can see that there is a range of between 2.5 and 5 ml, so it could be 5 ml up to 10 ml.
A Sorry, I have to turn back again.

Q I am sorry. It is 263, a few pages earlier.
A Yes.

Q So who would make the decision to start of at 10 mg?
A At this time I really do not know. I may have made the decision. I may have discussed it with Code A. I really cannot say.

Q All right.
A I do not know.

Q Then we can see, if we stay on the drug chart just for a moment – we will go back to the nurses' notes – we can see on the 16th, so two days after admission, he has put on the syringe driver?
A Yes.

Q Is that your entry?
A Yes, it is.

Q At 16.10?
A Yes, it is.

Q If we keep a finger there, but go back to page 266A. ---
A Do you want me ---

Q Go on.
A Do you want me to read it?

Q Yes, please.
A

"Patient very bubbly chest this p.m. Syringe driver commenced 20 mg diamorphine and 400 mg (sic) hyoscine ---"

THE SHORTHAND WRITER: Please could you slow down.

Code A It says, "Patient very bubbly chest this p.m."
A "…. very bubbly chest this p.m."

Q This is the entry on 16 October 1998 with "pm" next to it. Yes?
A Yes.

"Syringe driver commenced 20 mg diamorphine and 400 mcg hyoscine. Explained to family reason for the driver. Wife informed of patient's continued deterioration. Has been to visit …"

And I have signed it.

Q The decision to start him on the syringe driver would be taken by whom?
A At this time I could not tell you. I really do not know. I am sorry.

Q Does it follow from that answer that the decision at what rate to start him on was ---
A Looking at it, as Code A had been in that morning, Code A obviously was not present that day, so I would assume that myself and the other nurse on duty had made that decision.

A

Q And that was within the prescribed range ---
A Yes.

Q --- by Code A ?
A On the entry before it said Code A was there. That means Code A was not even on duty that day.

B

Q Why are you presuming, as you seem to be, that Code A would not have taken the decision to start the patient on the syringe driver?
A I am sorry? Why ---

Q You see the note above – "Seen by Code A ". Yes?
A Yes.

C

Q "... as deteriorated overnight"?
A Yes.

Q Yes? And then your note pm. "Patient very bubbly chest this pm. Syringe driver...". You are saying that was a nurse decision?
A I think it could well have been.

D

Q Why do you say that?
A I am looking at the time that it was started, it was ten past four. Doctors usually made their rounds after their morning surgery. I would just lead to that conclusion. I cannot obviously state, but that would be the conclusion I would come to.

Q We know that the diamorphine continued on the 17th. I do not think you made an
E entry on the 17th, but could you go to 267. We can see an entry, I think, initialled by Code A Code A at the top. And the next one is Code A as well. In fact, you have not made any other notes on this ---?
A No.

Q --- nursing note.
A No. Nothing on there.

F

Q Going back to 263, we can see that the dose was continued on 17 October of diamorphine and then increased in the afternoon to 40 mg, and then increased the following morning to 60 mg. Do you see where I am?
A Yes.

Q Did you make any of those entries?
G A No, I did not.

Q You tell us: did you take any part in that decision-making process?
A No, I did not.

Q We are almost there. Could you go to 282, please. I do not think we need you to comment particularly. We can read – is it your writing on this page?
H A Yes, it is.

Q If we keep a finger there, please, and go back to page 274, which is the Barthel index, you, I think, were the named nurse for this patient?
A No. I was not the named nurse for any patients on Dryad.

Q I am sorry. If we go to 282 again.
A Sorry. I have put that in there because I did the care plan, but I would not have been the named nurse because as an Code A I did not have named patients.

Q I see. It was just ---
A Sorry. It just because ---

Q --- you were "Named nurse"?
A Sorry, no. It is because I complete the care plan.

Q If we go back to 274, would you have completed the Barthel score?
A No. It is not my writing.

Q It is not? Okay. But is that Barthel score consistent with your note at 282 as to the sort of assistance?
A Sorry, I just do not have that. I do not think that is my writing.

Q All right. It may not matter too much.
A Not it is not. It is not my "w". Sorry.

Q But he has a Barthel score of about 4?
A Yes.

Q And we can see the comments made about the assistance that he required, and that seems consistent with your note, does it, at 282?
A Yes.

Q Had you yourself filled in Barthel scores for patients?
A Yes.

Q You have made various other notes, but I am not going to take you through them, because I think they are all obvious. On the issue of named nurses, who would decide who would be the named nurse for a patient?
A There were three E grade staff nurses on the unit and they all had I believe eight patients each that they were responsible for. They had one of the bays and two of the single rooms each. Depending on which room the patient went into depended on who was the main nurse.

Q There is one other matter that I meant to ask you about and that is the use of midazolam with this patient. If we go back to the drug chart at page 263 – and again, I am really asking for your experience on the use of midazolam and then move on – we can see that the midazolam was also increased on 18 October.
A Yes.

Q In your experience, what was midazolam used for?
A As sedation.

Q That is different to pain relief.
A Yes, it is.

Q Are you aware that diamorphine would have a sedative effect?
A Yes. I do not know the reason; I do not know why at that time we put the patient on that, because I do not remember him.

Q So you cannot give an explanation as to why the midazolam would have been given?
A I am sorry, no, because I do not remember the gentleman.

Q You can put that file away, please. Can you take up file J, please? That is the patient Code A This gentleman had effectively fallen at home and he was admitted to Dryad ward, your ward, on 23 August. I just want to go to a note at page 63, please, first of all. Again, do you have any independent recollection of this patient?
A If he is the gentleman I am thinking of, I think he was the gentleman who had stayed on the toilet for about three days and had the most horrendous pressure sore on his bottom and legs.

Q That was pretty memorable, I expect?
A Yes, it was actually.

Q Can we look at page 63 together?

"Admitted from Anne Ward following an episode of immobility and sacral sores. Catheterised."

Then is it, "On profile bed"?
A Yes. We had to order a special bed in for him because he was a large gentleman.

Q This is your note at the top, is it?
A Yes.

Q I am not going to go through all of that. Can we go to the bottom of the page, please, because I think your writing next appears right at the bottom. We can see at 1900 hours on 26 August, "Code A here." Can we just pause there for a moment? That is seven o'clock in the evening. What would Code A have been doing there at seven o'clock in the evening?
A She may have come in late for somebody that she was worried about or I may have phoned her and asked her to come in.

Q Then:

"For Oramorph 4 hourly. Code A explained Code A 's condition and medication used."

Who would have given that explanation?
A Code A

A

Q If we go over the page to 28 August, I think you have made a note.
A Yes.

"Remains very poorly – no appetite has refused all food. Code A visited - very distressed as she is [redacted] this coming week – QA Thursday"

B And I have signed it.

Q At this time, this patient was on Oramorph only.
A Yes.

Q Did that have an effect at all on people's appetite?
A Not really, because I think if Oramorph actually relieves their pain, they eat.

C

Q This discussion with the wife, who would have had that discussion?
A I believe Code A because at seven o'clock Code A would have been in there.

Q I do not think your name appears further on that page, does it?
A No.

D Q But if we go to the top of the following page, page 65, there is a crossed-through entry.
A Yes. I made an error. I wrote that about the wrong patient.

Q The reason you crossed that through is because, although you have used his name, it is the wrong patient?
A Yes, it is.

E

Q We know that this patient was in fact started on diamorphine on 30 August. Again, could I just ask you, please, to turn up the drugs? You will find the start of the drug chart at page 171 and then I am going to ask you to turn to page 174. Page 174 should be headed "Daily Review Prescriptions".
A Yes, I have that.

F Q Do you see under "Diamorph" that Code A has written a prescription for between 40 and 200 mg of diamorphine?
A Yes.

Q Did you administer any of that?
A I have signed the one on the 2nd, which is for 90 mg.

G Q So the day before, the patient had been on 60 mg and you increased it up to 90 mg at 1540 in the afternoon?
A Yes. I have signed that.

Q Can you help us, please, on what authority you did that?
A At this moment, no, I cannot.

H

A Q Does it follow that you cannot say whether that would have followed a discussion with a doctor or not?
A I really cannot remember, I am sorry, and I do not think there is anything documented.

Q In any event, it is an increase which is allowed for within the prescription.
A Yes.

B Q Were there occasions when you yourself would increase the administration of the drugs based on the prescription alone?
A I am sorry, do you mean if the patient needed extra, would I look at the prescription and see if I was allowed to give it and then increase it?

Q If in your view the patient needed extra, would you give it without reference to anyone else?
C A Yes.

Q Provided it was within the prescription written?
A Yes.

Q Then if we go to page 56, underneath "1.9.99", there is an entry which I think in fact is for the 3rd, according to our documents. It may help us all if we write in, if this is
D convenient, "3.9", just so that in future we know. Is this an example of you verifying somebody's death?
A Yes, it is.

Q Is this the procedure that you would go through: you would check their breath sounds, their heart rate, their pulse and you would check their pupils?
A Yes, I would.
E

Q You were allowed to verify death in this case. Why?
A I would assume because it was written in the notes.

Q If you look at the top of the same page, do we see Code A 's note, "I am happy for nursing staff to confirm death"?
A Yes.
F

Q You have told us that you did have a recollection of this man. Is that because of the extent of his pressure sores?
A Yes.

Q I want you to look at one other patient. You have not made a statement about this, but I hope there will be no objection. I would just like you to look at a drug chart for Patient I,
G who is Code A Could you have a look at page 178? This is a lady who had had a fall and fractured her femur and came to your ward on 26 March. If you look at both pages 174 and 178. First of all, do you have an independent recollection of this lady?
A I do not remember this lady at all.

Q It may not matter at all, but have you in fact administered any of these doses as far as you can see?
H A It looks like I gave the metoclopramide at one o'clock. That is all.

Q Metoclopramide is given for what?
A Anti nausea.

Q Finally, I just want to ask you this. You have told us that here was an unfortunate end to your time at Dryad ward and you moved on.
A Yes.

Q Did you move on to a place called Jubilee House?
A Yes, I did.

Q Was that immediately after Dryad ward?
A Yes, it was.

Q Are you still working now?
A Yes. I work in the community now.

Q How long did you work at Jubilee House for?
A About four years, I think.

Q What sort of work do they do at Jubilee House?
A It is palliative care.

Q Did they use syringe drivers at Jubilee House?
A Yes, they do.

Q Did they use diamorphine at Jubilee House?
A Yes, they do.

Q Midazolam?
A Yes.

Q When you were at Jubilee House, were the practices that you saw the same or different in any way to the practices you had seen at Dryad ward?
A Different.

Q How different?
A The doctor would come in. No syringe driver was pre-prescribed. The doctor would come in daily. We had a GP who came in Monday to Friday and a consultant would come in; a palliative care consultant would come in once a week. If we had a patient that we were concerned about who maybe could not swallow the analgesics any more, they would be reviewed. The doctor would actually speak to the patient and ask them what they wanted: did they want to be kept comfortable, did they want to be pain-free and have their anxiety allayed? It would be discussed and then a small starting dose would be worked out using the analgesic ladder.

Q Was that – it may be obvious from what you have just said – a ward where there was a doctor there the whole time, or was there just a clinical assistant?
A No. One of the local practices covered us Monday to Friday and the palliative care consultant, as I said, would come in once a week on a Thursday, but we could phone her if

A we needed to and, if we had somebody we were quite concerned about, she would actually come in if she was available and see the patient as well.

Q When the doctor came in, how long would they spend on the ward?
A It varied. However long they needed to.

Q Was it one ward?
B A No. It is 25 single rooms. They would not see everybody; only the patients that they needed to see.

Q So the differences in the practice, I just want you to set them out for us clearly, if you could. First of all, was it the initiation of the syringe drivers?
A Yes.

C Q The starting doses?
A Much smaller.

Q And increases. Were they different?
A They were very controlled and titrating them, depending on how much the patient had had, as top-ups. They used to titrate it, depending on how much top-up the patient had had through the last 24 hours. So if they needed an increase, they would have a look at that and
D then maybe add a little, because obviously their pain was not controlled.

Q Was that similar or different to what you had seen at Dryad?
A Different.

Q At Jubilee House, did they allow patients to die in pain?
A No.
E

Code A Would you wait there, please?

Code A I think we will break at this point, Code A rather than interrupt you in a matter of minutes. We will return at 12.05, Code A when Code A will start with his questions. I remind you that you remain on oath. Please do not speak to anybody about the case. Thank you.
F

(The Panel adjourned for a short time)

Code A Welcome back. Code A

Cross-examined by Code A

G Q As you will appreciate I am going to be asking you some questions on behalf of Code A I appreciate in this case it is sometimes difficult to avoid moving from topic to topic and having to cross reference things, but I am going to try to keep things in compartments as much as I can. May I start with something which you dealt with towards the end of your evidence a little while ago. You told us you worked as a nurse at Jubilee House?
A Yes.
H

Q I will come on to Jubilee House in a moment, but that is a ward attached to Queen Alexandra, is it?
A No.

Q Is it attached to any hospital?
A At the moment it is now Portsmouth City Trust.

Q Was it physically?
A It is a separate building off site, but it was actually run by East Hants.

Q Just the physical thing, how close is it to QAH?
A Half a mile.

Q But was it attached to that hospital in any way in terms of services?
A No.

Q You spent four years there. This is not an exercise in detailed dates, but four years. Is that right?
A Yes.

