**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Monday 8 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 ONE)

File Reference 00121031
Home Location IM Manchester
Owner Location Fitness To Practise
Subject Conduct
Start Date 08/06/2009
Volume
Date Created 08/06/2009
00167673

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)

GM1 00167673

# INDEX

Code A Good morning everybody. Before we begin a short matter of housekeeping, emergency evacuation procedures for this building.

(Emergency evacuations procedures read)

This is a Fitness to Practise Panel inquiring into the case of Code A is present and is represented by Code A and Code A counsel, instructed by the Medical Defence Union. I am not going to ask the doctor to stand while the allegation is read but as we do have members of the public and press here today; so I wonder, doctor, would you mind briefly standing so that everybody can see that it is you. Thank you very much. That is sufficient for now.

Code A, counsel, and Code A, counsel, instructed by Field Fisher Waterhouse represent the General Medical Council.

Before we hear the allegation, are there preliminary matters that need to be raised? Code A

Code A Sir, there are two matters to raise. The first is in relation to the heads of charge and your Code A has just pointed out two typographical errors, and may I draw your attention to them and apply to amend. If you go to page 6 of the charges on the yellow sheets which you have, and if you could go to head of charge 7(c), you will see that it is stated:

> "Your actions in prescribing the drugs described in paragraphs 7(a)(ii) and/or (iii) were,
>
> (i) inappropriate,
>
> (ii) potentially hazardous."

Then sitting rather on its own:

> "Not in the best interests of Patient F."

That should be: (iii) not in the best interests of Patient F.

The same fault has occurred on page 8 in head of charge 9(d), it reads:

> "(i) inappropriate.
>
> (ii) potentially hazardous.
>
> [and then] not in the best interests of the Patient H."

That should be: (iii) not in the best interests of Patient H.

May I apologise for those errors. I have read these charges countless times and I have missed that on each occasion.

You have the power to amend of course under the rules under which this Panel is hearing this case, rule 24(4), you are entitled to allow an amendment provided you are satisfied no

injustice would be caused and I do not think there is any objection to these amendments.

Code A

Code A Sir, in fact, I think there are different versions of the document. The one that I have, sent to us on 5 May, has the amendments which my learned friend is seeking to make. It sounds to me as if there is an earlier version which may have reached the Panel. There is no need to amend; if there was, I would have no objection but I think what my learned friend has just mentioned appears on the notice of hearing that I have.

Code A I am grateful for that indication but I am a little concerned that there is more than one version in circulation. Certainly the agenda that I have does not have those amendments already made, and I am checking with the members of the Panel, and they too have what appears to be an older version.

Code A I think I know what has happened. We will have provided Code A and his team with our last draft. That is then transcribed by the GMC. I suspect that the error has crept in at that transcription stage. Obviously it is right Code A and his team should have a copy of the yellow version. Apart from that – they have a copy of the yellow version.

Code A May I take it then that we are all sure that there will be no other discrepancies.

Code A I assume Code A who is the solicitor representing Code A has a copy of the yellow version and I am sure that he will point out if there are any errors.

Code A Very well.

Code A With that application, sir, there is one other matter before the charges are read but perhaps I can ask you to decide on that.

Code A My advice is that if Code A does not take the point, the Panel really can be satisfied that no injustice is caused by the amendment.

Code A We are perfectly happy, should it be necessary for the amendment to be made or amendments to be made, for them to be made, but if in fact the later edition is the governing one, then of course, as Code A pointed out, either way we are now working as it were from the same hymn sheet.

Code A The next matter is in relation to one of the witnesses who the GMC propose to call in due course in relation to a patient who at the moment is described on the charges as Patient H but I am going to deal with anonymity in a moment. We are not asking for anonymity in this case. We will give you a schedule of all the real patient names and we will be referring to patients by their names but for the purposes of administration and marking up files and the like, we have used Patient A through L.

This, sir, is a witness in relation to Code A who is Patient H, who is Code A He would like to be present during the reading of the charges. He accepts that he must leave before any evidence is given but he has a particular wish to be here when the charges are read.

That is a slightly unusual request. You will know that under rule 50(5), the rules provide as follows:

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

Then the rules go on in a way that is not, I think, relevant. So you would have to give leave not for him to be present as it were but for him to give evidence in due course knowing that he had been present during the reading of the charges. The purpose of that rule, I venture, is of course to avoid witnesses hearing the evidence of other witnesses, unless they are experts, and thus tailoring their evidence in accordance with the evidence that they have heard.

The charges of course are handed, I think, in fact to the press, they are read out in front of the press, they are published in the newspapers, anybody can read what they are, and you may think that although it is an unusual request there is no fundamental reason why he should not be allowed to be present during that part of the proceedings, provided he is excluded thereafter. I make the request essentially on his behalf.

Code A ?

Code A Sir, obviously the thing that one concentrates on is the practicality of the matter. I take my learned friend's point about being difficult to see there could be any fundamental objection. I also bear in mind that this particular gentleman has been present during a large part of various inquest proceedings that took place earlier on this year, involving not all the patients concerning this hearing but a number of them. I think the only matter I should properly raise on behalf of Code A is why. I think we would be comfortable if we knew what the reason was that this gentleman needs to be here in this room listening to the charges, I am not clear why.

Code A Are you able to assist with that, Code A ?

Code A No, I am not. I gather he wants to see if there is any reaction from Code A to the charges being read and he has not heard the charges before. They have not been provided to him because as a witness he is not provided with them in advance. He would obviously like to know what they are, I suppose.

Code A Is that sufficient for you, Code A or would you wish us to make enquiry?

Code A It just makes everything seem slightly more odd; but, sir, quite frankly, I do not want to delay the proceedings with some kind of inquisition. If he needs to be present and if the Panel think in the circumstances it is appropriate, then I am not going to pursue an objection, although the reason seems to me a strange one. As I understand it, the application is simply for him to be present during the reading of the charges, not during the opening or anything like that. That is all I would say.

Code A Yes, I think it is the reading of the charges and any admissions that might be made.

Code A You have just enlarged it slightly, Code A

Code A Yes, I have just been instructed to that effect.

Code A Given that enlargement, Code A does that make any difference to you?

B Code A That does not trouble me in the circumstances. Thank you.

Code A

Code A Yes. Thank you, Code A

You heard the reasons given for the GMC's application and the basis of the application. C There is no suggestion of course that the witness should listen to the evidence, just to the charges and to any admissions which are made. The criminal law here does not give much assistance. It says this at paragraph 8-22 of Archbold:

> "In practice, witnesses remain out of court until called to give their evidence, so that each witness may be examined out of the hearing of the other witnesses on the same side who are to be examined after him. But there is no rule of law to this effect."

D It goes on to point out this, experts, for example, are permitted to be present in court.

As you have heard, the rule applicable in this case does offer you assistance:

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

So the general principle is that no one listens to any part of the proceedings, including the reading of the charge and any admissions, made before he gives evidence, unless the Committee gives leave.

F How is that discretion to be exercised? There is no explicit guidance within rule 50(5) but rule 50(2), on a different point of course, does make reference to the Committee having a discretion in a different area if it is satisfied that the interests of justice will not thereby be prejudiced and that might give the Panel today some guidance. You might find it helpful to apply that test.

I advise in coming to your decision, you weigh up the following. Firstly the general rule is G that the witness will be excluded. That rule, you may think, is generally adhered to. There should be, in your view, a good reason for departing from that general rule and you should consider in this case whether there is a good reason. Secondly, the rationale of the rule no doubt is it may affect the evidence of a witness and any other witness to whom he speaks if that witness hears an earlier part of the case. Here of course it is not suggested the witness will listen to any evidence but nonetheless might it enable a witness or somebody to whom he could later speak to tailor or differently emphasise their evidence later on? Might departing H from the general rule cause you problems in assessing the reliability of a witness later on?

You must carefully consider whether that might be the case here.