Q So we think of you being there from 2000 to 2004?
A Yes, roughly, yes.

Q What grade were you there?
A I went there as an Code A just a staff nurse, yes.

Q Grade E?
A Yes.

Q When you were at Dryad, you were Code A if I remember correctly?
A Yes, I was.

Q Is going back to Code A going backwards or what is it in terms of career?
A Career wise it was going backwards. It gave me a job away from Dryad, and I wanted to leave Dryad and I needed another job and that is the one I took.

Q I think you had an opportunity of going to Queen Alexandra?
A Yes, as an Code A.

Q As an Code A?
A Yes.

Q It was a choice between Queen Alexandra and Jubilee, was it?
A Yes.

Q You spent four years at Jubilee as Code A and then you left?
A Yes.

Q What have you been doing since, have you still been working in nursing?
A Yes, I work on, it is called, the Rembrandt Unit. It is a community unit based at another hospital. We are, physically, in the hospital grounds but we are not actually part of the hospital.

Q Are you given a grade for that as well?
A I am an Code A there as well.

Q You have been Code A, in effect, since you left Dryad?
A Yes, I have.

Q Dealing with Jubilee in general terms, obviously a very different situation with regard to the provision of medical facilities in terms of doctors being there and being available?
A Yes.

Q There will be a number of doctors, presumably, who carried out the functions from time to time at Jubilee?
A Same as there was at Dryad Ward.

Q Doctors might be there for two or three hours per day?
A Not usually that long, no.

Q Four or five days a week – actually there – I am talking about back in 2000 to 2004?
A They would come in five days a week at lunch time between their surgeries, the same as Code A did.

Q But spending more time on the ward than Code A, would you say?
A As much time as they needed to.

Q In general terms, did that compare more or less the same with what Code A did?
A Probably there a bit longer, I would say.

Q There a bit longer.
A Yes.

Q Also they would be more available in terms of getting hold of a doctor to come to the ward if necessary than they were on Dryad?
A No, probably about the same.

Q A consultant, you told us, would come once a week?
A Yes.

Q And would be available if you needed the consultant?
A Yes.

Q That is something different to Dryad I think.
A Code A used to be able to contact the consultant we had when I first went there, Code A if she needed advice about anything, but that did change when Code A left and we had Code A

A Q In terms of the availability of the consultant, in terms of the consultant doing a once-a-week round on Jubilee, one ward, would you agree or disagree with the suggestion that that was rather more consultant attendance than there was at Dryad?
A Yes.

Q Obviously you have told us about the use of the analgesic ladder. Again at Jubilee there might be times, depending on the condition of the patient and their needs, when you
B would have to jump a step, omit a step on the analgesic ladder. The needs of the patient would cause you to do that because of the pain they were suffering?
A No, I do not agree.

Q You never had an incidence of that in your time at Jubilee?
A Not that I recall.

C Q You were asked about a number of patients, and I am going to turn to those first before I ask you about more general matters. I turn, first, to the patient who has the designation Patient F, Code A If you turn to page 394 and look at the entry – you have already looked at this – on 19 August halfway down the page, "Complaint of chest pain" and so on. The Oramorph was given by you, or it does not matter who gave it to her, but Oramorph 10 mgs?
A Yes.
D
Q "Doctor notified"?
A Yes.

Q That signifies what, a notification to Code A probably?
A I would have phoned to say what symptoms the patient had.

E Q I am looking at the time, 11.50. Is that something you may have notified her about when she did a lunch time visit, or something you would have telephoned her about, or are you unable to say?
A If I put "doctor notified", that meant I actually telephoned.

Q You telephoned her to say that that is what had happened?
A Yes.
F
Q You found, as your next bit of the note indicates, that the pain was only relieved for a short period, "very anxious", and then the diamorphine was commenced?
A Yes.

Q If you had been unhappy about that, you would have said so to the doctor, would you not?
G A Yes, I would have done.

Q I appreciate the difficulties of trying to remember something which took place a long time ago, but does this appear to be a possible picture because you administered this at a later stage, the diamorphine, and we have the time on the drug chart. It is consistent with Code A, perhaps, having come in at lunch time and you having spoken to her?
A It is consistent.
H

A Q We cannot say for certain, but it is consistent because it is later on in the afternoon that you started with her saying:

"If this continues, then I think it would be sensible to start the syringe driver."

Had you disagreed with that, you would have said so to Code A would you not?
A Yes, I would have done.

B Q On occasion, can I ask you this generally, just leaving this patient for a moment, had you on occasion ever spoken to Code A about, perhaps, it not being the appropriate time to start a syringe driver?
A Yes, I have.

Q Would that be once or more than once?
C A More than once.

Q On those occasions she listened to what you had to say and the syringe driver, she would indicate, "All right, we will delay it and see"?
A No, not always.

Q Are you saying there was an occasion when you administered diamorphine via a
D syringe driver when you had said to Code A, "I do not think this is appropriate"?
A No, not myself personally.

Q You may have discovered that that happened without yourself being present---
A Yes, I did.

Q --- during what had happened to the patient between the time you spoke to Code A
E and the time of the administration?
A Yes.

Q There was never an occasion when you said to Code A, "I wonder if it is right to start it now", or suggested that you had that view, there was never an occasion when Code A said, "No, I am ignoring that, I am going to go right ahead", was there?
A No.

F Q She listened to what you had to say and would indicate, "All right we will leave it for a bit"?
A Yes.

Q You indicated to us that, obviously, this patient was conscious when you noted down, "Very anxious"?
G A Yes.

Q We have had to look at a number of notes made by a number of different nurses, and it is quite helpful to have what is actually meant by a particular nurse in respect of a particular note. In your experience patients, when they were initially given diamorphine, might well be made sleepy by it, I think was the expression you used, and then they get used to it. There is

H

A no dispute about it, we have heard about that. In you view, it was the midazolam which contributed to them feeling sleepy?
A Yes.

Q The administration of diamorphine and midazolam was quite common?
A Yes.

B Q And something that you have seen occurring at Jubilee. It is a sensible combination, so far as you can judge. I appreciate that you are not a doctor, but it is a sensible combination in your experience?
A Sorry, there is something you said just now, I am sorry, something I disagree with.

Q What shall I do, shall I go back? What is it you would like to clarify?
A It was just the bit when you said about Code A would not give the medication and
C would agree to delay it. But I felt – well I know for a fact – that was done when I was off duty because I actually have a written statement saying that.

Q I am not suggesting you are wrong, but there might have been occasion when you said to Code A, "I wonder whether it is right to start it now?" expressing that view in those sort of terms?
A Yes.
D

Q And later on, on a different shift, a later shift, the patient might have received diamorphine on a syringe driver?
A Yes.

Q That is what you say, on occasion, had happened?
A Yes.
E

Q I was making the point that when the patient was on the syringe driver, albeit not at your hands but later on, there had been an intervening phase when you would not know what the state of the patient was except by the notes because you were not there?
A No, that is true.

Q The point I was trying to make, and you correct me if I have it wrong, is that there
F was no occasion when Code A if you spoke to her, indicated that it was your view that perhaps it should be delayed. There was no occasion when Code A said, in effect, "I am ignoring that, I am going to start him or her on the syringe driver"?
A Not to me, no.

Q Obviously there must have been authority to start the syringe driver later, otherwise, presumably, it would not have been started?
G A I do not agree. I am sorry, I really do not agree. It is quite a contentious point this with me.

Q You just do not know what happened after you left, do you?
A I do not know, but Code A actually wrote a statement when I put in my grievance saying it was easier to change drug regimes when I was not on duty.

H

A Q That may well be the case and I will come to that, if necessary, later on. What I am talking about is what Code A did when you raised with this her. I am making the point that you would not know, yourself, what had happened to the patient after you had gone off duty?
A No, that is true.

Q Can we go back to what I was asking you about in relation to that. There was no problem with your understanding my question, or giving the answers you were clear about, in
B relation to diamorphine and midazolam used together?
A Yes.

Q In your experience, both on Dryad and at Jubilee, they were an effective and sensible combination?
A Yes.

C Q In relation to Code A you are not criticising anything that happened, so far as you are aware, when you were involved in the treatment of that patient?
A No.

Q May I put it in this way. You are not somebody who would hesitate to criticise if you felt criticism was due?
A No, that is true.
D

Q Can we turn to the next patient you were asked about in this group we are dealing with. That is Patient G, Code A If we turn to page 861. We dealt with the entry you made at the top of this page?
A Yes.

Q You mentioned the sores, which you described as horrendous, on the sacrum. Perhaps
E it was another patient you mentioned where you used that word in respect of the sore, but "large necrotic sore on the sacrum, seen by Code A" and so on. Oramorph given prior to the dressing of the wound, which you said was something that was sensible to do and I think we can all understand precisely why. You indicated you, yourself, had not been involved with the commencement of the syringe driver, which was later on that day, and you explained that, apart from the fact it is not your writing, you would not have been on duty at 11 o'clock that evening?
F A Yes.

Q The next day you had dealings with Code A
A Yes.

Q When you spoke to a relative, you gave them the true picture when you spoke to them, did you not?
G A Yes.

Q You were not somebody who was being deceptive in any way when you were talking to a relative?
A No.

H

Q You were confident in explaining to him why the syringe driver had been commenced?
A I must have been because I have written it on there, yes.

Q I appreciate you were not involved in starting it, but if it appeared to you to have been something that was wrong, you would not have said what you said to Code A would you?
A No.

Q Because you indicated what the reason was, for pain relief and to allay his anxiety?
A Yes.

Q A history is set out which it appears you had actually witnessed yourself.
A Yes.

Q Plainly a case, perhaps we can note, of somebody who had been on diamorphine and midazolam, although not necessarily for very long, who certainly was not rendered so sleepy or unconscious or anything like that so as to prevent him from doing what he did?
A Yes.

Q You had seen that and it did not surprise you that the syringe driver was continued as it was?
A Yes. What do you mean "continued"?

Q During that day, the syringe driver was continued?
A Yes.

Q If you look over the next page, I appreciate it is not your entry, the same day it was changed?
A Yes.

Q If you move on to the next page, 862, you dealt with the other entry in your handwriting. Do you have 23 September?
A Yes.

Q "Seen by Code A Becoming chesty overnight. To have hyoscine added. Code A contacted and informed of deterioration."

That would have been you, would it?
A Yes, it would have been if I have written that in there, yes, it would.

Q That would be you telling him the true story as you observed it?
A Yes.

Q "Code A asked if this was due to the commencement of the syringe driver and was informed..."

That is by you.

"... that Code A was on a small dosage which he needed."

Is that correct?
A Yes.

Q That expressed your view. Again, you are not a doctor but that expressed your view?
A Yes.

Q And you were saying to him – and there is not criticism, of course . I am sorry – he was saying to you to phone him if there was any further deterioration?
A That is correct.

Q A situation you were no doubt quite familiar with?
A Uh-hu.

Q I think that is the end of any entries by you with regard to that patient. May we move on, please, to the next one in the order in which you were asked about these things. That is Code A Patient H. Just before I ask you about any particular entry with regard to that patient, you were indicating to us that in terms of the decision to go to palliative care, that that normally would be something that would be a product of joint discussion. Yes?
A I am sorry? For a patient, you mean?

Q Forget about the patient for the moment.
A Sorry.

Q I am just going to your evidence, just to make sure I have it right. When the point had been reached when palliative care seemed to be the only option left.
A Yes.

Q All right?
A Yes.

Q There would normally be a discussion about that issue?
A Yes.

Q Involving, you have told us, the doctor?
A Yes.

Q The nurses?
A Yes.

Q It might be one, it might be more than one?
A Yes.

Q And the relatives?
A Yes.

Q And that would happen, would it not?
A Yes.

A

Q Obviously the ability of the patient to make any helpful contribution to that would depend on the state of the patient?
A Yes.

Q And there were obviously a number of patients on Dryad who were not in a state to give an informed view about that. Right?
B A Uh-hum.

Q That in particular was why one needed to try and bring in the relatives?
A That is the ideal, but looking at the notes, it looks as if not all relatives had been told because it looks there as if with **Code A** I had told him the next day.

Q Yes?
C A But some relatives, to qualify that, do not always want to be called at night.

Q One appreciates there is a whole range.
A Yes.

Q Some relatives are not really that interested?
A No.
D

Q Some patients may barely have received a visit from a relative?
A That is right.

Q Some relatives were much more pressing?
A That is right.

E Q For whatever reason, and this is not a criticism of them, but might as a matter of practicality be more demanding on your time ---
A Yes.

Q --- in terms of wanting an explanation or wanting assistance or whatever?
A Yes. They are all different.

F Q Exactly. But the general picture, assuming there was not something to prevent it happening, would be that there would be a discussion ---
A Yes.

Q --- where feasible, involving the relatives?
A Yes.

G Q In your experience – you cannot speak for every case obviously. All right? And you told us, I think, that **Code A** herself would speak to relatives and, indeed, she might come in specifically to speak to a relative at the hospital?
A Yes, she did.

Q In relation to this particular patient, may we look please at page 266. I think it has sometimes been described as 266A. I just have the 266, but I think maybe 266A was a
H

A replacement with better copying. I am told that is 266B. I do have 266B, which I think is the clearest copy we have of that page.

THE CHAIRMAN: Code A I think all it was was that 266A had some additional notations on it. The quality of the copies is the same. The fuller one, if you like, is "A".

Code A I am going to stay with 266 because there is less to look at. We can
B always move to 266A if necessary. However, I do have a 266B which seems to be a blow-up version of 266. It does not matter. The important thing is that you have a clear copy of what I am asking about. (To the witness) Here we dealt with the note on admission at the top of the page – all right?

A Yes.

Q For 14 October, made by you and the Oramorph being given?
C A Yes.

Q Again, I appreciate every time I ask you this, you can only speak as a nurse. You are not making a criticism of that, are you?

A No.

Q You were asked about the decision to start the Oramorph, because it was a variable
D prescription, in the sense it could go from 5 mg to 10, or 2.5 ml to 5. It looks as though you decided to start it at 10. This is not a criticism. Would you agree?

A No. I could not say at the moment because I do not know.

Q You simply do not know?

A No, I do not know.

E Q But it might be that you would feel it appropriate ?

A It could have been

Q Yourself.

A Yes, it could well have been.

Q That is as far as we can take that, I think.
F A Yes.

Q Then, on the 16th, on that same page – 16 October –

"Patient very bubbly chest this p.m. Syringe driver commenced 20 ... diamorphine, 400 ... hyoscine. Explained to family reason for driver. Wife informed of patient's continued deterioration. Has been to visit."

G

It might have been – I know you cannot say now after this distance of time – but it might have been that it was your view at some time after midday – we can check on the drugs charts and so on – that you made the decision that his condition justified the commencement of the syringe driver?

A Yes, it could have been

H Q Obviously if the doctor is there, you would always check it with the doctor?

A A Uh-hu.

Q If you were in real doubt about it, you might make an effort to contact the doctor, or whoever was on call? There might be occasions where, if in your view this was justified, you would feel it right to start it?
A Yes.

B Q The object being to stop the patient being in unnecessary pain?
A Yes.

Q I appreciate you cannot now precisely remember, but you said, "It looks as though I and the other nurses...", because you would always consult with another nurse, would you not?
A Yes, I would.

C Q "I and the other nurse (or nurses) had made that decision." Code A not on duty that day, is what it looks like?
A That is right.

Q There is no dispute about that?
A That is right.

D Q It was administered at 4.10 in the afternoon. All right?
A Yes.

Q You were taken through the administration of the medication so far as Code A is concerned, not only the diamorphine but also the midazolam, and I think it is right to say that you, in your view, did not think that any of the dosages of drugs in the case of Code A
E were excessive?
A No.

Q I am going on a statement that you made to the police a long time ago. I appreciate that. I think you had had the opportunity when you made your statement about Code A 's case, that you had had the opportunity of reading some of the notes?
A Yes.

F Q And you said you had no issues with Code A 's care?
A No. That is right.

Q That is all I need to ask you about that particular patient. Can we move on, please, to Patient J. This is the patient where you used the words, he had a most horrendous pressure sore?
G A Code A

Q It is Code A , that is right.
A Yes.

Q You may also remember with him, he was an unusually large gentleman?
A Yes, he was. I remember because we had to order a special bed. We had not had one
H before.

Q That obviously created nursing problems of its own anyway?
A Yes.

Q We started there, I think, at page 63 when Code A was asking you some questions. The admission you dealt with at the top of the page on 23 August. Is that right?
A That is right.

Q I do not need to go through all that. Then we took it up again, I think so far as you are concerned, with 7 o'clock in the evening at the bottom of the page at 19.00.
A Yes.

Q Is that you?
A Yes, it is.

Q "Code A here. For Oramorph 4 hourly. Code A seen by Code A, explained Code A 's condition and medication used."

So obviously it follows you were there when that was discussed or spoken about?
A Yes.

Q And would it be right to say that Code A on this occasion was not being either rude or harsh, otherwise you, no doubt, would have noted it or remembered it?
A Not to my knowledge.

Q Indeed, in terms of Code A speaking to relatives, so far as you witnessed it, did she ever come across to you as being rude or harsh with relatives?
A No. Outspoken more, I would say. Not rude or harsh.

Q Forthright?
A Yes. Yes.

Q Similarly, I think there is another note by you on the following page, page 64, on 28 August. That is you, is it not?
A Yes, it is.

Q "Remains very poorly – no appetite...". That is where you were making the comment about how Oramorph might in fact in your experience sometimes have the effect that it got patients to eat?
A Yes, if they were pain-free.

Q It relieves the pain?
A That is right.

Q I was not clear, and it is my fault, not yours. Were you indicating that Code A was there? There is no reference to it. I may have misunderstood what you said. I think it probably is you dealing with the wife. Yes? "Code A visited – very distressed"?
A Yes, sorry. On the 28th? Yes. Yes.

A Q I just want to be clear that this ---
A I would have put 'Code A' if she had been there.

Q I was going to say that exactly. You had recorded it.
A Yes.

Q So that is you speaking to the wife and, again, can we take it that you did that in, as
B you saw it, a helpful and relaxed way?
A I believe so.

Q It is difficult to always judge oneself but that is what you would say. I need not trouble you with the crossing out on page 65, but may we move on, please, to page 174. There you were asked on page 174 in relation to the diamorphine, towards the bottom of the page ---
C A Yes.

Q --- where the range is 40-200?
A Yes.

Q And you told us that looking at the date heading for that section over towards the right, 2 September. Yes?
D A Yes.

Q "2.9.99." The administration of 90 mg – because it has gone up from 40 to 60, on the second day, and then 90 by the time we get to the 2nd. All right?
A Yes.

Q All right?
E A Yes.

Q Administered by you. Yes?
A And again, you would not have administered that amount of diamorphine by way of increased unless in your view the patient's condition justified it?
A That is right.

F Q Obviously these decisions are sometimes difficult to make, are they not.
A I have never made that decision on my own because I have always had a colleague on to discussed it with.

Q I am not suggesting to the contrary. Assuming there is not a doctor there?
A Yes.

G Q And nursing staff have to make a judgment?
A That is right.

Q Based on their experience and all the rest of it. It would not be just one nurse suddenly deciding, "Oh well, I am going to up the dose." It would always, in your experience, be two nurses discussing it?
A Yes.
H

A Q And if it was a junior nurse to you who had noticed the patient's condition deteriorating and was concerned about it, they would tend to come to the senior nurse on duty?
A Yes, this would.

Q If you are there. If Code A was not there it would be you they would come to?
A Uh-hum.

B Q Similarly, you yourself, if you thought it was necessary to increase would consult another nurse?
A Yes, I would.

Q That is a given. But it is quite a difficult decision to make, sometimes, is it not? You have to hold the balance and keeping the patient out of best?
C A That is right.

Q And making sure you are not giving them too much?
A Uh-hum.

Q It is not always easy, is it, to decide?
A No. That is why, if I am on with another nurse, which usually I am, I say to them,
D "Would you go and have a look and tell me what you think."

Q Sorry. We quite understand that. Whether it is a joint decision ---
A Yes.

Q --- or whatever, in the end it is probably you who has to say, because you are the senior nurse, if you are the senior nurse, a joint decision having consulted, but it is quite a
E difficult decision sometimes to make in your experience. Yes?
A No, not always.

Q All right.
A No, I would not agree because if a patient has pain, there is usually some indication, either turning them or their facial expression. I do not find it is a difficult decision to be quite fair, to assess pain, because there is always an indication.
F

Q I am not going to press you on that.
A No.

Q It is what you have to say about it that we are interested in.
A Yes.

G Q Patients might be exhibiting pain even if they are drowsy?
A That is right.

Q Or even if they are slipping sometimes in and out of consciousness?
A No, that is right.

Q They can indicate by what you have just described, or signs of agitation and distress?
H A That is right.

A

Q Which can be indicators of pain?
A Uh-hum.

Q But in any event, I appreciate that you cannot remember the precise circumstances. You did what you did for good reason, as you saw it at the time. Yes? With regard to the administration of diamorphine?
B A Well, I must have done.

Q Obviously, because you simply would not have done it if you thought it was wrong?
A That is right.

Q I do not think I need to trouble you with any further with that patient. Can we move on, please, to patient I, the last of the group you were asked about. You were asked about
C certain entries with regard to Code A but another one, or possible two I need to ask you about in addition to what you were asked to look at. You were asked to look at page 174, I think. We had better just turn that up to make sure I do not get anything wrongly described. That is the drug chart again. In case I do have it wrong, is there an entry there by you on 12 April? 12?
A Is this the drug chart?

D Q Yes. I have 174 at the bottom. Diamorphine top left.
A No.

Q The dates are 12, 13, 14 and 15.
A No. That is not my signature.

Q Very well. That is not you?
E A No, it is Code A and Code A

Q Code A ? Thank you. That is the first, and then the Code A
A Code A

Q Just checking again with you, if I may. The next page, 178, I think you said there was something there?
F A Yes. I signed the metoclopramide at one o'clock.?

Q I need not trouble you with that. Then can we go back, please, to page 134. It is part of the summary. Do you see just over half way down there is an entry on 11 April – 11.4.99?
A Yes.

Q Where she talks about the nephew telephoning. That is not your handwriting?
G A No.

Q All right? But would you be kind enough to look at the last line: Code A "

A Yes.

Q "To commence syringe driver"
H A Yes.

Q Is that you?
A Yes, it is.

Q It may not be too good on the photocopies. We can there is a different initial in the line above that, or different signing on for the person who did the note earlier on. All right?
A Yes.

Q That note, if the last line is you and anything on the following page by you?
A No.

Q Would you just help us, please, with the signature for the 12th - 12.4 – at the top of the following page. "[Seen by] Code A Is that... It looks like Code A 's signature. It is not an additional initial, is it? Or is it? I better see what you say. "[Seen by] Code A .."?
A No, no. It is Code A It is the "Code A, and then there is a long line, and then ---

Q It is a continuation of her name?
A Yes.

Q I just want to make absolutely sure. I am not suggesting to the contrary, but just looking at that last line on 11.4.99, obviously the patient had been seen by Code A - right?
A Yes.

Q And had indicated to you that the syringe driver being commenced?
A Yes.

Q It would appear that you did not take exception to that, because that is what happened?
A Yes.

Q Once again, if I can ask – and this again is not a criticism – if you thought that was wrong, you would have made your opinion clear.
A Yes, I would have done.

Q I have not dealt with those particular cases. I need to ask you about some more general matters, if I may. When you arrived on Dryad in 1998, would it be right to say that prior to working on Dryad, you had not really done a lot of palliative care?
A Not a lot, no.

Q It was all fairly new to you?
A Yes.

Q In general terms, did you find that general patient care on Dryad was excellent?
A Yes.

Q Not just at the beginning, but I am asking you in general terms.
A No. In general terms, it continued until I left, yes.

Q Obviously I have documents and statements you have made and things of that kind. They were all very well looked after.
A Yes, they were.

Q Indeed, I think you expressed it in the way of saying you were very impressed with the level of patient care on that ward.
A Yes.

Q I appreciate there were clashes between you and Code A and I am going to try to avoid going over past history and disputes, although I may have to touch upon it. But there was a clash between you.
A Yes.

Q She is a strong personality.
A Yes.

Q You are hardly a weakling in that department either.
A Yes.

Q The clashes could never really resolve themselves and there remained a difficult working relationship, whoever's fault it was, throughout the period of time with which we are concerned.
A Yes.

Q Nonetheless, whatever criticisms you may have had of her, did you find her to be an excellent nurse?
A Yes.

Q I think we can put it in this way. She ensured that the staff under her kept up the standards.
A Yes.

Q Rather like, I think in your view, an old-fashioned type of matron in a hospital.
A Yes.

Q Somebody who worked closely with the nursing staff, although she was the one who made the decisions.
A Yes.

Q Did you find that the nursing staff generally under Code A – and we are looking at Dryad ward obviously – were quite a close-knit group?
A Yes, fairly close.

Q Was an element of your dissatisfaction – and I am not raising this by way of criticism, but just as a fact – the fact that you felt excluded from the group?
A No.

Q Not at all?
A No.

Q You felt fully integrated into the group, did you?
A I think as much as anybody could have been.

Q So far as Code A was concerned, did you find her to be a good and experienced doctor?
A Yes.

Q You may have had a disagreement ---
A Yes.

Q --- about some issues, but she was somebody who was caring about her patients.
A Yes.

Q Indeed, somebody who was aiming, even if you might have felt you could criticise certain things, always aiming for the best for her patients.
A Yes, I would agree with that.

Q Similarly, Code A whatever you might have disagreed with her about, again, that was something which was the case with her so far as you could judge it.
A Yes.

Q Whatever issues there may have been, to use the word which actually always means "problems", with regard to your feeling you had been harassed, did you find that Code A at all times remained civil to you?
A Yes.

Q And displayed a professional attitude?
A Yes, always.

Q In terms of Code A, you indicated I think – I just want to be clear about this – that there had been an occasion when you had spoken to Code A in these circumstances. This is my way of putting it and you can tell me if I have it wrong. There was a time when you had gone off from being on the early shift, the shift starting round about seven o'clock in the morning. When you came back the next day, you saw that a patient was on a syringe driver and in your view of the patient's history from when you had been tending to them, you could not understand why the patient had been put on the syringe driver.
A That is right.

Q So on that following day, you spoke to Code A and asked her why that was the case.
A That is right.

Q It was on that occasion I think – I appreciate this is not Code A, but I just want to get it straight what you are saying – she said, "Because" when you asked why and you did not really get an explanation.
A That is right.