Bear in mind too that if all the circumstances you do permit a particular witness to listen to the charges being read you would, I would advise, have to tell that witness not to discuss with anyone else what he has heard because the permission will only have been given in respect of that particular witness. You would then have one witness of course who has knowledge of the case which other witnesses do not. You must also consider whether that is in the interests of justice.

I emphasis, it is a matter for you. I express no view. You may wish to consider this matter in camera.

Code A Are there any observations on the advice just proffered?

Code A : No, only this, that I do not think the Code A has mentioned that the words in brackets, "other than a party to the proceedings", do of course allow for circumstances where a complainant would be a party to the proceedings, would be giving evidence and would be entitled to be in fact in for the first part of the case in any event. So there are circumstances allowed for where witnesses who are not experts are in fact allowed to be in the hearing.

Code A Members of the Panel, do you wish to go into camera to discuss this? Yes, very well. Then we will go into camera, which means, ladies and gentlemen, 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.

DECISION

Code A The Panel have received an application from Code A to in effect allow a scheduled witness to be in the hearing room to hear the reading of the allegation and also to hear any response to that allegation in terms of admissions, which might or might not be made. Technically, of course, this is a public hearing and anybody is entitled to come in to that part of the proceedings or indeed any part of the proceedings other than when we are in camera. However, our rules do indicate that a person who has been present during earlier parts of the proceedings will need the permission of the Panel to give evidence at a later stage and the reason for that is clear – we need to avoid any possibility that a person's evidence is going to be affected by what they might hear before they give evidence in the Panel room, and we need to ensure that the interests of justice will not be prejudiced by such an action.

Very helpfully Code A whilst observing that it is a somewhat unusual request, has not in the final analysis objected to it. I have to say that it is a matter that did give the Panel some disquiet and did result in some fairly strenuous discussion. But at the end of the day we have taken the view that this is a public hearing; that any member of the public is entitled to come in and hear these proceedings; that what is anticipated that this potential witness would

hear is something that will become immediately a matter of public record. There are members of the press here today and one can anticipate that any person, whether they are going to be a witness or not, would without a great deal of diligence be able to discover what the allegation was and indeed whether any admissions were made and, if so, what they were.

So for those reasons we have taken the view that staying only for those parts of the proceedings would not affect the evidence of a potential witness and we are satisfied that the interests of justice will not be prejudiced by allowing that to happen, subject only to the point that our Code A made, that we should warn the individual concerned that he should not discuss with any persons what he has seen and heard during the currency of these proceedings. So if he could be brought in, Code A, we will give him that warning and then you can continue.

Code A: Somebody has just gone to fetch him. Could I say this? I was going to say this but perhaps it would come better from you, Code A, that there are a number of members of the public here and there are obviously interested parties and no doubt relatives of witnesses who will be giving evidence and it may be worth stating – although it may be obvious – that it is terribly important that those who are present during the course of the hearing do not reveal to witnesses or potential witnesses what is going on in the hearing. There is a good reason for their exclusion and I would respectfully submit that that warning ought to be given generally – not just to Code A but so that the members of the public are aware that it could cause difficulty later on in the proceedings if that were to happen.

I think that is a very pertinent observation, Code A, thank you. Is Code A in the room now?

Code A: Yes, I am.

Code A you will have gathered that your request has been acceded to and you will probably have heard the words just spoken by Code A and I am going to paraphrase them for your benefit and for the benefit of all present. Whilst these are open proceedings to the public and quite rightly so, we nevertheless have to balance that transparency and openness with the fact that it is most undesirable that persons who are going to come before us at later stages in these proceedings to give evidence for us, that those persons should know anything about what has transpired in this room before the beginning of their evidence. So may I ask all of you – members of the public and those of you who are interested parties – please do not discuss what has been said here today and indeed on subsequent days with anybody whom you know is waiting to give evidence? That really is most important. Code A does that fit the bill?

Code A: Yes, thank you very much indeed.

Code A any observations before we move on?

Code A: None, thank you.

Code A: We will now have the reading of the allegation. As I indicated previously, doctor, you do not need to stand for this; you have identified yourself to the gathering.

A

# CHARGES

Code A
Code A BM BCh 1972 Oxford University: The Panel will inquire into the following allegation against

That being registered under the Medical Act 1983, as amended,

B

1. At all material times you were a medical practitioner working as a Code A Code A in elderly medicine at the Gosport War Memorial Hospital ("GWMH"), Hampshire;

2. (a) (i) Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care,

C

(ii) between 5 and 10 January 1996 you prescribed Oramorphine 5mg 5 times daily, as well as diamorphine with a dose range of 40 - 80 mg over a twenty four hour period to be administered subcutaneously ("SC") on a continuing daily basis,

(iii) on 11 January 1996 you prescribed diamorphine with a dose range of 80 - 120 mg and midazolam with a range of

D

40 - 80 mg to be administered SC over a twenty four hour period,

(iv) on 15 January 1996 a syringe driver was commenced at your direction containing 80 mg diamorphine and 60 mg midazolam as well as hyoscine hydrobromide,

(v) on 17 January 1996 the dose of diamorphine was increased to

E

120 mg and midazolam to 80 mg,

(vi) on 18 January 1996 you prescribed 50 mg Nozinan in addition to the drugs already prescribed,

(b) In relation to your prescriptions described in paragraphs 2(a)(ii) and 2(a)(iii),

F

(i) the lowest doses prescribed of diamorphine and midazolam were too high,

(ii) the dose range was too wide,

(iii) the prescription created a situation whereby drugs could be

G

administered to Patient A which were excessive to the patient's needs,

(c) The doses of diamorphine administered to the patient on 15 and 17 January 1996 were excessive to the patient's needs,

(d) Your prescription described at paragraphs 2(a)(vi) in combination with the other drugs already prescribed were excessive to the patient's needs,

H

(e) Your actions in prescribing the drugs as described in paragraphs 2(a)(ii), (iii), (iv), (v), and (vi) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient A;

3. (a) (i) Patient B was admitted to Daedalus Ward at the GWMH on 22 February 1996,

(ii) on 24 February 1996 you prescribed the patient Morphine Slow Release Tablets (MST) 10 mg twice a day,

(iii) on 26 February 1996 you increased the prescription for MST and prescribed diamorphine with a dose range of 80 mg - 160 mgs and midazolam with a dose range of 40 - 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(iv) on 5 March 1996 you prescribed diamorphine with a dose range of 100 - 200 mg and midazolam with a dose range of 40 mg - 80 mg over a twenty four hour period to be administered SC and a syringe driver was commenced containing diamorphine 100 mg and midazolam 40 mg,

(b) In relation to your prescriptions for drugs described in paragraphs 3(a) and (iv),

(i) the lowest commencing doses prescribed on 26 February and 5 March 1996 of diamorphine and midazolam were too high,

(ii) the dose range for diamorphine and midazolam on 26 February and on 5 March 1996 was too wide,

(iii) the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraphs 3(a)(ii), (iii) and/or (iv) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient B,

(d) In relation to your management of Patient B you,

(i) did not perform an appropriate examination and assessment of Patient B on admission,

(ii) did not conduct an adequate assessment as Patient B's condition deteriorated,

(iii) did not provide a plan of treatment,

(iv) did not obtain the advice of a colleague when Patient B's condition deteriorated,

(e) Your actions and omissions in relation to your management of patient B were,

(i) inadequate,

(ii) not in the best interests of Patient B;

4. (a) (i) on 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care,

(ii) on 3 March 1998 you prescribed diamorphine with a dose range of 20mg - 200mg and midazolam with a dose range of 20 - 80mg to be administered SC over a twenty four hour period on a continuing daily basis,

(b) In relation to your prescription for drugs described in paragraph 4(a)(ii),

(i) the dose range of diamorphine and midazolam was too wide,

(ii) the prescription created a situation whereby drugs could be administered to the patient which were excessive to the Patient C's needs,

(c) Your actions in prescribing the drugs described in paragraph 4(a)(ii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of your patient;

5. (a) (i) on 6 August 1998 Patient D was transferred to Daedalus Ward at GWMH for continuing care observation,

(ii) on or before 20 August 1998 you prescribed diamorphine with a dose range of 20mg - 200mg and midazolam with a dose range of