Q I think it would follow from that, whatever may have been the rights and wrongs of what she said, you of course did not know what had happened so far as the patient's condition between the time you left and the time that the syringe driver had been started?

A A That is true. However, there was a time when I had discussed with Code A and with Code A about the use of the syringe drivers to the extent where Code A actually had a doctor come in from Countess Mountbatten House, which is a hospice near Southampton. Code A came in and actually gave us a talk on the use of the drivers and---

Q I do not mean to interrupt you, but I was coming on to that.
B A I am sorry.

Q It is not your fault. Let us deal with it now.
A Sorry. It is just that it seemed to follow on.

Q I am very happy to ask you questions about that. It was a topic I was going to come to. Let us deal with it now. You say you had spoken to Code A and Code A
C A Yes.

Q First of all, I am going to try to get from you – and I am not going to criticise you if you cannot remember – when about would this have been that this meeting took place?
A I would think in 1999, I believe. I cannot remember the exact year.

Q 1999 rather than 1998?
D A Maybe. I cannot say for certain, I am sorry. I was only there two years.

Q Can you help us with this? Would this be before you raised your complaint against Code A and Code A ?
A Yes.

Q We know that that was in the spring roughly of 2000. So it looks like 1999. Probably
E the latter part of the year.
A It may be. I do not know.

Q You had spoken to those two nurses about your concern about syringe drivers being ---
A About the use of them.

F Q --- started too early.
A Yes.

Q It is not that you were complaining that a syringe driver should not be used, your view was ---
A No. I had no problem with syringe drivers.

G Q You have made that clear. I am not suggesting you had. You thought in some cases a syringe driver was being started too early.
A Yes.

Q Maybe you were right, maybe you were wrong, but that was your view.
A Yes.

H

Q You have told us that on occasion – and I am not suggesting this happened a lot – you had said in a particular case to Code A, "Does it need to be started so quickly?" or something like that. We have covered that already. How did it come about, as you saw it, that there was a meeting arranged with Code A? Could you help us with that?
A Because I think other people had complained to Code A about the use of the syringe drivers and she felt that there was some concern and she contacted Code A who came out to our unit and actually gave us a talk.

Q So it was Code A who had arranged for a doctor to come to a meeting about this?
A Yes.

Q You think – and I am not criticising you – maybe somebody else or other people had spoken to Code A
A Yes.

Q That is something you learned from what others had said to you.
A Yes. I cannot say for sure.

Q We have heard from other nurses. If you cannot say for sure, I am not going to bother to ask you, because you would be speculating. Code A arranged a meeting which Code A attended.
A That is right.

Q You said she came from – just help us.
A She came from the Countess Mountbatten Centre, which is a hospice just outside of Southampton and she gave all of us, all the staff, a talk on the use of syringe drivers and the analgesic ladder.

Q So this meeting was at the instigation of Code A
A Yes, I think so.

Q Code A spoke to you about this.
A Yes.

Q Was Code A present at the meeting?
A No, I do not think so.

Q It is very difficult to recall.
A I do not think so.

Q Can you help us as to who was present? Code A, you.
A I have a feeling Code A might have been there from nights. There was quite a lot of us. I think Code A I cannot remember everybody who was there. I know we had a lot of people. The room was quite full.

Q No doubt it was explained by Code A by way of clarification that there was a need to use syringe drivers in appropriate cases and were your concerns allayed, laid to rest, by what you heard from this expert in palliative care?
A Not really.

Q Even after the explanation had been given, for whatever reason, you still were not happy?
A No, some of us were not. I think Code A and I had talked about it and we felt that the information she gave us, everybody already knew, about using the analgesic ladder, but that was not always instigated.

Q That was presumably mentioned at the meeting?
A No, it was not. I do not think anybody brought it up.

Q Do you mean to say that you sat there at the meeting and did not raise your concerns?
A It is very hard to do that when you are actually sitting there, with all your colleagues and your ward sister and Code A who was from another hospital, and actually say that.

Q Forgive me. Was that not the entire point of the meeting: to assist with your concerns, because you have told us you expressed concerns to Code A, she arranged the meeting. I am trying to find out from you why you did not say anything?
A Because I could not see the point. To be fair, I do not think, to actually turn round to a doctor from another unit and say, "Well, our syringe drivers are being used too soon", I could not see what input she would have on that. She was there to teach us the proper way to use them and that is what she did.

Q Forgive me for pressing you on this. Why on earth did you not raise it?
A Probably the same reason other people did not go to a hospital manager with it. I think everyone was a bit reticent.

Q On your account, you have not hesitated to speak out about this and indeed on your account there were other nurses who agreed with you.
A That is right. It is very, very difficult to speak out. It is not easy. It is really, really hard to do.

Q Do you mean that everybody sat there and nobody raised a single question?
A No, they did not.

Q I have to ask you. If that was the purpose of the meeting, brought about as a result of your concerns, why not say ---
A I do not know that it was necessarily my concerns. All I know is that the meeting was arranged for us to have this talk from this doctor.

Q In order to deal with the concerns that you had, and maybe others as well, about the syringe drivers being commenced too soon. That was its purpose, was it not?
A That was the purpose in our mind, but it might not have been the purpose in Code A Code A's mind. She may have thought it was just to clarify why we used them. We all knew why we used them, but it was when they should be instigated and that was the problem that some of us had.

Q Forgive me. You are not a person who hesitates to speak out, are you?
A But it is not always easy to do it.

Q Can you help as to what the problem was, as a nurse, a Code A nurse, sitting there, saying to Code A "I'm a bit troubled about how we decide when to start the syringe drivers"? What was the difficulty about saying that?

A Because she had already told us when to start the syringe drivers. She went through the analgesic ladder with us. But her telling us when we should be using them and what was put into practice was a different issue. She was not working on our unit, so she had no input into our unit. Even our Code A was aware of the difficulties we had, because I spoke to her about it and all I was told was, they were aware, but nobody ever got anything done.

Q I think your answer is perhaps indicating that there was no difficulty about your saying to Code A, without getting excited about it, "I feel sometimes syringe drivers are started too early." Can you help us with that? An easy question and the whole point so far as you were concerned.

A Not really. She was from a different trust and she would have had no input into our unit. It was for our hospital trust to actually instigate those changes and those changes should have come from the top and the top knew what was happening.

Q I am going to ask you once more. What was the problem about just saying that to Code A when she is right there at the meeting?

A Well, I thought I had made that quite clear in what I have just said to you. She had no input in our unit. She came from a different unit, she was not part of our hospital, she came from a hospice to explain to use the use of the syringe drivers. She explained the analgesic ladder, but we already knew the analgesic ladder. We needed somebody who could actually -- I am sorry, I am getting really upset.

(The witness left the room)

Code A Sir, it may be appropriate to have an adjournment.

Code A I think so, Code A On the subject of that particular question, I think the witness has answered it to the best of her ability. Certainly I understand what she is saying and I understand what you are saying. I am not sure that we are ever going to get any further on that.

Code A Sir, I entirely agree and I was not going to ask any more. I was going to let her finish her answer. I can leave that particular topic very easily and move on to something else.

Code A Very well. What I suggest is that we do break for lunch now and that will give the witness an opportunity to compose herself.

Code A Sir, before you do, can I just raise a matter of housekeeping, please? We are hoping to call Code A whose name the Panel has heard a number of times. She is presently in New Zealand, in a not terribly heavily populated part of the country, and we are trying to set up the possibility of a video link on Thursday 16 July and Friday 17 July. Obviously there may be objections to us calling a witness over a video link, but because she is in a fairly remote part of the country, we need to set up the arrangements now. You will be aware of the time difference between here and New Zealand. If she were to do a slot between 8.00 p.m. and midnight her time, that would correlate to between 9.00 a.m. and 1.00 p.m. our

time. What we are hoping to set up is a link for both those dates, three weeks from today, Thursday 16 July starting at 9.00 a.m. for the Panel and again the following day, Friday 17 July, 9.00 a.m. to 1.00 p.m.

(The witness returned into the room)

THE WITNESS: I apologise for that.

Code A That is perfectly all right. What are going to do now, it is past one o'clock, which is the time we would normally break for lunch, we are going to take the luncheon break now and return at 2.05. The reason we are still sitting is because Code A has raised a matter of housekeeping about the availability of a future witness and we are just working out the details for that. You are absolutely free now to go and get some lunch, leave the building if you wish and get some air, and if you could be back for 2.05, that would be great.

Code A In case it assists, perhaps the witness could be told I am not going to be asking any more questions about the Code A meeting.

THE WITNESS: That is fine. I am happy to continue with it.

Code A What I have already said to Code A in your absence is that I at least, and I think the rest of the Panel, understood very clearly what you were saying and what your point was. We understood his too and the fact that you are not coming together is by no means a difficulty for us. We felt that there was not perhaps any value in him continuing and he agreed that he was going to not continue with it.

Code A If I can just finish, I would invite the Panel to check their diaries for those two mornings: Thursday 16th and Friday 17th, if it is possible for the Panel to do that over the lunch adjournment.

Code A But those are both dates that we are due to sit. I am not aware certainly of any difficulties in the pipeline and I am getting clear "no"s from everybody else. Code A I take it that you are reasonable confident that the GMC case will have finished by that time?

Code A The GMC case I would hope will have finished a while before that. It is possible that we would then be in the middle of Code A 's evidence, if she gives evidence. We will cross that bridge of course when we come to it. Can I just mention this?

We have been in some discussion about expert reports. We have not yet had an expert report; we do not know if an expert is being called. If it is proposed, however, to use Code A as an expert to comment upon Code A 's method of dealing with patients with whom Code A did not deal, then it seems to us that she would then – I do not know if this is intended; it may be that my learned friend can help.

Code A I am perfectly happy to do that. I do not envisage Code A being asked about other patients. She will be asked about her views, her opinion and her expertise as a consultant and she will be asked only about the patients with whom she had dealings. I am not proposing to ask her to give an opinion about a patient with whom she had no dealings.

Code A Presumably she may be asked questions about the general customs and procedures of the ward at the time when she was there.

Code A Of course. We are going to be hearing, for example, as a GMC witness, from Code A and Code A who no doubt will be covering some of those areas. I know exactly what my learned friend's concerns are and I am not for a moment suggesting they are inappropriate concerns, but they will not arise.

Code A So it would appear that there is no particular difficulty. Thank you very much indeed, both of you. We will make it ten past two.

(Luncheon adjournment)

Code A Welcome back everybody. Code A

Code A I want to turn to one or two particulars matters and then I want to deal with things that you said about the harassment complaint that you made with regard to Code A Code A and Code A You said in your evidence that every patient, and I stress that, every patient, admitted to Dryad Ward had a syringe driver and diamorphine written up on admission. Do you really mean that, every patient?

A Every patient that I can remember that I dealt with.

Q Every patient that you remember that you dealt with?

A Had a syringe driver written up.

Q You dealt with Code A Patient I, she did not have a syringe driver written up on admission.

A Right.

Q I think certainly at least three of the patients that the Panel are considering did not have syringe driver written up for them on admission, so would you like to amend your answer to say that, "Sometimes patients on admission..."?

A No, I would say most of the time.

Q Most of the time?

A Yes.

Q You also indicated in your evidence, and this is a different matter in a different context in relation to Code A, and you felt she did not want somebody like you – I do not mean this personally – somebody like you at your grade acting as her number 2. Is that right?

A Yes, it is.

Q You felt left in limbo?

A Yes, I did.

Q I put to your earlier on that one of the reasons for you being unhappy in your position is that you felt excluded. Do you now agree that in fact you did feel excluded?

A No, you said as a member of the team, if I remember rightly.

A
Q Excluded, yes.
A No, not as a member of the team, not of the team in general, no.

Q You have spoken about an occasion when you had been speaking – without going into too much of the tangled history – with Code A and Code A about the possibility of moving. That was moving to QAH, was it not?
A That is right.

B
Q Code A at some point, you told us, said that you had upset Code A ?
A That is right.

Q You spoke to Code A and said, "I believe I have upset you".
A That is right.

C
Q And you told us your recollection was that she said, "No you have not, but you do not understand what we do here"?
A That is right.

Q Did you take that to mean that you had concerns about dealing with palliative care?
A I am sorry, say that again.

D
Q When she said, "You do not understand what we do here", you understood, I think you told us, that you thought it was about regarding syringe drivers.
A That is what I took to be the meaning. That was my interpretation of it.

Q Might I ask you, why did you not say to her, "What do you mean", or were you satisfied in your own mind that that is what she must mean?
A I do not remember saying anything else to her after that actually.

E
Q For clarification, you have spoken about somebody I think you described as the Code A
A That is Code A .

Q I just wanted to make sure we are talking about the same person, that when you say that you are referring to Code A
F
A Yes, I am.

Q You say that you thought that increases of doses, an increase of a dose, they were increased by too large an amount?
A Yes.

Q Is that right?
G
A Yes.

Q You told us also that you did not know what the guidelines were with regard to increases?
A That is right. Well no, apart from titrating them to top up doses, but that did not always happen, patients were not always given top up doses in between.

H

A Q What I am asking you is, and it is not your fault it is mine, is there any suggestion by you that you thought that the increase in a dose range, within a dose range, that is what I am asking about, in relation to subcutaneous analgesia – and let us keep it to diamorphine, I appreciate it often involves midazolam as well – that sometimes the increases were too large. Maybe I have misunderstood you?
A No, I think sometimes they were.