20mg - 80mg to be administered SC over a twenty four hour period on a continuing daily basis,

(b) In relation to your prescription for drugs as described in paragraph 5(a)(ii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient D which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs as described in paragraph 5(a)(ii) were,

(i) inappropriate,

(ii) potentially hazardous,
(iii) not in the best interests of Patient D;

6. (a) (i) Patient E was admitted to Daedalus Ward at GWMH on 11 August 1998 after an operation to repair a fractured neck of femur at the Royal Haslar Hospital,

(ii) on 11 August 1998 you prescribed 10 mg Oramorphine 'prn' (as required),

(iii) on 11 August 1998 you also prescribed diamorphine with a dose range of 20 mg - 200 mg and midazolam with a dose range of 20 mg - 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(b) In relation to your prescription for drugs described in paragraph 6(a)(iii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient E which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraph 6(a) (ii) and/or (iii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient E;

7. (a) (i) Patient F was admitted to Dryad Ward at GWMH on

18 August 1998 for the purposes of rehabilitation following an operation to repair a fractured neck of femur at the Royal Haslar Hospital,

(ii) on 18 August 1998 you prescribed Oramorphine 10 mg in 5 ml 'prn' (as required),

(iii) between 18 and 19 August 1998 you prescribed diamorphine with a dose range of 20 - 200 mg and midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

(b) In relation to your prescription for drugs described in paragraph 7(a)(iii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient F which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraphs 7(a) (ii) and/or (iii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient F;

8. (a) (i) Patient G was admitted to Dryad Ward at GWMH on 21 September 1998 with a painful sacral ulcer and other medical conditions,

(ii) on 21 September 1998 you prescribed diamorphine with a dose range of 20 - 200 mg and midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(iii) on 25 September 1998 you wrote a further prescription for diamorphine with a dose range of 40 - 200mg and midazolam with a dose range of 20 – 200mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

(b) In relation to your prescriptions for drugs described in paragraphs 8(a)(ii) and/or (iii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraphs 8(a) (ii) and/or (iii) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient G,

(d) You did not obtain the advice of a colleague when Patient G's condition deteriorated;

9. (a) (i) Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease as a result of alcoholism and other medical conditions,

(ii) on 14 October 1998 you prescribed Oramorphine 10 mg in 5 ml, with a dose of 2.5 ml to be given every four hours thereafter as needed, following which regular doses of Oramorphine were administered to the patient,

(iii) on or before 16 October 1998 you prescribed diamorphine with a dose range of 20 mgs - 200 mgs to be administered subcutaneously over a twenty four hour period on a continuing daily basis,

(iv) on or before 17 October 1998 you prescribed midazolam with a range of 20 mgs - 80 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

(b) In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph (9)(a)(ii) was,

(i) inappropriate,

(ii) potentially hazardous,

(iii) likely to lead to serious and harmful consequences for Patient H,

(iv) not in the best interests of Patient H,

(c) In relation to your prescription described in paragraph (9)(a)(iii),

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient H which were excessive to the patient's needs,

(d) Your actions in prescribing the drugs described in paragraphs 9(a)(ii), (iii)

A

and/or (iv) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient H.,

B

(e) You did not obtain the advice of a colleague when Patient H's condition deteriorated;

10 (a) (i) Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital,

C

(ii) on 12 April 1999 you prescribed diamorphine with a dose range of 20 - 200 mgs and midazolam with a dose range of 20 - 80 mgs to be administered SC over a twenty four hour period on a continuing daily basis,

D

(iii) on 12 April 1999 a syringe driver with 80 mgs diamorphine and 20 mgs midazolam over twenty-four hours was started under your direction but later the dose was reduced to 40 mgs by Code A

(b) You did not properly assess Patient I upon admission. This was,

E

(i) inadequate,

(ii) not in the best interests of Patient I,

(c) In relation to your prescription for drugs described in paragraph 10(a)(ii),

F

(i) the dose range was too wide,

(ii) the prescription created a situation whereby drugs could be administered to Patient I which were excessive to the patient's needs,

(d) Your actions in prescribing the drugs described in paragraph 10(a)(ii) were,

G

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient I,

(e) The dosage you authorised/directed described in paragraph 10(a)(iii) was excessive to Patient I's needs. This was,

H

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient I;

11 (a) (i) Patient J was admitted to Dryad Ward at GWMH on 23 August 1999 following his treatment at the Queen Alexandra Hospital where the patient had been admitted as an emergency following a fall at home,

(ii) on 26 August 1999 you gave verbal permission for 10 mg of diamorphine to be administered to Patient J,

(iii) you saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death',

(iv) you did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition,

(v) on 26 August 1999 you prescribed diamorphine with a dose range of 40 - 200 mg and midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(vi) on 26 August 1999 you also prescribed Oramorphine 20 mg at night'

(b) In relation to your prescription for drugs described in paragraph 11(a)(v),

(i) the lowest doses of diamorphine and midazolam prescribed were too high,

(ii) the dose range was too wide,

(iii) the prescription created a situation whereby drugs could be administered to Patient J which were excessive to the patient's needs,

(c) Your actions in prescribing the drugs described in paragraphs 11(a)(ii) and/or (v) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient J,

(d) Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11(a)( iv) was,

(i) inappropriate,

(ii) not in the best interests of Patient J;

12 (a) (i) Patient K was admitted to Dryad Ward at GWMH for continuing care on 21 October 1999 from Queen Alexandra Hospital She was reported to be suffering from chronic renal failure and multi infarct dementia,

(ii) on admission you prescribed Morphine solution 10mg in 5 ml as required,

(iii) on 18 and 19 November 1999 there was a deterioration in the Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch,

(iv) on 19 November 1999 you prescribed diamorphine with a dose range of 40 - 80 mg midazolam with a dose range of 20 to 80 mg to be administered SC over a twenty four hour period on a continuing daily basis,

(b) The prescription on admission described in paragraph 12(a)(ii) was not justified by the patient's presenting symptoms,

(c) In relation to your prescription for drugs described in paragraph 12(a)(iv),

(i) the lowest doses of diamorphine and midazolam prescribed were too high,

(ii) the dose range was too wide,

(iii) the prescription created a situation whereby drugs could be administered to Patient K which were excessive to the patient's needs,

(d) Your actions in prescribing the drugs described in paragraphs 12(a)(ii), (iii) and/or (iv) were,

(i) inappropriate,

(ii) potentially hazardous,

(iii) not in the best interests of Patient K,

(e) You did not obtain the advice of a colleague when Patient K's condition deteriorated;

13 (a) (i) Patient L was admitted to Daedalus Ward at GWMH on 20

May 1999 following a period of treatment at the Haslar Hospital for a stroke,

(ii) on 20 May 1999 you prescribed,

(a) Oramorphine 10 mgs in 5 mls 2.5-5mls,

(b) Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

(c) Midazolam with a dose range of 20 to 80 mgs to be administered SC,

(iii) you further prescribed Oramorphine 10 mgs in 5 mls 4 times a day and 20 mgs nocte (at night) as a regular prescription to start on 21 May 1999,

(iv) doses of Oramorphine, diamorphine and midazolam were subsequently administered to the patient [on] 21 and 22 May 1999,

(b) In relation to your prescription for drugs described in paragraph 13(a)(ii) and/or (iii),

(i) there was insufficient clinical justification for such prescriptions,

(ii) the dose range of diamorphine and midazolam was too wide,

(iii) the prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs,

(iv) your actions in prescribing the drugs described in paragraph 13(a)(ii) and or (iii) were,

(a) inappropriate,

(b) potentially hazardous,

(c) not in the best interests of patient L,

(c) You did not obtain the advice of a colleague when Patient L's condition deteriorated;

14 (a) You did not keep clear, accurate and contemporaneous notes in relation to Patients A, B, C, D, E, F, G, H, I, J K and/or L 's care and in particular you did not sufficiently record,

(i) the findings upon each examination,

(ii) an assessment of the patient's condition,

(iii) the decisions made as a result of examination,

(iv) the drug regime,

(v) the reason for the drug regime prescribed by you,

(vi) the reason for the changes in the drug regime prescribed and/or directed by you,

(b) Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were,

(i) inappropriate,

(ii) not in the best interests of your patients;

15 (a) In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K, L,

(b) Your failure to assess the patients in paragraph (a) appropriately before prescribing opiates was not in their best interests.