B Q Not in the cases we looked at when I looked at the cases you had dealt with, the three or four we looked at earlier on?
A I would have assumed that those – I cannot say for certain because I cannot remember most of those patients – I would have actually discussed that with one of my colleagues or with Code A

Q You told us you, yourself, would not increase a dose if you thought the increase was
C too great.
A No, that is right.

Q I have drawn your attention to those cases because when you say, "I was concerned about it", your concern was that somebody within a dose range was increasing it by too much. My point is that, if you did not know what the guidelines were for increases in dosage, how could you make a judgment about that?
D A Because we did not have the guidelines written down, but actually to either double or put up by a third it just seemed rather a lot and the change in a patient would be quite dramatic.

Q It seemed to you quite a lot?
A Yes.

E Q You would sometimes notice a change in the patient?
A Yes.

Q But not in the ones that you dealt with out of the twelve people we have been considering?
A I may have done, but I have not documented in there and, as I say, I cannot remember those patients.
F

Q In terms of guidelines, we have been dealing with a document, a handbook, which has had more than one name. Some people seem to call it the Wessex Protocol, or Wessex Protocols, and other people describe it as the Palliative Care Handbook. There was one of those available, was there not?
A Not to my knowledge, I have not seen that.

G Q I am going to ask you to look at a document. If you turn to file number 1, this is a file you have not looked at before but I want to ask you about this. Do you see this file has tabs?
A Yes.

Q Would you turn to tab 4. Obviously this is a photocopy, so it would not look exactly like the handbook itself, but does that ring a bell with you looking at it?
A I do not remember ever seeing this document.
H

Q That is all I need to ask you about that if it does not ring any bells with you. Can I hold up a document, Palliative Care, something looking like that, does that ring any bells with you (document shown)?
A I do not remember seeing it.

Q I will not press you on it if you do not remember it. In terms of the question of increasing a dose, it was something, in the cases that you dealt with, which you would make your own judgment about within the dose range prescribed?
A No, not always. I believe that sometimes I would have discussed it with Code A when she came round or with my colleague.

Q You would not involve yourself with an increase, you have already told us this, which you did not think was appropriate?
A That is right.

Q So you would make your own judgment about it in consultation with others?
A Yes.

Q In your experience you were not aware of any other nurse who was increasing doses too much, were you, because you would have raised it with them?
A I did raise it with them, I raised it with Code A.

Q No, with any nurse, forget Code A
A She was a nurse.

Q But you had a senior role amongst the nursing staff under Code A My question was, were you aware of any nurse on Dryad, under you in the order of things, who, in your view, increased a dose by too much?
A Not to my knowledge.

Q Because if there had been such a nurse, somebody junior to you, you would have spoken to them about it, would you not?
A Yes, I would have done.

Q I want to turn to the question of, I think you used the expression, to make sure we are talking about the same thing, "I put a grievance in". Is that right?
A Yes, I did.

Q I think that was in the early part of 2000?
A I cannot remember the exact year.

Q We will look at some documents which may help us with that?
A Yes, I did.

Q That was a complaint alleging that you had been harassed in some way by Code A Code A and Code A?
A Yes.

Code A I think you wrote a letter to a Code A The date of the letter – I will show you a copy of we need to – is 24 March 2000, a letter where you were writing to

A complain about the way you were being harassed. I am going to ask you to look – I think we have copies of these documents. (To the Panel) It may be that some of these will have to come to the Panel. If, in some cases, I can deal with the points when the witness has looked at it and there is no dispute about the document, it may be it will not be necessary.

Code A You have photocopies to hand?

B Code A Of what I am proposing to put to the witness, yes, but I want to start with this letter, just one copy first to the witness. (Same handed)

Code A May I see it as well?

Code A Of course. One copy to Code A (Same handed). (To the witness) If you would read it through, it is just one page. May I make some things clear, I do not want to C get involved in all the details of the problems that there were between you and Code A so I am not concerned with that. If you want to say anything, do not let me stop you, but I am trying to avoid everybody getting involved in a past dispute. You were suggesting that syringe drivers, or the use of syringe drivers, had played a part in your complaint about being harassed, so I am directing my questions in particular to that issue.

A Yes.

D Q When you look at the letter, which is writing to complain about the way you are being harassed at work, would you agree that nothing at all is said in that letter about syringe drivers, their use or doses of medication?

A No, it is a very general, open letter.

Q There may be a good reason, so the first thing is, "No, there is not". I am going to ask for the Panel to have a copy of the letter now we have established that. I think it is right you E should receive it. I am sorry to burden the Panel with more documents, but I think we need to deal with it. (To the witness). You can take in the date, 24 March, top right.

A Yes.

Code A The Panel are receiving that and marking it exhibit D1 (Document distributed and marked D1).

F Code A I am not going to read out every word. You are writing to complain about the way you are being harassed at work, almost to the point of leaving your job. You want to evoke the Trust's harassment policy:

> "I know that things have gone so far that the informal stage would be of no use...
>
> I work Dryad...I am constantly being harassed by my line manager Code A to G consider moving to QAH as an Code A
>
> Recently I have received similar overtures from Code A It is obvious to anyone listening that I am not wanted on Dryad Ward and this is causing me great distress and stress. I have no wish at the moment to leave Dryad under this cloud, and want the status quo to apply.

H

A I realise things are going to be uncomfortable, but I have reached the end of my tether and know that what is happening is not right."

That is what starts the process.
A Yes.

Q In due course the matter was looked into by somebody who had the title of the
B Investigating Officer?
A That is right.

Q That was Code A Does that ring a bell?
A Yes.

Q You had a meeting with her some six days after your letter. You will not remember
C the date, but you had a meeting with her about it?
A Yes, I did.

Code A We have notes of the meeting and I will ask you about that meeting. Would you, first, have a copy of the notes. These are notes you signed, so it can be clear to the Panel and the Legal Assessor that the witness signed the notes of this meeting. Take a moment to read through it, if you would. If that is coming to the Panel now, there is no
D difficulty about it because the witness has signed it.

Code A We will receive that as D2. (Document distributed and labelled D2).

Code A Having had an opportunity of reading through that, would you agree that there is nothing there in relation to syringe drivers, their use or medication.
A There is not, nothing specifically mentioned, no.
E

Q The real thrust of your complaint was that you felt you were being encouraged in an unfair way to move on to QAH. Is that right?
A Yes, I still do feel that, yes.

Q I am not seeking to be the arbiter of the rights and wrongs of that, but that is what you felt?
F A Yes, I did.

Q You mentioned in the course of the questions I asked you earlier on, you said something that Code A had said in relation to this investigation into the complaint about her saying that it was easier really to agree with you rather than have a contentious dispute; not my words, not yours?
A Not your words, that is not what is in the letter.
G

Q You were referring to the notes you had seen in the course of the complaint of a meeting between Code A and the Investigating Officer. That is what you were talking about, was it not?
A That is right.

Code A I am going to ask you to have a look at this. I do not think there is any
H dispute or any problem about it being admitted to the Panel because it is a document

A Code A signed, compiled by the Investigating Officer, the witness has referred to it, we know what we are talking about it, so it seems to me that it is sensible that the Panel have it now.

Code A: We will admit that as exhibit D3.

B Code A: If you would read through that. When you get it, if I can say to the Panel, you will see that in handwriting what says Code A has been amended to Code A that is my handwriting, it is not on the original.

(Document was marked D3 and circulated)

A (After a pause for reading) Yes, I have read it.

C Q I will just wait for the Panel to finish. (After a pause) I am not proposing to ask you about the detail of that, because that is what Code A was saying to the investigating officer. I am not going to get locked in to what she may have found you to be like at certain times, and so on and so forth. That is not the issue are really concerned with, but the passage you were talking about – that is why I want us all to see it is the passage in the third paragraph down.

D "In describing Code A 's manner Code A felt..."

et cetera, et cetera.

"It was often easier not to disagree...."

and so on. That is the passage you were referring to. Is that right?

E A Yes, it is.

Q Then lastly, if I may, I may be able to take this through without us all having to look at more pages. If you deal with my questions and answer them, if your answer involves having to look at the document in detail, please say so.

A Right.

F Q As you know, because you would have received a copy of it, you got a report of the investigation into the allegations of harassment by Code A relating to Code A

A Yes, I did.

Q That is how the report was headed. The report reviewed what the purpose of the investigation was, the documentation which had been used in compiling the report, and set

G out the issues which had led you to make the allegation or the complaint - right?

A Yes.

Q In the report, it had spoken about the changing role of Dryad ward and the change had produced a more demanding client group and increased expectations of relatives and carers which had increased the service pressures of the ward. Is that something that you felt?

A Not really, no.

H

A Q All right. If it does not come from you, I am not concerned about it. If it is in a section of the report ---
A Only because at that time we were not full up. The beds were not all full so actually we adjust our workload.

Q If it is not your view, then I will not ask you about it. It set out what the perspective was from Code A 's point of view, and the perspective of Code A and so on, and gave
B some background information about what other people have said, which I need not trouble you with. Then the investigator, at the end of the report, made certain observations and came to a conclusion?
A That is right.

Q Would you agree that nothing was said in that report about the issue of syringe drivers or medication?
C A No. They were not mentioned.

Q You will know that because I expect you read it pretty carefully. It indicated in terms of the conclusion, which is pretty short, that "Misinterpretation, fuelled by poor communication, differences in perceptions, professional rivalry and unsubstantiated expectations seems to be the theme of the investigation rather than a calculated and malicious attempt to drive Code A from the ward. In fact, both defendants" – and that in
D these circumstances means Code A and Code A – "appear to have played quite supportive roles when asked for advice by Code A in the past." That was the conclusion reached?
A Yes it was.

Q As I say, in the circumstances I do not think it is necessary for us to have the entire part of the report. If Code A wants to put it in as a document, I will not object. I am trying
E to cover what may be the relevant parts. (To the witness) That may not have made you particularly happy, but that is what the investigation produced.
A No. It did, because they were going to actually then have liaison between myself and Code A to sort out the issues, but I decided to leave.

Q I think perhaps we can summarise it in this way. Whatever efforts were made by you, Code A or anybody else – but really it is between the two of you – you found that
F working with her during the rest of the year was something you found not appropriate, and you decided you wanted to leave?
A That is right.

Q Again, whatever the clashes were.
A Uh-hum.

G Q Then there is one final matter I need to ask you about, simply for clarification. I asked you about your having said what you said about the case of Code A , Patient H – do you remember – when I asked you about what you had said in the statement to the police about, you had no complaints about his care or the doses of medication that he received?
A Right.

H

A Q Right? I just want to try to clarify with you, if you can. Do you remember what notes – because you mention in the statement looking at notes. Do you remember what notes you had seen with regard to that patient? Had you seen the whole ---
A No. When the police came they showed me odd pages and odd portions of this. I never saw ---

B Q I just want to make it clear, using your statement, what it appears you saw when you said what you said.
A Right.

C Q Because if you did not see the whole range of notes, then you have to bear that in mind when we look at your answers. I think in relation to Code A you looked at prescriptions relating to 14 October and an "as required" prescription, with regard to paracetamol, which was never in fact given, and hyoscine. You also saw records of the 15 October, 16 October and the 17 October, showing the history of the drugs. Also the 18th. Shortly after dealing with those you said, "I would state in my experience none of the dosages of the drugs in the case of Code A were excessive". All right? That is a passage I have already put to you?
A Yes. If I said that, then I said it.

D Q But we just to have establish what it was you had a chance of looking at. All right?
A Right.

Q Then you saw Code A 's entry with regard to 14 October and it is again, I think, in that context you said, "I have no issues with Code A 's care, having read some of the notes." Can we take it that that is what you were referring to?
A It would seem so. I am sorry. It is a long time ago the police interviewed me.

E Q It is not your fault. You may have seen something else and the police did not put it in the statement?
A Yes.

Q But that is all we can go on to try and identify it?
A Yes. As I say, they showed me portions of notes and not even whole pages. I just saw pieces that they would produce, and they would be flicking back and forth, just showing me bits.

F Q We have indicated what those are ---
A Yes.

Q --- in the statement?
A Yes.

G Q And you also saw, I think, the ward controlled drugs records book?
A Yes. They did bring that.

Q They had that? Thank you. So you could check in relation ---
A Yes.

H

A Q --- to things where you had withdrawn particular medication, and I think with that patient... You made two statements about him. You had seen the entry on 14 October which you referred to in another statement. Your entry, obviously, of 16 October we have covered. It is probably covered in the rest. A plan of the 14 October, the nursing plan – various pages of that. And the other drugs that were administered, which we have not been troubling with – frusemide and trazadone, and things like that – but also Oramorph and so on. The 14 October – probably reduplicating what you said in the later statement and on 16
B October – you had seen those records. So far as you can tell at this distance in time, that appears to be what you looked at?
A Yes. If I had signed it with the police then, yes, that is what they showed me and what I read and what I said.

Code A That is all I need to ask you, thank you.

C **Code A**

Re-examined by **Code A**

Q Just in relation to that last topic first of all, in order to know whether dosages of drugs are excessive or not in global terms what would you have needed to have seen. It has been pointed out that you saw certain documentation?
D A Right.

Q What would you have liked to have seen?
A As I say, I cannot tell you now what I saw but obviously, looked at the CD book (the controlled drug book), prescription chart and the notes as to how the patient was at the time.

Q And leading up to that point or not?
E A I am sorry?

Q Leading up to that?
A Leading up to the change of the medication?

Q Yes. Exactly.
A Yes, the increase into it. Yes.
F

Q I want to go back to the grievance procedure. Do you have those documents, D1, D2 and D3 available to you still?
A Sorry, I do not know what numbers they are.

Q I am sorry. D1 is the letter dated 24 March?
A Yes, I have that here.
G

Q Then D2 was the note of the meeting held on 30 March?
A Yes.

Q Then D3 is a note of the meeting on 7 April?
A Yes, I have that.

H Q The tenor of these was that you felt you were being encouraged, really, to move on?

A A Yes, I did.

Q Why do you think you were being encouraged – if you were right about that – why do you think you were being encouraged to move on?
A I think because I questioned.

Q Questioned what?
B A I questioned the use of the syringe drivers, the use of the medication and the whole way that we dealt with patients when they came in in control of their pain, etcetera.

Q Going back to the letter of 24 March, you end with these words:

"I realize that things are going to be uncomfortable but I have reached the end of my tether and know that what is happening is not right."

C

A That is right.

Q What were you referring to there?
A I knew that once I put the complaint in I would have to stay there and that I would have to work every day and obviously ---?

D Q Why?
A --- see these people. I am sorry?

Q Sorry. Once you put a complaint in you would have to continue to work?
A I would have to continue obviously to go into my job every day.

Q Right, yes.
E A And that could make things uncomfortable because it is never pleasant when a complaint has been made.

Q No. I understand that.
A I had reached the end of my tether with it. I had had enough. I had had enough of everything there, and I did not agree with the way that patients were treated. I did not agree with the use of the syringe drivers at times.

F

Q What I was trying to explore with you is when you used the words "and know that what is happening is not right" – what were you actually referring to?
A The way I was being treated and the treatment of the patients. And I think what was so very difficult, what the gentleman asked me before lunch, is that it is so difficult in the position that I was in to come into this sort of area and to actually be presented with a mode of working that was already in place. I had come in with a new set of eyes and looking at
G things maybe different. Because I had come from a new area and was seeing how these things were working, and they just did not seem right.

Q Code A put this to you, and you agree; that prior to Dryad you had not really had a lot of palliative care experience and it was all fairly new to you. You felt that was right?
A Yes, it was.

H

Q You accepted that?
A But I had obviously dealt with patients who were dying in acute wards.

Q I understand that. So when you came to Dryad and were met with this way of working, and the increases, was that something you had come across before?
A No.

Q Was it something you were comfortable with?
A No.

Q I think it is being suggested that the issue that you ventilated over syringe drivers was irrelevant to the grievance procedure. In your mind, was it irrelevant to the grievance procedure?
A No, it was not. I think that was part of the underlying problem. There were issues between Code A and myself. I cannot say there were not because there were, but they were personality issues and I cannot deny that.

Q All right.
A And I would not attempt to.

Q And those are quite separate?
A Yes. This is a completely different issue and, as I say, we had this visit from Code A Code A who, even in hindsight, I do not feel that I could have actually said to that doctor that this is what is happening, because that was not a doctor who could actually initiate any changes. They were not working for us.

Q I was going to come back to that.
A Sorry.

Q No, not at all. I was going to come back to that and I am afraid I was going to come back to the point at which you got upset.
A Sorry about that.

Q I am hoping not to upset you again.
A No, that is all right. I am all right now.

Q People get upset for different reasons, but I wanted to try and explore with you why it was upsetting for you. What was it about that scenario, that meeting?
A It was the whole scenario... I do not want to get upset again because it makes me think about it.

Q I am sorry. That is why ---
A That is quite all right. It has been so frustrating.

Q What was frustrating?
A It was frustrating. I realised that patients change, and can change overnight. I know that. I know patients can rapidly go downhill in an hour and I am aware of that. I have been a nurse for a long, long time, but to actually come back on a shift to find a patient not responding and being on a syringe driver when the day before there was no reason, and to have my manager just dismiss it as "because", because surely anybody, even a student nurse,

A has the right to question and certainly as an Code A I felt I did. Therefore I thought, I needed to know why these patients were being put on syringe drivers.

Q Right.
A It got to the point where I used to go home. I know what you said about my mother's diaries is irrelevant but the police actually took her (sic), because it was the only way I could prove that way back I had had concerns. Obviously I did not tell her details about patients
B but I can actually tell her details about the use of the syringe drivers, and that is when she wrote it down. And the police actually came and took her diary and copied it.

Q All right. In D3, which is the note of the last meeting, there is this line in the third paragraph. It talks about you sulking, and I am not going to go into that, but if you look three lines down, you see this. Are you with me?
A Yes.
C
Q "In consequence changes to treatment routines particularly relating to opiate administration would happen on shifts that Code A was not working."

A That is right.

D Q And that accords with your evidence?
A Yes, and that is what happened.

Q You told the Panel that there were occasions when you objected to the use of syringe drivers?
A Yes, I did.

E Q And as a consequence of that they did not happen at that time?
A No. That is right.

Q And Code A has explored that with you, and he has explored the possibility with you that something might have happened to the patient to cause the syringe driver to start?
A That is right.

F Q You cannot say anything about that?
A No. That is right.

Q And that might be right?
A And that is fair comment.

Q But what was the rapidity, as it were, of the patient going on the syringe driver after
G your objection? How quickly did you find they were going on syringe drivers when the ---
A The following day was the earliest one I can remember.

(The Panel assistant approached the witness table)

Q I am sorry. This is not the right time to do that. Sorry. I will ask you that question again. Sorry – can you give us that answer again, if you please?
H A You said what was the quickest.

A

Q No, no. I know what my question was. What was your answer?
A The following day.

Code A "... was the earliest one I can remember."

B Code A Thank you very much. Thank you. You were asked about other nurses giving too much and you told Code A that you were not aware of other nurses giving too much, and I think Code A ---
A Yes.

Q --- was being excluded from that reply. Can I just ask you: at the time when Code A Code A was there, not when she was on leave but when she was there, was it any part of your role to review the administration of drugs by other nurses?
C A When Code A was there?

Q Yes.
A No.

Q You have told Code A – and again, this is my précis of what you said – when you were asked about increases, you said, "To double up seemed quite a lot and the change in
D the patient could be quite dramatic." Can you just give us an example of what you mean?
A Because by giving such a large increase to a patient, because it was not just the diamorphine that was increased, it was the midazolam as well, and it made the patient more drowsy and unresponsive.

Q You were asked about Code A and the increase. It is file J, page 174. You were being asked about the increase. I think this is the increase up to 90 mg.
E A Yes, it is.

Q You said that you would not have administered that unless the patient needed it.
A That is right.

Q Is that something about which you would normally make a note, or not?
A I should have done. If I have not, then it was an omission on my part. I should have
F made a note.

Q Page 65 is where I think we have the relevant notes in relation to 2 September. We have the notes for 1 September, which are not yours, and then we have the note for 2 September relating to that increase.
A This is Code A 's signature, I believe.

G Q Against the – ?
A The increase of the diamorphine.

Q Can you just help us about that? Why is Code A making a note about an increase that you apparently have authorised?
A I have signed the medication chart, she has signed the notes, because two trained nurses have to go and give it. So usually whoever gives it signs the treatment chart, but the
H notes, if we have both done it, either one of us could write that.

Q The last note before that occurring was:

"Incontinent of black tarry faeces on ..."

I cannot read the next word.
A I think that is "settling".

Q Then:

"Peaceful night. All care given. Syringe driver satisfactory."

Is there any indication there why the diamorphine needed to be increased?
A No, there is not.

Q We can take it that perhaps you cannot now remember why that was.
A No, I cannot.

Q Patient Code A This is file I. There is just one matter to ask you about. I think if you turn to page 174, I think it was you who started her on that dose of 80 mg.
A No. That is Code A and Code A 's signature.

Q I beg your pardon. Did you have anything to do with that initiation of the dose?
A No, I did not.

Q You can put that file away. Could you go to Code A s file, which is file G. It is the entry at page 861. You were asked about this by Code A It was you speaking to Code A on 22 September.
A Yes.

Q You were explaining what was happening with Code A
A Yes.

Q The words that you begin with are:

"Explained that a syringe driver containing diamorphine and midazolam was commenced yesterday evening for pain relief ..."

You were there the evening before, I think, were you?
A I am not sure, because I gave the Oromorph at ten to three. If I was on an early, I would have been on until 4.15 that day, or I could have been on a late. So I am actually not sure. I am sorry.

Q The syringe driver, I think we can see, did not start in fact until 11.00 p.m.
A That is right.

Q Would you have been on duty then?
A No. That would have been the night staff would have started that.

Q So the basis of your information that you were handing over to Code A was based on what?
A It would have been from what I had been handed over by the night staff at handover in the morning at 7.30.

Q Not your own information, as it were, but that which you had received from others.
A Well, about when the syringe driver was started, no. Yes. No. That must have been from handover, the way I have written it, yes.

Q Would you be reviewing the decision to start the patient on the syringe driver, or simply explaining it?
A No. I would have just explained it.

Q Finally ---
A Sorry. It reads differently when you read it a second time, does it not?

Q Is there anything else you want to say about it?
A I was thinking that I actually, the way I put it in the first place is that when I spoke to him, that was my information, but actually I think that had been told to me by the night staff.

Q That is why I asked you to clarify it.
A The night staff would hand over exactly what had happened, so I would not have any hesitation in taking their word for what had happened.

Q You can put that file away. Finally, this. You were asked by Code A after you had left Dryad, you had gone on to something called the Rembrandt Unit?
A No. I went to Jubilee House from Dryad ward, which is palliative care.

Q That was where you had the GP doctor coming in during the day.
A Yes.

Q When he first asked you about this, Code A put to you that it was very different to Dryad ward and you agreed with him, but then you seemed to disagree when you were talking about the doctors and I just want to know what your evidence is about the similarities and differences.
A The set-up with the doctors was more or less the same. We had a GP practice which would cover us from Monday to Friday and come in at lunchtime. Sometimes obviously they would be pressed for time as well and what they would do is, they would look at what needed to be done. If it was something really simple that could wait until the next day and they were busy, we could put it off to the next day, but if it was something that had to be done that day, they would do it regardless of how long it took. Then the consultant would come in weekly on a Thursday, which we did not have, a consultant weekly, at Dryad ward. That was the difference. At Jubilee we had a consultant weekly.

Q How often did you see a consultant at Dryad?
A I believe – I cannot remember if it was once a fortnight. I am actually not sure. It was not weekly.

Code A Thank you very much. That is all I ask.

Code A Thank you, Code A We have reached the point now when two things would be happening. One, you would be entitled to your break, because another hour has passed, and two, the Panel would be asking you their questions. What we have been doing prior to going into Panel questioning mode is taking a few minutes for the Panel on their own to consider what, if any, questions they wanted to ask. So what we will do now is take an open-ended break and I will say we will break now, but the Panel will remain and consider, may very well then take its own break and we will call everybody back as soon as we are able to do so. I do not think it is going to be a long time, but it may be longer than the normal 15-minute or so break. So we will break now, please, ladies and gentlemen, and would all strangers please withdraw?

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

STRANGERS HAVING BEEN READMITTED

Code A Welcome back, everyone. The Panel has used the time to focus our thoughts on the areas where we still require some assistance. I am going to turn now to Code A who is a lay member of the Panel.

Questioned by THE PANEL

Code A Good afternoon to you. It is just one question and it is with regard to this letter of grievance that you put forward. Do you have it?

A Yes, I do.

Q It may be that you feel as though you have answered this, but I just want to clarify it. It is the last paragraph:

> "I realise that things are going to be uncomfortable, but I have reached the end of my tether and know that what is happening is not right."

Is that solely relating to the relationship between yourselves or does that also mean the things that are happening on the ward with regard to the patients?

A Yes, that as well. It meant both.

Q It meant both?

A It meant both.

Q Was it just one specific aspect of what was happening to the patients, or was it a number of different aspects?

A It was the use of the diamorphine that was my big issue.

Q Solely, not anything else?

A No. On the whole, the patients on Dryad ward were really, really well taken care of.

Q It was just the ---

A Just the use of the syringe drivers that I had an issue with.

Code A That answers my question. Thank you very much.

A

Code A I am also a lay member. We have heard from you that you did have this concern, particularly about the times when you felt that the syringe driver with the diamorphine and midazolam mixes were being initiated earlier than you would have expected.
A That is right.

B Q We have understood very clearly that you have nothing against syringe drivers per se and indeed you accept that there are occasions when syringe drivers loaded with those sorts of medications may be very appropriate for a patient who has reached that stage in the terminal elements of their life when it is needed by them.
A That is right.

Q Your concern, as we understand it, is that there were times when patients appeared to C be being put on to that regime when it was not justified, when it was too early.
A That is right.

Q What I would like to do is to try to understand whether, thinking back on it now, there were any particular triggers that you noticed, any things that would happen that would tend to make it likely that this problem that you saw, the early start on syringe drivers, occurred. You were answering questions earlier about patient G. That was Code A you recall, D and there was a little initial confusion in your reading of the note when you gave your evidence first. I think the reason for that was actually made very clear, because I think you said words to the effect that you assumed that you had witnessed the poor behaviour of Code A Code A, because you would have expected, if it had happened the previous night, for the night staff to write it up.
A Yes, I would have done.