And that in relation to the facts alleged you have been guilty of serious professional misconduct.

Code A Thank you, Code A

Code A it will have been apparent to both of you during the reading of the allegation that there has been a small typographical error at paragraph 13(a)(iv) in that the word "in": "administered to the patient in 21 and 22 May 1999" should of course be "on". May I take it that we can simply make that amendment without further discussion? (Agreed) That amendment is made. The paragraph in question now reads: "were subsequently administered to the patient on 21 and 22 May 1999". Code A I can see you are on your feet already.

Code A There are a number of others as well.

Code A Yes, please.

Code A It may have been in the reading, and I hope your Panel Secretary will not take undue criticism for that because these are very long. First of all, in head of charge 2(e), if it is not there already, may I ask to insert the word "or" after "and" where it reads: 2(a)(ii), (iii), (iv), (v), and", it should be "and/or (vi)", and that is consistent with the other charges.

Code A Yes, that certainly was not in the one I have got.

Code A That was not in the reading and that is certainly our fault.

Code A any objection to that?

Code A No.

Code A Very well. In relation to paragraph 2e, the header, of the final line of that header should read: "as described in paragraphs 2(a)(ii), (iii), (iv), (v), and/or (vi)".

Code A I am grateful.

Code A Thank you.

Code A In 3(b) the Code A did not read out 3(a)(iii) but, as long as that is there, it is fine. So 3(b) reads: "In relation to your prescriptions for drugs described in paragraphs 3(a)(iii) and (iv)" I think that appears.

Code A Yes, that does appear. If it was an error of omission, it was only in the spoken word, it is in the written record.

Code A Thank you. Yes. In paragraph 9(b), this is our fault it reads: "In light of the Patient H's history", could we take out the word "the" so that it reads: "In the light of Patient H's history."

Code A Yes. Code A no objection?

Code A No objection.

Code A Very well. So 9(b), header now reads: "In light of Patient H's history", the word "the" having been removed.

Code A Paragraph 12(a), there should I think be a full stop after "Queen Alexandra Hospital", the third line down, just to make sense of it.

Code A Yes, indeed. There is following capitalisation.

Code A Yes.

Code A 12(a)(i), that paragraph is divided into two sentences, a full stop being placed after Queen Alexandra Hospital.

Code A Thank you. Yes, 12(a)(iii), we have an extra "the" in front of "Patient K's condition". Again, could we excise that?

Code A Yes, this is the same principle, Code A

Code A Yes.

Code A 12(a)(iii) now reads: "On 18 and 19 November 1999 there was deterioration in Patient K's condition", the word "the" having been omitted.

Code A In 12(a)(iv), just to make better sense of it, it is right as it is, but it reads at the moment, 12(a)(iv): "On 19 November 1999 you prescribed diamorphine with a dose range of 40 - 80 mg..." and then it goes straight on to midazolam. I think we should insert an "and"

A just to make better sense of it: "and midazolam with a dose range of 20 to 80 mg..."

Code A Are you happy with that, Code A ?

Code A Yes.

B Code A Very well. Paragraph 12(a)(iv) on the second line after the words "dose range of 40 - 80 mg" insert the word "and" before "midazolam".

Code A In 13(a)(iii) it was read as follows: "You further prescribed Oramorphine 10 mgs in 5 mgs", I think that does read "millilitres".

Code A Yes, it does. It should be and it does read "5 millilitres".

C Code A Then finally in 15(a), could we ask for the insertion of the words "and/or" after the letter "K": "In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K and/or L" which is on consistent with the way that we have put it in 14(a).

Code A Yes.

D Code A Thank you, Code A

Code A I am sorry for all of these corrections.

Code A These things happen no matter how hard we try to eliminate them.

Code A I am grateful.

E Code A Only in the press do we find that they somehow manage to be free of them. Certainly within the GMC we never do. 15(a), between Patients "K" and "L" we insert the words "and/or".

Code A Before the admissions are made by Code A could we also hand to the Panel the patient identification sheet which will give the names of all these patients?

F Code A I was going to ask for one of those. That is very helpful. Thank you. (Same handed)

Code A We are going to use this hereafter. Thank you very much.

G Code A can could I ask you to confirm the doctor's full name and GMC number?

Code A As it stands it is correct I am told.

Code A That is GMC reference number Code A

H Code A That I understand is correct.

A Code A: Are there any matters admitted?

Code A: Sir, yes. May I assist the Panel with certain admissions? It involves a little bit of the detail because of the wording of some of the charges and obviously, as you have seen, there are quite a large number of figures involved. I think it is going to assist the whole Panel if I indicate the areas where there is not any dispute. These are matters with regard to admissions, which are made at this stage. May I turn first of all to allegation 2, B which relates to Patient A?

Code A: Is allegation 1 admitted?

Code A: Of course, sorry. It was so obvious that I omitted to mention it. Patient A who, as you will have seen, is Code A from the identification schedule that has been given to you. In relation to 2(a), (i) to (vi), in other words the history of the prescribing or C administration, that is not in dispute. Sir, if it turns out that there is some error with regard to a particular date or a particular amount, all of that can be corrected at a later stage, but those are admitted. In relation to the same patient at 2(b), an admission is made that in respect of 2(b)(iii), "the prescription created a situation whereby drugs could be [and I am emphasising deliberately could be] administered to Patient A which were excessive", that is admitted.

Then in relation to that same patient, 2(e), in relation to the drugs described in D paragraph 2(a)(iii), it is confined to that, 2(a)(iii), it is admitted that (e)(ii) potentially hazardous. Again, I stress the word "potentially". With regard to 2(e), drugs prescribed in 2(a)(iii) potentially hazardous as at (e)(ii).

Then heading 3, Patient B, Code A again with regard to 3(a), (i) to (iv), the actual prescriptions, and so on, set out there, admitted. At 3(b)(ii) admitted that the dose range was too wide. That is the dose range is admitted as being too wide. Then 3(b)(iii), E "the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs", again, "could be administered" admitted. Then 3(c) with regard to the drugs prescribed in paragraph 3(a)(iii) and/or (iv), admitted as being potentially hazardous. So 3(c)(ii) admitted as potentially hazardous with regard to the drugs in paragraphs 3(a)(iii) and 3(a)(iv). Moving on, still the same instance, at 3(d), it is admitted at 3(d)(iv), "did not obtain the advice of a colleague"; that is admitted as a fact.

F I move on to Patient C, Code A in relation to 4(a) admitted. 4(b), the dose range at (b)(i) too wide, admitted. Creating a situation whereby drugs could be administered which were excessive, 4(b)(ii) admitted. Similarly 4(c), at 4(c)(ii), it is the same allegation of potential hazard, potentially hazardous, admitted.

Moving on to Patient D, Code A 5(a) is admitted. In relation to 5(b), admitted with regard to (b)(ii) and (b)(ii), the dose range was too wide and the prescription created G a situation whereby drugs could be administered to Patient D which were excessive. Similarly, at 5(c)(ii), again, the allegation of being potentially hazardous on the same basis admitted. So (c)(ii) is admitted.

Then Patient E, Code A 6(a) is admitted. 6(b)(i) is admitted, the dose range was too wide. Similarly, 6(b)(ii) is admitted, the situation whereby drugs could be administered which were excessive. Then in relation to 6(c), and confining it to the drugs described in H paragraph 6(a)(iii), so confining it to 6(a)(iii), admitted potentially hazardous.

A Patient F, Code A 7(a) is all admitted. 7(b), which deals with a prescription set out in 7(a)(iii), admitted: dose range too wide, and creating a situation whereby drugs could be administered which were excessive. Looking at 7(c) admitted with regard to (c)(ii), potentially hazardous, but only in relation to the drugs prescribed in paragraph 7(a)(iii). So in relation to 7(a)(iii), admitted as being potentially hazardous.

I move on to Patient G, Code A 8, 8(a) is all admitted and 8(b) is admitted, dose
B range too wide, creating a situation, et cetera, so (b)(i) and (ii) admitted. With regard to 8(c), 8(c(ii), potential hazard, admitted. 8(d), not obtaining the advice of a colleague, is an admitted fact.

Then Patient H, Code A 9(a) is admitted. I move on to 9(c), which is making an allegation with regard to the prescription at 9(a)(iii), it is admitted the dose range was too wide and creating a situation where drugs could be administered which were excessive. So
C (c)(i) and (ii) admitted. Then in respect of 9(d), with regard to the drugs prescribed in paragraphs 9(a)(iii) and/or (iv), so not 9(a)(ii), confining the admission to 9(a)(iii) and/or (iv), potentially hazardous, as at 9(d)(ii). Similarly with regard to this allegation, 9(e), you did not obtain the advice of a colleague, that is an admitted fact.

Patient I, allegation 10, Code A admitted 10(a), in terms of the history. Moving on to 10(c), which relate to the drugs described in paragraph 10(a)(2), admitted the dose range was
D too wide and the creation of a situation, and so on, so 10(c)(i) and (ii) admitted. At 10(d), the potentially hazardous point, 10(d)(ii), is admitted.

I move on to Patient J, Code A the history set out at 11(a) is admitted. At 11(b), where there is an allegation with regard to the prescription described in paragraph 11(a)(v), it is admitted, at (ii) and (iii) of (b), that the dose range was too wide and a situation was created whereby drugs could be administered which were excessive; so (b)(ii) and (iii)
E admitted. Then moving on to 11(c), and confining it to the drugs described in paragraph 11(a)(v), so excluding 11(a)(ii), in relation to 11(a)(v), an admission that prescription was potentially hazardous.

Paragraph 12, Patient K, Code A 12(a), the history is admitted. Moving on to the last part of the allegation, with regard to that particular patient, at 12(e), admitted did not obtain the advice of a colleague in the same way as the other admissions that have been made.
F

Lastly in terms of patients, at 13, Patient L, Code A the history again, 13(a) is admitted. In relation to 13(b), the dose range at 13(b)(ii), of diamorphine and midazolam, too wide, is admitted. The next allegation at (b)(iii), the creation of a situation, admitted. Then at 13(b)(iv), confining it to the drugs prescribed and described in paragraph 13(a)(ii)(b) – sorry, 13(a)(ii)(b), I am sorry, this is one of the worst ones for confusion on these paragraph numbers. The potentially hazardous point is admitted with regard to 13(a) -
G

Code A 13(b)---

Code A - (ii)(b), which is the diamorphine prescription. I am afraid it is an error in my own notes which led me to believe it related to the Oramorphine. It is the diamorphine at 13(ii)(b), potentially hazardous. Again, a similar factual admission in that case of 13(c), did not obtain the advice of a colleague, that is admitted.
H

Sir, turning to the last two numbered paragraphs, 14 and 15, with regard to the paragraph for allegation 14, this is an allegation with regard to the failure to keep clear, accurate and contemporaneous notes relation to the patients. There are admissions there: (i), (ii) and (iii) are admitted, and (v) and (vi) are admitted. Then turning to 14(b), "Your actions and omissions in relation to keeping notes for [the] Patients ... were, (i) inappropriate", admitted; "not in the best interests of your patients", admitted. So all of those allegations in that paragraph concern the failure to keep clear, accurate and contemporaneous notes.

Those are the admissions that are made on behalf of Code A

Code A Right, Code A you have presented me with quite a challenge.

Code A Sir, before the Panel reads out the matters that have been admitted and found proved, can I just indicate, we are going to ask for a little time in any event. I am not complaining about it, this is the first time we have heard those admissions and it may that be with some further amendment, we could encourage more admissions as it were. If that were to help you, you do have a bit of a task now, and I was going to ask for 20 minutes in any event. I just thought I would mention that now in case that assisted you.

Code A Yes. I think what I will attempt to do is to deal with what we have heard first from Code A. Then we will break. We would be breaking around now in any event. Will that break be sufficient for you also to break or would you wish to extend that?

Code A I am afraid I do not know at the moment because my suggestion may fall on deaf ears as it were but if we need more time, can we pass a message through?

Code A Yes, please do, and in any event it would be useful as a matter of housekeeping, I will say this on an ongoing basis, throughout this hearing to update us as to what effect any changes like this are likely to have on the overall timetable. That would also be helpful.

Very well. Code A paragraph 1 has been admitted and is found proved. Paragraph 2(a) has been admitted in its entirety and is found proved. Paragraph 2(b)(iii) has been admitted and is found proved. Then paragraph 2(e)(ii) is admitted only in respect of actions in prescribing the drugs as described in paragraph 2(a)(iii).

Code A That is right.

Code A Paragraph 3(a) – sorry, I should say therefore: and is found proved. Paragraph 3(a) is admitted in its entirety and is therefore found proved. Paragraph 3(b)(ii) is admitted and found proved. 3(b)(iii) is admitted and found proved. Paragraph 3(b), (c)(ii) is admitted only in respect of drugs described in paragraphs 3(a) (iii) and/or (iv).

Code A That is right.

Code A And on that basis is found proved.

Code A That is right.

A

Code A I should say therefore and is found proved. Paragraph 3(a) is admitted in its entirety and therefore found proved. Paragraph 3(b)(ii) is admitted and found proved. Paragraph 3(b)(iii) is admitted and found proved. Paragraph 3(b)(c)(ii) is admitted only in respect of drugs described in paragraphs 3(a)(iii) and/or (iv).

Code A That is right.

B

Code A And on that basis is found proved. Paragraph 3(d)(iv) is admitted and found proved.

Paragraph 4(a) is admitted in its entirety and found proved. Paragraph 4(b) is admitted in its entirety and found proved. Paragraph 4(c)(ii) is admitted and found proved.

C

Code A Yes.

Code A Paragraph 5(a) is admitted in its entirety and found proved. Paragraph 5(b) is admitted in its entirety and found proved. Paragraph 5(c)(ii) is admitted and found proved. Paragraph 6(a) is admitted in its entirety and found proved.

Paragraph 6(b) is admitted in its entirety and found proved. Paragraph 6(c)(ii) is admitted only in respect of actions in prescribing the drugs described in paragraph 6(a)(iii).

D

Code A Yes.

Code A And is on that basis only found proved.

Paragraph 7(a) is admitted in its entirety and is found proved. Paragraph 7(b) is admitted in its entirety and is found proved. Paragraph 7(c)(ii) is admitted but only in respect of actions

E

in prescribing the drugs described in paragraphs 7(a)(iii) and on that basis only is found proved.

Code A That is right.

Code A Paragraph 8(a) is admitted in its entirety and is found proved. Paragraph 8(b) is admitted in its entirety and is found proved. Paragraph 8(c)(ii) is admitted and found

F

proved. Paragraph 8(d) is admitted and found proved.

Paragraph 9(a) is admitted in its entirety and found proved. Paragraph 9(c) is admitted in its entirety and found proved. Paragraph 9(d)(ii) is admitted only in respect of those actions in prescribing the drugs described in paragraphs 9(a)(iii) and/or (iv) is admitted and therefore in that respect only found proved. Paragraph 9(e) is admitted and found proved.

G

Paragraph 10(a) is admitted in its entirety and is found proved. Paragraph 10(c) is admitted in its entirety and is found proved. Paragraph 10(d)(ii) is admitted and found proved.

Code A Yes.

Code A Paragraph 11(a) is admitted in its entirety and is found proved. Paragraph 11(b)(ii) is admitted and found proved. Paragraph 11(b)(ii) is admitted and found

H

proved.

I think I may be going wrong here. As I read it paragraph 11(c)(ii) is admitted only in respect of actions in prescribing the drugs described in paragraphs 11(a)(v).