E Q When you looked at it the second time, you realised of course that it had happened the previous night, but for reasons that we do not know, the night staff did not do what you would have expected and write up what was clearly some pretty horrendous conduct on the ward. All they did was record the words:

> "Remained agitated until approximately 2030. Syringe driver commenced as requested ..."

F

And then the dosages, followed by the simple statement "Peaceful", which one might anticipate. I have two questions about that entry that you may or may not be able to help me with. The first is that there is a signature that follows it. Are you able to decipher that? Above your entry for 22 September, in the middle of the page, 21.9.98, "Remained agitated until approximately 2030." Would you recognise the signature there?
A No. I think it must be one of the night staff, but I am not sure who. I am sorry, I do G not recognise that.

Q It would have been helpful if you had known, but the chances of you knowing perhaps would not be great. Are you able to comment on the phrase "as requested"? "Syringe driver commenced as requested." Would that mean anything to you from a look at the notes?
A I am sorry, no. I have no idea. I really would not have any idea, no.

H

A Q If we are not able to ascertain who the writer was, that probably will remain a mystery for all time. But clearly this was a case in which there had been some, from a nursing point of view, shall we say some challenging behaviour on the ward.
A Yes.

Q It had been followed in short order it seems with commencement of syringe driver without what we have been told was the customary consultation with family?
B A Yes.

Q There was another occasion we have looked at, I am not going to take you to it specifically because it was not a patient that you were involved in, but there was a patient who had had a tussle, a fight, on a ward with a nurse. Within one hour of that happening, that particular patient was also on a syringe driver with the same sort of mix of diamorphine and midazolam. Again, that was prior to any discussion with family. What I am wondering is
C whether, when you were first having concerns about people in short order going onto syringe driver at a time when you felt there was nothing you had seen that would have justified it, whether you noticed any particular triggers in common; for example, did it seem to be where patients had been challenging in their behaviour or in their needs, crying out in pain all night?
A It seemed to be for pain. May I refer to another case or am I not allowed?

Q By all means?
D A There was a lady that came into us from, I believe she came from Haslar, who was actually in one of our single rooms. I cannot tell you her name it was so long ago. She had had a fractured hip and she was put on to Oramorph and was becoming very, very sleepy. Code A the consultant, saw her and he had this lady up and walking and he took her off of it all. She ended up getting better and actually being discharged. That was a case where this lady was in bed and drowsy and it was reviewed and she actually, as I say, progressed and became better. It was that sort of incident. I am not saying Oramorph does not have its
E place, but having seen what I had seen, I could envisage this lady having gone on and maybe not going home.

Q Of course the areas that we are looking into are involving patients who went on to the syringe driver and did not go home. Whilst it was heartening to hear that there were patients who were coming onto the ward and making great recoveries, what I am interested to know is whether you discerned any particular pattern, any particular triggers that would put patients
F on to this end of life regime?
A I think it was the pain triggers. It seemed to be mostly pain and, instead of using the analgesic ladder properly, steps were missed.

Q If I understand you correctly, you are saying that, principally, it was if somebody was in pain your concern was that they would, because of the pain, be put too fast on to the syringe drivers?
G A Yes. I cannot truthfully ever say that I saw anybody put on a syringe driver because of behaviour.

Q That is very encouraging to hear, thank you. It follows also, does it, that it was not purely random. You say that you were not expecting people to go on and yet suddenly you would come back the day after and find that somebody was on the driver, that was not random then?
H A No.

Q You are saying it would always have been because of pain?
A It seemed to have been but, from my point of view, that is why they went on. But, on the days, as I say, when I would come back and ask why someone had been put on a driver, I never ever got a satisfactory answer ever, so I cannot speak on why other people rationalised what they did – sorry, is that what ---

Q I think you did, but I want to focus on the pain issue. If I understand you correctly, you are telling me that on every occasion when you were surprised to find somebody had been put on the syringe driver, in your view earlier, that patient had been exhibiting pain?
A No, I never got an answer for that. The ones that I know that I was there or present, or that I was not surprised at, I knew had pain was fine. But the ones that I was surprised at, I had never been handed over that they had excessive pain, I was never given a reason why ---

Q I had misunderstood you. I thought you were saying that whenever anyone ended up on the syringe driver, it had always been because they were in pain?
A No.

Q I understand that there will have been many occasions when you saw people ending up on syringe driver and you were not surprised, and you are telling us, if I understand you correctly, that the common feature in those cases where you were not surprised is because the patient had been in pain?
A Yes.

Q I am asking you specifically about the occasions when you were surprised. Was there anything that you saw?
A No, because, as I say, I would go off duty one day and patients would be on analgesia – not morphine, but just analgesia, ordinary analgesia – and the next day they would be on a syringe driver and that is when I would be surprised because I did not see the rationale for it and I was never given any.

Q On each of the occasions when you were surprised, you were surprised because, on the papers and on your own knowledge and experience of that patient, there was no apparent reason for them to be put on to it?
A That is right.

Q When you did ask, you did not get answers so you still do not know?
A No.

Code A Thank you, that is most helpful. Code A do you have anything arising out of the questions from the Panel?

Further cross-examined by Code A

Code A I do in relation to two matters. On that very last point, when you were dealing with some questions asked by Code A you said, in those cases when you would come back the following day and had been surprised to find that the patient was on a syringe driver, they had been on analgesia the day before.
A Yes.

A Q But not a syringe driver?
A No.

Code A So in those cases ---

Code A Sorry, I thought the answer was not on opiates.

B Code A No, that was not what she said and that is what I am asking. You said "on analgesia". Does it follow that in those cases the patients might well have been on Oramorph before the syringe driver was put up?
A No.

Q Not?
A No.

C

Q Are you saying that in every instance?
A No, I am not saying in every instance.

Q Maybe in some instances, maybe not?
A Yes.

D Q But they were on an analgesia of some kind?
A Yes.

Q Back to your letter of complaint which you were asked about?
A Yes.

Q You said in answer to a member of the Panel, Code A that the last paragraph, and
E indeed the last words of the paragraph, meant not just the problem with being harassed at work, but also the use of syringe drivers?
A That is right.

Q To anybody reading that letter and, in particular Code A no doubt, that would not be clear, would it, in any way at all?
A No, this was a very general letter that Code A my Union representative,
F helped me to write because I went to her with my concerns and she advised me to make a grievance, which I did, and she sat down with me and helped me to compose this letter.

Q Sorry, can we repeat the names to make sure ---
A Code A she is my RCN rep. She sat down with me and helped me to compose this letter.

G Q She did not tell you to leave out syringe drivers, did she?
A This was a very informal letter to put the grievance in.

Q Forgive me, what you say in the letter – look at it again – just over halfway down, you do give the reasons to Code A do you not?
A Yes.

H Q

A "I am constantly being harassed by my line manager Code A to consider moving to QAH as an Code A

So you are making clear your complaint about her?
A Yes.

Q
B "Recently I have received similar overtures from Code A '

So it is the same complaint about Code A, is it not?
A Yes.

Q
C "It is obvious to anyone listening that I am not wanted on Dryad Ward and this is causing me great distress and stress. I have no wish at the moment to leave Dryad under this cloud, and want the status quo to apply."

What I am asking you to clarify is, why not put in one extra sentence, "I am also being harassed...", or whatever the right word was, "...because I do not agree with what is happening with syringe drivers", if that was really part of your complaint?
A It was and two people knew about what was going one. One was Code A
D the hospital manager, and when I went down and saw Code A about this complaint, she said to me that it was already in hand and that a complaint was ongoing but I obviously was not privy to it and I had no knowledge of what it was. When she helped me write this, she did not advise me to put it in about the syringe drivers, but I had expressed to her my concern about them.

Q I am sorry, it is your letter?
E A Yes, I know, but I still had my RCN representative to help me.

Q If you let me finish. It is your letter and, of course you listen to advice, but it would just have been one sentence, would it not, "I am also concerned about the use of syringe drivers"?
A It would have been, but I felt that I had been to my hospital manager who knew what the issues were, my RCN rep knew what the issues were. Nothing had been resolved or done.
F I was unhappy working under those conditions and at the time the only thing I could see was to leave.

Q So, "I know what is happening" is not right?
A The way I was being treated and what was happening on the ward.

Q Somehow Code A is meant to read that in, is she?
G A No, that would have been what I would have explained later, but it never came up. I did not bring it up later.

Q You got your chance, of course, to say what it was that concerned you when you met with Code A ?
A Yes, I did.

H

Q This is the other document you looked at, six or so days after your letter. You were trying to get across to Code A what the nature of your complaint and concerns were?

A I was, but the thing is, the reason that... It was very, very hard for me, as a nurse, to actually sit and at the time it was very, very difficult to actually criticise the doctor's practice when... I mean somebody had already mentioned here today that I had not been in palliative care before and sometimes I used to go home and I used to think to myself, "Is it me, am I wrong, am I challenging the doctor, am I going to look silly when I challenge a doctor", because they are going to look at me and say, "You are not a doctor, you are only a nurse". In my heart of hearts, as an experienced nurse, I still knew that what was going on was not right. My issue was, in the end, that I did feel that Code A did not want me there anymore, I did feel that Code A would have been happy if I left and, consequently, I did leave.

Q You did not have any trouble making a complaint about the doctor?

A No, I did not.

Q You did not have any trouble saying what you felt about Code A to Code A Code A

A No, I did not, but I had already raised the issue of the syringe drivers with my Code A Code A

Q We appreciate that, I think we have the point. What I am asking you about is, why not say it in the meeting you had with Code A to demonstrate that your concerns were justified, that you had a legitimate ground for complaint?

A I just did not.

Q The reason you did not, I suggest, is because what you were really concerned about is what was in the notice of meeting, not the syringe drivers?

A You are actually wrong because, to be fair, this was so bad I was actually willing to go down to an Code A from an Code A and take a cut in money because I could not live with it any more.

Code A That is all I ask, thank you.

Code A

Further re-examined by Code A

Code A I want to come back to Code A s questions very briefly. There were occasions when you were not surprised somebody was put on a syringe driver?

A That is right.

Q In those cases the trigger was always pain?

A Yes.

Q There were occasions when you came back and found that somebody was on a syringe driver and you found it surprising?

A Yes.

Q Are you saying that in some of those cases, the patient had been on opiate analgesia?
A No, some of them had not.

Q And some had not?
A That is right, yes.

Code A That is all I ask.

Code A I am pleased to be able to tell you that after a whole day of giving evidence you have come to the end of that testimony. It is always stressful and difficult for witnesses coming before us at the best of times. You have had to come before us and endure a whole day of questioning from a variety of different people. I want you to understand we really do know just how very difficult that is and that we really do appreciate very greatly every witness who is willing to come and assist us in our enquiries. It is only by hearing from witnesses such as you that we are able to build up a clear and accurate picture. For your assistance in that regard, we are most grateful and you have our gratitude and thanks. You are now free to leave.

(The witness withdrew)

Code A If the Panel can bear it, we have some evidence to read. I do not want to leave it too long and get too far behind. I wonder if it would be convenient now to go back in our list and to begin some of the reading and see where we get to. The statements we have to read are those of Code A We propose to start that process now and perhaps you can give an indication when you have had enough.

Code A I would tell you that the Panel did not take a break when you were absent, it was a full discussion. I am not going to propose we break now, but to ask you to bear in mind that they will all be fairly tired at this stage.

Code A Could we deal with two?

Code A The important point is that we should still be fresh and receptive when we hear this evidence.

Code A Particularly when hearing statements read because it is harder to concentrate.

Code A I think if we do two, that should be it.

Code A I will ask Code A to deal with those two.

Code A These are statements that are made by witnesses who are unavailable now to give evidence. They are read on the basis that the defence accepts that, because they are unavailable they could be read, but it is not agreed evidence as such.

The first witness to be read is Code A, a nurse. She made a statement dated 8 February 2006. This statement deals, in part, with Code A our Patient J. It may be that it is sensible to have the files at the ready to deal with her entries in relation to that. The matter she deals with is of a general nature. She says:

STATEMENT OF Code A Read

"I am a Registered General Nurse. I am current a Code A

Code A

From November 1996 until December 1999 I was employed as a Code A working night shift on Daedalus Ward at the Gosport War Memorial Hospital. On occasions I was required to work on other wards including Dryad.

My responsibilities as a Code A included overall charge of the ward which consisted of 24 beds. The ward was a mixture of continuing care for elderly patients and slow stream stroke rehabilitation for elderly patients.

I supervised two health care support workers. My responsibilities included administering drugs prescribed to patients.

I also looked after the patient's general well being during my shift.

Night shift commenced at 2015 and finished at approximately 0745.

My experience in the use of Syringe Drivers began whilst working on the newborn unit, neonatal, at St Marys Hospital.

At that stage between 1992 and 1996 I received training from senior colleagues in the use of Syringe Drivers. The Syringe Drivers were used for delivering intravenous drugs to newborn babies.

I received training for competence in the administration of intravenous drugs and additives on the 28/1/1993 (28/01/1993)."

I should point out, she later said something slightly inconsistent with that but it is what features in the statement.

"When I commenced working at Daedalus ward in November 1996 I was given supervision from senior colleagues in the administration of drugs delivered subcutaneously via a Syringe Driver to patients requiring palliative or terminal care.

From December 1998 until May 2001 I worked as an Code A on Dryad ward which was on day shifts. I can confirm that I was on duty as a Code A Code A for night duty in 1999 on Dryad Ward.

I worked part time 30 hours per week at that time and my tour of duty would have been between 0730 and 1300 and between 1415 and 2030.

A My understanding of the named nurse is that they would be the person who has the overall care of the patient when on duty and would be the person to whom the patient's family could confer.

My responsibilities on the ward could ... be that I was in charge of the ward and the bleep holder for the hospital, that I would supervise Health Care Support Workers and Students, but my overall responsibility was the care of the patients.

B I had not received training or certification in the administration of I/V drugs.

I have heard of the term the 'Wessex Procedures', the Analgesic Ladder. The term TLC, tender loving care, would indicate that a patient was coming to the end of their days. We would make them as comfortable and pain free as possible.

C The term 'I am happy for staff to verify death' is a term I am familiar with at GWMH. This would mean that two members of staff would be available to verify death of a patient, when there was no Dr's on site.

Ward rounds were done most days at about 0800 hrs and Code A would see any patient to whom it was indicated there was a problem.

D I have been asked to detail my involvement in the care and treatment of the patient Code A I do recall this patient due to his size and terrible bed sores on his buttocks. I believe that he had been stuck on the toilet. From reference to his medical notes ... I can state that on page 65 of those notes, dated 2/9/99..."

and it is the entry for the second of the ninth 1999 –

E "..... I have written, Diamorphine increased to 90 mgs/24hrs Midazolam 80mgs. I have signed that entry.

I can cross refer this to an entry ... of the Dryad Ward Controlled Drugs Record Book ... where I have witnessed Code A administer 90mgs of Diamorphine [to] Code A

F I can cross refer this..."

and this is a note at page 174, the entries for diamorphine and midazolam at the bottom of the page –

"... to page 174 of the notes dated 2/2/99 at 1840 hrs which indicates that 90 mgs of Diamorphine and 80 mgs of Midazolam were administered to Code A by
G Code A and initialled by her.

These entries were written up by Code A In relation to the Diamorphine, this indicates that the dose was variable between 40 – 200 mgs ... over 24 hrs. The dose appears to have increased from 40 mgs to 60 mgs to 90 mgs, which is quite a step up.

In relation to the Midazolam, the entry indicates that the dose was variable between
H 20 and 80 mgs ... over 24 hours. This dose appears to have increased from 20 mgs to

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A

40 mgs to 60 mgs to 80 mgs over the same period of time as the increase in Diamorphine.

The entry between 26/8/99 and 2/9/99 on page 174 of 40 mgs of both Diamorphine and Midazolam administered at 1545 on what appears to be the 1st is marked 'Dose Discarded' and initialled by Code A

B

This medication was administered not by me but by Code A The decision to increase the medication would have been taken by a Dr, either by way of a verbal message or a phone call."

Sir, the next sentence is in poor English, but the sense is probably clear. I apologise; this is how it is written.

C

"I can't imagine that an increase in medication, especially the Diamorphine increase from 60-90 mgs, without authority of a Dr, and would depend on the patient's condition.

All nurses do is administer drugs which are prescribed by a Doctor.

I do not however see on the notes where this decision was recorded."

D

That is the end of the statement of Code A

Can I move on, please, to a statement by Code A, also a nurse.

Code A May I just say in relation to this lady, that she died a number of years ago. The rules of evidence are such that the prosecution could apply to read this statement. Sadly, it will be obvious she cannot be called but we have allowed this statement to be read because of that reason.

E

As has been made clear, we certainly do not agree the contents.

Code A Understood. Thank you. The Legal Assessor is asking for clarification there. You are referring to the lady who is about to be read? Nurse Code A

F

Code A Yes.

Code A Thank you.

Code A Sir, this will take about ten to fifteen minutes, if that is acceptable to the Panel. (The Panel agreed) Thank you. I am very grateful.

G

The patient that will be referred to in due course is Code A if anyone wanted to have that file out.

The first statement made by Code A is dated 12 December 2002, her occupation being retired nurse. She said this:

H

STATEMENT OF Code A , Read

"In 1973 I commenced work at the Gosport War Memorial Hospital ...

I worked at the Redcliffe Annexe which was a unit based approximately half a mile from the main hospital site. The Redcliffe Annexe was a unit of about 17 beds used for the elderly patients, who were coming to the end of their lives. I worked happily at the unit and felt that we treated the patients well and that we made them comfortable as they approached the end of their life. This was based on a 'tender loving care' type of treatment.

However this all changed when Code A took over as the sister for the unit in the early nineties. It seemed that she had a vendetta against people she did not like. She made it obvious that she did not like the night staff and she targeted me in particular.

I remember on one occasion that Code A , the senior nurse in charge of the unit, visited us early one morning stating the Code A had complained about our work.

However, Code A congratulated us because she could not find any problems. The other problems with Code A was that she encouraged the use of syringe drivers.

A syringe driver is a syringe attached to the patient that injects them over a 24 hour period to give constant pain relief.

Prior to Code A coming to the unit we rarely used the syringe drivers. However when she arrived their use escalated, although this was at the time when they were initially introduced. I felt this was wrong, because it seemed that most patients were going on drivers even when they were not in pain and their use was a matter of course rather than need. I felt that in the right circumstances the syringe drivers were the correct method to ease pain. But I did not agree with their 'blanket' use on patients.

The other problem with the syringe drivers was the fact that when they were first introduced we did not receive any formal training on their usage.

Another problem was the fact that on nights there was only one trained nurse and two untrained healthcare workers. Which meant that when I was on duty at night, I was the only trained nurse in the unit.

There was no medical care at night therefore if there was any problems with the patients and the drivers, I had to contact the main hospital unit.

The decision to place patients on the syringe drivers was entirely down the doctor responsible for the ward. This was Code A She was the unit doctor for several years.

I got on well with Code A and felt she was a competent doctor.

However what usually happened was that Code A would 'sign up' that a patient was suitable to be placed on a syringe driver then Code A or one of the duty staff

would decide if and when it was necessary to place the patient on it. This meant that if the drivers were required in Code A 's opinion, the authority was already signed.

Eventually I spoke to my colleagues at the unit about my concerns over the drivers. I remember we had a meeting and it seemed that they shared my concerns. However when I complained to the management they did not support me because they were frightened of losing their jobs.

It was not until Code A another nurse, became involved that I got any real support. Though I did approach Code A who was based at the main hospital building and she was also supportive.

Finally I contacted my union rep, Code A who wrote to Code A the general manager for the nursing staff and conveyed my concerns.

Various meetings between staff and management were arranged but these were mainly aimed at pacifying our fears and make us feel that something was being done. We also had a meeting with the 'pain control people' in order to train us in the use of the syringe drivers.

I remember at one meeting Code A stated that she felt we were accusing her of euthanasia. Despite these meetings and my protestations the use of syringe drivers continued to increase.

I cannot remember the names of any patients that I felt suffered or died because of the syringe drivers.

Another problem with the drivers that continued after the meetings was although the correct dosage of say Diamorphine was given to them, the dosage would automatically increase once they got used to it. This would also upset me a great deal.

Eventually I gave up complaining despite the fact I was not happy with what was occurring.

After a few years we moved to the new hospital building and we worked in different wards. Until after sometime we were once again 'ward based' and I ended up on Daedalus Ward.

In September 2002 I left the nursing profession after being on sick leave for a year with stress brought about by the problems I was having at the hospital.

A few weeks ago ..."

bearing in mind this is her statement from 2002 –

"I became aware that there was an enquiry into work procedures at the hospital. Therefore I sent Code A copies of paperwork I had saved from the 1991 episode. This consisted of letters, reports and minutes of meetings."

A Sir, a selection of the paperwork relating to that of course is within our file number 1. We have looked at it already a little bit, and I am sure there will be further reference.

> "I would like to add that I worked on nights at the Redcliffe Annexe for ten years before someone died on nights.
>
> However once Code A arrived it became a regular occurrence."

B That is the first statement by Code A She also made a statement relating more particularly to Code A dated 6 June 2000. She said this:

> "I am employed by Portsmouth Health Care Trust at Gosport War Memorial as a Staff Nurse."

C This was before she had resigned.

> "I have worked as a Staff Nurse at the War Memorial since 1972. I work mainly at Daedalus Ward on night duty for about the last three years, covering August 1998.
>
> The ward is mainly occupied by elderly patients. The ward is visited daily by a General Practitioner responsible for the treatment of the patients. The GP will
> D prescribe drugs and treatment which will be administered by the Staff Nurses on the ward.
>
> In August 1998, the GP in question was Code A A consultant would visit the ward once a week. This was Code A
>
> Code A is also on call for any emergency cases. On other occasions when Code A
> E Code A was not only duty, a GP would be contacted via a Healthcall system based at Cosham.
>
> The patient capacity at Daedalus is twenty four.
>
> I work a permanent night duty at Daedalus Ward which would consist of 8.15 pm (2015) to 7.45am (0745). I work mainly Friday and Saturday nights.
> F
> In relation to the inquiry regarding Code A I was at work on Thursday 20th August 1998 (20/08/1998) and Friday 21st August 1998 (21/08/1998)."

Sir, just referring to the chronology for a moment, it was on the Code A Code A

> G "On the ward with me on 20th August 1998 (20/08/1998) was Code A Code A Code A These three were on night duty with me on Friday 21st August 1998 (21/08/98).
>
> When I started work at 8.15 pm (2015) on Thursday 20th August 1998 (20/08/1998) I was made aware that Code A was on the ward. I do not recall receiving any
> H specific instructions regarding Code A care or treatment. I do not remember

A who gave me the handover. I was aware at this time that Code A was on a syringe driver. The practice of using a Syringe Driver subcutaneously at the hospital has been in use for about ten to twelve years.

The syringe driver is commonly used at the hospital in order to relieve a lot of pain or discomfort. The driver is able to provide a constant level of pain relief as opposed to oral pain killers which wear off after a period of time causing the patient discomfort
B prior to the next administration of pain killers.

In relation to the drugs administered by a Syringe Driver, in August 1998, Code A as the GP responsible for the ward, would have completed the prescriptions. This was backed up by a weekly ward visit by Code A who would assess the treatment given to the patients.

C The syringe drivers are used on all wards at the hospital to the best of my knowledge.

The care and treatment of Code A would have been part of my responsibilities overnight. Code A was in overall charge of the ward and the hospital on 20th August 1998 (20/08/1998) and 21st August 1998 (21/08/1998). I was made aware, I believe by Code A another Staff Nurse, that Code A had had a fall. I cannot remember if Code A told me anymore about the incident. I also
D remember that Code A had been in the ward previously before returning to Haslar and then returning to Daedalus ward.

Code A was present with her on Thursday 20th August 1998 ... to Friday 21st August 1998. I spoke to her and learnt that she had previously worked in a nursing capacity. The Code A had concerns over the transport of Code A from
E Haslar Hospital to the War Memorial.

I do not recall administering any drugs to Code A I would have checked her treatment card to ensure any drugs prescribed were to be administered however it would be unusual to administer drugs overnight.

I have been shown a prescription record for Code A Having looked at this record I can state that I did not administer any drugs through the syringe driver or
F otherwise to Code A I have looked at the record and noted that the syringe driver was loaded at 11.15 a.m. on Thursday 20th August 1998. The driver should last for 24 hours meaning that the night duty would not normally be expected to reload the driver.

I have noted the drugs that were administered to Code A .. were as follows

G Diamorphine, Haloperidol, Hyoscine and Midazolam. My perception of their effects are as follows

Diamorphine is for pain relief. Haloperidol quietens the patient down if they are agitated or jittery. Hyoscine stops fluid building up on the chest. Midazolam also quietens the patient down. Midazolam is not a strong drug.

H

Code A may have been taken off Oramorph and put on to Diamorphine via syringe driver as the Oramorph was not holding the pain. The syringe driver would ensure the pain relief was constant.

I do not recall giving Code A any fluids either by mouth or subcutaneously. Code A would not have been given fluids by mouth due to the fact that Code A Code A was not conscious. She therefore would have choked if anyone had tried to force fluids or food into her mouth.

Code A was not given fluids subcutaneously. I recall that there was nothing to alarm me over Code A condition. I did not receive any instruction to administer or not to administer any fluids to Code A

I was not concerned about the drugs Code A was being administered. I could not comment on what effect the drugs were having on Code A as I had not seen her prior to the drugs being administered. I did not speak to a doctor regarding her drugs dosage nor did I alter the card of drugs given to Code A I checked regularly on [her] and she appeared comfortable. The training received for the driver was on the ward with an instruction booklet in the treatment room. Without having at Code A case notes I believe [she] died at about Code A Code A There was no attempt to resuscitate ... I was able to pronounce death as her death was expected.

At that time both Code A were present. I recorded death pronounced on the case notes and the nursing notes.

I would add that the other reason why a patient may not be able to take Oramorph is if they are unable to swallow. In this case the patient may be transferred to a syringe driver."

Sir, Code A was also interviewed by the police and there are a very limited number of further extracts that, in conjunction with the defence, we have agreed should be read. I will therefore just read these extracts from an interview conducted on 19 June 2000. She was asked by an officer about Code A

Code A

Would she actually visit every patient daily or would it be more of speaking to the staff?

No, she would have gone into the office and speak to whoever was in charge at the time and depending what she, what messages were passed on, she would go and see the patients they wanted her to.

Right so if there was a specific problem with a patient she would visit but if there was change to a patient, there were no concerns then she wouldn't necessarily do so?

It would take her a long time.