Code A That is correct.

Code A So that is admitted and therefore found proved. Paragraph 12(a) is admitted in its entirety and is found proved. Paragraph 12(e) is admitted and found proved.

Code A Yes.

Code A Paragraph 13(a) is admitted in its entirety and is found proved. Paragraph 13(b)(ii) is admitted and found proved. Paragraph 13(b)(iii) is admitted and found proved. Paragraph 13(b)(iv)(b) is admitted only in respect of those actions in prescribing the drugs described in paragraph 13(a)(ii).

Code A Yes.

That is admitted in that respect only and found proved.

That is (a)(ii)(b).

Thank you. And paragraph 13(c) is admitted and found proved.

Yes.

Code A Paragraph 14(a)(i), (ii) and (iii) are admitted and found proved. And 14(a)(v) and (vi) are admitted and found proved.

Code A That is correct.

Paragraph 14(b) is admitted in its entirety and is therefore found proved.

That is correct.

Code A Thank you very much indeed, Code A We will break now for an initial 20 minutes, partly so that everybody can refresh themselves but also so that some discussion can take place between counsel. If you do require further time please inform our Panel assistant or Panel Secretary and I will grant you that time.

(The Panel adjourned for a short time)

Code A Welcome back, everyone. Code A

Code A Sir, first of all, thank you for that short extra time. We did have discussions but we decided that the best thing is to get on with the opening, so it did not resolve anything.

Sir, it now falls to me to open this case and I want to confirm, of course, that at this point there should be no witnesses in the public gallery from here on in.

A Code A Can I confirm that there are no potential witnesses now with us? (Confirmation of no witnesses in the hearing room)

Code A: Sir, this case concerns the treatment provided to 12 patients at the Gosport War Memorial Hospital, all of whom were inpatients there between 1996 and 1999.

B Code A was employed during the period as a Code A which meant that she had day to day care of the patients on the two relevant wards which were Daedalus and Dryad.

The Hampshire Primary Care Trust boasted four hospitals at the relevant time in the Portsmouth area. The Queen Alexandra Hospital has a number of sites clustered around the top of Portsmouth. St. Mary's Hospital is in Portsmouth itself. There is the Royal Haslar Hospital, which was once the Royal Naval Hospital, the first version of which was built in the middle of the 18th century. Finally, there is the Gosport War Memorial Hospital known as
C the GWMH within your heads of charge. The GWMH was opened in 1923 and since then it has occasionally been extended, but at the relevant time you will be asked to consider it was acting effectively as a cottage hospital in terms that it would receive patients who required longer term or rehabilitative care.

Prior to the period that we are considering the GWMH had been spread around a number of sites but by the relevant time period it was centred in a single large building. It did not have
D an acute ward, nor did it have any emergency facilities.

Originally palliative care patients or those terminally ill were cared for in part of the GWMH called the Redcliff Annex, which was some miles from the main hospital. That was a geriatric ward for patients who could not cope on their own and that was closed in around 1995 and those patients were sent to Dryad Ward.

E Dryad Ward was one of the three wards which you are likely to hear about – the two elderly care wards being called Daedalus and Sultan. Emergencies which arose on the wards at GWMH would have to be transferred by ambulance to one of the local hospitals where emergency treatment could be provided and the Royal Haslar Hospital was a few minutes away.

F Code A was a local general practitioner practising in Gosport in Hampshire. She had qualified at Oxford University in 1972 as a Bachelor of Medicine and a Bachelor of Chemistry. She became a GP, initially as an assistant and then as a partner.
In 1980 she was appointed to the General Practitioner medical staff at the GWMH.

In 1988 she applied for and was appointed to the post of Code A at the Gosport War Memorial Hospital. The period of her employment there upon which this case will focus was between 1996 and 1999.
G

During her period at the hospital she continued in her full time post as a GP doing morning surgeries at her GP practice every day and evening surgeries on a rota basis with her other GP partners. She was also doing one night a fortnight on call and one weekend on call in four.

Code A had not specialised in either geriatric or palliative medicine and had no specific training, other than some half-day sessions, which she appears to have undertaken in 1989.
H

A Code A 's main job was as a GP in a local Gosport practice, but she would conduct ward rounds at GWMH as a general rule on a daily basis, excluding weekends, between 7.30 and 8 o'clock in the morning. She would also, according to the witness Code A from who you will be hearing, and according to the statement Code A herself made subsequently to the police, she would attend at midday to clerk any new admissions. She would be fairly reliant on nursing staff to flag up any problems and she would not necessarily see every patient every day.

B There are two wards at the GWMH to which all of the twelve patients upon whom we are focussing were admitted. Dryad Ward which was an elderly care ward consisting of approximately 20 beds; Daedalus Ward was a 24 bed ward. Eight of those beds were for slow stream stroke patients and the remaining beds were for the continuing care of elderly patients. Many of the patients admitted to those wards were expected to be rehabilitated sufficiently so that they could either return home or to care homes. This was not a hospice, C although of course some patients were very ill and inevitably some were not going to leave hospital.

You are also going to hear a little bit about another ward called Mulberry Ward at GWMH. That was an old age psychiatric ward.

Code A appears to have developed a practice on the two wards, Dryad and Daedalus, of D prescribing large quantities of opiates on what she described as an "in-case" or, as she called it, an "anticipatory" basis. "In case" the patient found themselves to be in pain or "in case" the patient's pain was uncontrolled by the opiates already given, or in case Code A was away or it was a weekend.

Many of the patients that you are going to hear about were opiate naïve: in other words, until they set foot inside the GWMH they had not been given opiates as a form of pain relief; nor E had apparently required them.

In the view of the GMC's expert, Code A none of the patients about whom you are going to hear, were properly and appropriately prescribed opiates by Code A

There was, we say, a series of failures which led to patients being over medicated and F unnecessarily anaesthetised. The failures included a lack of proper assessment before opiates were prescribed and an irresponsible method of prescribing opiates. There was an almost universal failure by Code A to make proper notes either of assessment of the patients if such assessments were in fact taking place, or to justify her actions in prescribing opiates. Frequently opiate medication was increased with no explanation noted, even though these were drugs which were capable of ending life.

G The favoured method of prescribing to these patients was to provide for a variable dose of the drugs diamorphine and midazolam which were to be administered by way of syringe driver. The dose range prescribed by Code A was, in each case that you are going to consider, far too wide and breached acceptable medical practice.

A syringe driver, I ought to mention, is a device which some of you may already know about – indeed all of you may already know about – it is an electrically operated syringe which H delivers a measured dose over a 24-hour period and is permanently connected to the patient.

A Prior to the syringe driver being administered, many of the patients were unnecessarily prescribed oral Morphine in the form of liquid Morphine called Oramorph or, on occasions, slow release Morphine tablets known as MSTs.

Code A, one of the nurses and Code A of Daedalus Ward, put it this way when he was spoken to by the police, he said:

B "It is the nursing staff who really have the full picture of how a patient has been, and then we would discuss and talk about how we would do it with the medical staff making decisions about care. We would call a doctor if we needed to, but we would have discussed the patient's on going care and prognosis on each occasion we saw the doctor, so we are empowered to initiate a syringe driver. The syringe driver would be written up and the instruction would be 'if this patient's condition worsens you can utilise the syringe driver to keep that patient
C pain free'."

Therefore, there appears to have been a considerable discretion left with the nursing staff as to the commencement of the syringe drivers and the quantity of opiate to administer. Some nurses will say, no doubt, that they always consulted the doctor first, but it seems that some may not have done.

D When patients became agitated they were then administered increasing quantities of diamorphine and midazolam by the nurses under Code A's prescriptions until they were agitated no more. And, on occasion, the patient's agitation may itself have been the result of the effect of the Oramorph that they had been given in the first place.

Many of the patients who are described in the nursing notes as "calm and peaceful" were, according to Code A in drug-induced comas. Code A is the Professor of
E Pharmacology of Old Age at the Code A and he practises as a consultant physician in Clinical Pharmacology at the Code A. He is the co-editor of Code A published in July 2000. He has examined each of the cases which we have placed before you and he is highly critical of Code A's practice in terms of her prescribing, her lack of assessment of patients and her failure to make relevant and necessary notes.

F Code A may of course claim that she was entitled to rely on the experience of the nurses when prescribing the large quantities of diamorphine and midazolam, which she did. She may say that she was entitled to rely on the nurses not to provide the medication which she was prescribing unless it was necessary. However, there was a lack of a proper system to ensure that patients were not over medicated and, in the view of Code A over-medication was a frequent, recurring problem. Code A effectively delegated responsibility for her patients in relation to the administration of opiates to the care of the nurses and there
G were frequent occasions when the nurses went on to use the prescriptions inappropriately. As Code A, however, said in her police statement:

"On a day-to-day basis mine was the only medical input".

That was true and her responsibility was, therefore, a high one.

H There were three Code A who had duties in relation to these two particular wards. The

A wards were visited on a weekly basis by one Code A or the other. However, in general they were reliant on what they were told about the patients by Code A The Code A were Code A None of them appeared to have seen the patients more than once a week on the wards and often it appears to have been less than that. The day-to-day control was left to Code A and her nursing staff. Code A was away on [redacted] leave from April 1998 until February 1999 and at that time her post was not filled by a locum. She was a Code A geriatrician at the Queen Alexandra Hospital in Portsmouth
B who was essentially responsible for Dryad Ward as a Code A from 1994, but she was away on a number of periods of Code A and when she was there she carried out a ward round once every two weeks on Wednesdays. It appears that she was only there during the period when Patients A and B, and that is Code A and Code A, were on the ward as she would have left by the time Patient C, Code A, arrived. She describes Code A as more experienced than her in long term and palliative care.

C Code A was based at the Queen Alexandra Hospital in Portsmouth as well. He was also a Code A geriatrician, he carried out one session a week at the Dolphin Day Hospital, and from February 1999 was the Code A in charge ever Dryad Ward. He was in post at the time that patients I, J, K and L, in other words, Code A and Code A were admitted to Dryad Ward. He would carry out a ward round on Monday afternoon and on alternate weeks Code A would accompany him. He would, therefore, only see her apparently once a fortnight. He was not aware that Code A was
D writing up prescriptions for patients with a variable dose in advance of them complaining of pain and he spoke to her on one occasion about a variable dose that he noticed on the records but appears to have accepted her explanation for it. He was aware that Code A was working very hard and believed that without her the GWMH would not have been able to function on those two wards.

Code A would carry out a consultant ward round once a week alternating between Dryad and
E Daedalus. She is now we understand in New Zealand, and careful consideration has been given as to whether she should be called as a witness. A review of the notes of the 12 patients with whom you are specifically concerned reveals that although she provided medical services to a number of them prior to their transfer to the GWMH, her input post transfer was very limited indeed, and she had no role in prescribing treatment at the GWMH for patients A, B, that is Code A and Code A E and F, Code A and Code A H and I, J Code A and Code A J, K or L, that is Code A
F Code A, and Code A In the circumstances it has been decided that she will not be called by the GMC.

Code A may well say she was overworked and under pressure. If that is shown to be true then of course that may be some mitigation for some of what occurred. But it does not provide a defence for some of the practices which built up and which were directly contrary to good medical practice.
G

In due course Code A did resign after these events, apparently because of the pressures of work. There was, however, unfortunately quite clearly a period of time under her management when her patients were receiving very sub-standard care.

I am going to turn to deal with the drugs and the various protocols. Of the drugs that you will be hearing about, there were really five which are central to the case: Oramorph,
H diamorphine, midazolam, hyoscine and haloperidol. Oramorph is an oral solution of

Morphine. It is suitable to be given as an opiate where the patient is able to swallow. It has the effect of depressing respiration and causing hypotension and it should be avoided for acute alcoholics. Can I pause to tell you that in one of your bundles, which you are going to receive this morning, you have all of the relevant BNFs for the relevant period so you can check all of these drugs and their contra-indications for yourselves. I am trying at the moment not to burden you with too much paper. Can I tell you also that great effort has been made really by both sides to limit the amount of paper you are going to have to deal with.

Diamorphine, as you will know, is what drug users call heroin. It is a powerful opioid analgesic and can be given via syringe, in this case it was given by syringe driver.

Apart from removing the sensation of pain, it has a depressive effect on the vital functions and frequently causes nausea and vomiting. As with Oramorph, its use should be avoided in cases of acute alcoholism. Great care has to be taken when exchanging oral morphine for subcutaneously delivered diamorphine. The dosage delivered subcutaneously should, according to the BNF, be one third to one half of the oral dose of Morphine. So an oral dose of 30 milligrams of Morphine over a 24 hour period should be replaced if the same level of analgesia is required by a dose of no more than 10 to 15 milligrams as a subcutaneous infusion over 24 hours.

Midazolam is a sedative and anti-epileptic and is said to be suitable for the very restless patient. It can be mixed in a syringe driver with diamorphine. Midazolam can cause respiratory and cardiovascular depression, hypotension and ultimately death.

hyoscine has the effect of reducing salivary and respiratory excretions. In the elderly particularly it can cause drowsiness.

Finally, haloperidol is anti psychotic drug used to relief anxiety and tension. It can also provide relief from nausea and vomiting and it also will increase and cause drowsiness.

Can I now give you the first of the bundles that you are going to receive? Can I ask for Panel bundle 1, please? (Same handed) This is a miscellaneous bundle. It should be marked "Panel bundle 1" on the back. It does not relate to any specific patient. We will ask for this to be exhibited as C1, please.

**Code A** Panel bundle 1 will be marked as Exhibit C1, please, ladies and gentlemen.

**Code A** I hope you will find an index in the beginning. Can I just take you through what you have here? The first tab is simply a glossary of medical terms. You will not by any means have all of the medical terms that we are going to come across but I hope that is helpful. Tab 2 is the job description post the application for the appointment of **Code A** Tab 3 contains the extracts of the British National Formulary.

Can I ask you to turn up Tab 3 first of all? I am going to start on page 2. Each of these tabs you will find I hope have been numbered from one through to whatever page number you get to so that as it becomes necessary, and if it becomes necessary, we can easily add documents to the back of each tab without having to renumber everything. Page 2 deals with the guidance given in prescribing in palliative care.

A "Prescribe in palliative care. In recent years there has been increased interest of providing better treatment and support for patients with terminal illness. The aim is to keep them as comfortable, alert and free of pain as possible."

If we go down to the third paragraph headed "Hospital or Hospice Care":

B "The most important lesson to be drawn from the experience of hospices is that both doctors and nurses must give time to listen to the patient. This gives great support and comfort to a patient who may otherwise suffer intolerable loneliness."

If you go to the next paragraph headed "Drug Treatment":

C "The number of drugs should be as few as possible, for even the taking of medicine may be an effort. Oral medication is usually satisfactory unless there is severe nausea and vomiting, dysphasia, weakness or coma, in which case parenteral medication may be necessary.

Analgesics are always more effective in preventing the development of pain than in the relief of established pain. The non-opioid analgesics, aspirin or paracetamol given regularly will often make the use of opiates unnecessary."

D Then down to next paragraph, please:

"Morphine is the most useful of the opioid analgesics. In addition to the relief of pain it confers a state of euphoria and mental detachment."

It deals then with the oral route, and four lines down:

E "A dose of 5 to 10 milligrams is enough to replace a weaker analgesic (such as paracetamol or co-proxamol) but 10 to 20 milligrams or more is required to replace a strong one (comparable to Morphine itself). The first dose of Morphine is no more effective than the previous analgesic. It should be increased by 50 per cent, the aim being to choose the lowest dose which prevents pain. Although a dose of 5 to 20 milligrams is usually adequate, there should be no hesitation in increasing it stepwise according to response to 100 milligrams or occasionally up to 500 milligrams, or higher if necessary."

F Could I ask you then to go down about five lines:

G "The starting dose of modified release preparations, designed for twice daily administration, is usually 10 to 20 milligrams every 12 hours, if no more analgesic has been taken previously, but to replace a weaker opioid analgesic, such as co-proxamol, the starting dose to usually 20 to 30 milligrams every 12 hours.

The effective dose of modified-release preparations can alternatively be determined by giving the oral solution of morphine every 4 hours in increasing doses until the pain has been controlled, and then transferring the patient with the same total 24-hour dose of morphine given as the modified-release preparation".

H "Parenteral route", last paragraph on the page:

A

> "If the patient becomes unable to swallow, the equivalent intramuscular dose of morphine is half the oral solution dose; in the case of a modified-release tablets it is half the total 24-hour dose ... Diamorphine is preferred for injection because being more soluble it can be given in a smaller volume. The equivalent intramuscular (or subcutaneous) dose [which is what we are dealing with normally in this case] is only about a quarter to a third of the oral dose of morphine".

B That is worth bearing in mind.

Can I ask to you go to page 7. If you look on the left-hand side about three paragraphs down from the top, "Guidelines":

> "First always question whether a drug is indicated at all.

C

> "... It is a sensible policy to prescribe from a limited range of drugs and to be thoroughly familiar with their effects on the elderly.
>
> "... Dosage should generally be substantially lower than for younger patients and it is common to start with about 50 per cent of the adult dose. Some drugs ... should be avoided altogether."

D Then on the right:

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

Now drugs maybe prescribed, as you will be aware, PRN or as the occasion arises or as required. This can be appropriate and is often used but it is important to provide clear
E instructions to those who are going to administer the drugs as to what event would trigger the use of the drug.

The analgesic ladder is a phrase which you are going to hear in the course of these proceedings. It describes a simple concept which you will be well versed in when you apply the sanction stage of a normal FTP case, in other words you should start with the lowest sanction first. Well, in just the same way, the analgesic ladder provides that drugs are
F classified into three groups, depending on the severity of the pain that they are intended to meet. The starting point is non-opioid analgesics, such as aspirin, paracetamol and ibuprofen. Next there are more potent anti-inflammatory drugs, such as diclofenac and codeine. Except in an emergency, which we suggest did not really arise in any of the cases that you are going to be considering, it is only for patients for whom those first two stages have provided ineffective to control their pain that morphine and diamorphine are recommended. The lowest starting dose should be used at the commencement of pain relief and increased, if
G necessary, by 50 per cent on subsequent occasions.

You will hear reference to a document called the "Wessex Protocol", and you will find that behind tab 4, and it is also known as "The Palliative Care Handbook. Guidelines on clinical management". This is the fourth edition, which appears to have been published in 1998; that appears on page 69 if anybody wants to check it. This sets out guidance as to best practice when applying a palliative care regime. That means of course a medical regime to ensure
H that the patient is comfortable and pain free when their illness is no longer responsive to

potentially curative treatment, in other words when it is recognised that the patient is dying and cannot or should not be saved by medical intervention.

One of the issues in this case is whether the nurses were in fact following the guidance given and whether in respect of certain patients the decision was taken inappropriately to treat them under a palliative regime as opposed to a curative regime.

Again, if I can just ask you to look briefly at this document, I am not going to take you all the way through it, page 3 please. It is important to bear in mind that this is the document for a palliative care regime:

> "Introduction
>
> "Palliative care:
>
> - Is the 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;
> - Provides relief from pain and other symptoms;
> - Aims to achieve the highest possible quality of life for patients and families;
> - Responds to physical, psychological, social and spiritual needs;
> - [And] extends as necessary to support in bereavement.
>
> This handbook contains guidelines to help GPs, community nurses and hospital staff as well as specialist palliative care teams."

There is a 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".

Over the page please to page 4, "General principles of symptom management", and the first bullet point is this:

> "Accurate and full assessment is essential for both diagnosis and treatment".

Five lines down:

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

Then I think it is about eight bullet points down:

> "Consider referral for specialist palliative care opinion:
>
> – if there is a problem which does not respond as expected

– in complex situations which may benefit from specialist expertise

– for support for the hospital primary healthcare team."

On the right we can see under the heading "Pain", and the second paragraph down, second line:

"The analgesic ladder approach ... is the basis for prescribing but careful choice of appropriate adjuvant drugs such as anticholinergics".

We do not need to worry, I do not think, about that, but then the analgesic ladder is set out on page 5, which describes the three steps from mild pain through moderate pain to severe pain. It says this:

"The WHO analgesic ladder has been adopted to emphasise that it is essential to use an analgesic which is appropriate to the severity of the pain".

We would submit that in this case there are a number of occasions when it could be demonstrated that that guidance simply was not followed.

The GMC proposes to call a number of the nurses who cared for the patients and who administered doses of diamorphine and midazolam of which criticism is on occasion made. Many of the nurses who worked on the relevant wards can remember nothing beyond the notes that they made and it has not been thought necessary to parade those nurses before you. Some of the nurses do have recollection of the patients or the practices at the hospital and will be called by the General Medical Council. Many are likely to be highly supportive of Code A with whom they worked over many years. You, as a Panel, will have to be alert when listening to the evidence of those nurse witnesses to guard against evidence which in fact may be biased or self-serving.

Nurse Code A, by way of example, was a senior and experienced nurse who worked at the GWMH from the late 1980s. She apparently had no concerns about the use of syringe drivers, nor the quantities of drugs that were being prescribed by Code A. She apparently takes the view that as a result of the issues raised at the Gosport War Memorial Hospital, patients will now not get the pain relief that they need. She feels that Code A is being used as a scapegoat. You will need to assess that evidence but it is called so as to provide you with as complete a picture as possible.

There are a number of nurses, as I say, not being called by the GMC. If the defence decide they wish to call them, then that is a matter for them.

Code A was the Code A and Code A. It is clear from a substantial body of evidence that she was a formidable person who effectively ran the wards in Code A's absence. She is too unwell to be called to give evidence and in any event the GMC have taken the view that it would not be appropriate to rely upon her evidence in statement form.

Nurse Code A who will be called, takes a simple line: syringe drivers were always used correctly and only when necessary. Other nurses however have expressed concern about the extent to which both diamorphine and syringe drivers was used on the wards. Some nurses speak with the use of diamorphine without adopting the analgesic ladder first and they speak

A of the considerable trust that Code A appears to have placed in Code A and they speak about concerns which were raised as far back as the early 1990s.

As I have mentioned, for a period, Code A had worked on the Redcliff Annex prior to the transfer. Nurse Code A remembers that once she started, the ward became better organised and syringe drivers were introduced at around the same time. It was prior to the transfer to Dryad and Daedalus that Nurse Code A remembers concerns being raised in the early '90s
B about the use of syringe drivers and particularly about the quantity of diamorphine that was being used, and meetings were held between nurses and management and Code A attended at least one of those meetings. Unfortunately, although there were calls for a formal written policy on the use of diamorphine and syringe drivers, no such policy appears to have been produced.

Nurse Code A was similarly concerned and initially certainly she was worried that
C the analgesic ladder was not being used appropriately. However, her view is that once the ward moved and became Dryad ward, the culture did change and syringe drivers were only used when needed. You will have to look carefully at whether in fact there was a change of culture or whether people had just become used to what were in fact inappropriate practices.

Nurse Code A does however reflect in her evidence that the regime allowed the nurse in charge to increase the dosage of drugs at their discretion, provided it was kept within
D the parameters set by Code A The difficulty is of course, as you have seen, that the parameters set by Code A were very wide indeed.

Meetings were apparently held and fears were apparently allayed. As I say, it will be a matter for you to consider whether the concerns should in fact have continued and whether or not they had been addressed by a true change of culture.

E Code A who I have mentioned, who is the Code A of Daedalus ward in 1998, described how Code A would attend the ward at 9 o'clock every morning and to carry out a review of the patients. He is supportive of Code A and had no concerns about her. It was a busy ward.

Nurse Code A remembers the concerns about syringe drivers being raised in the early '90s and that there were meetings with Code A and management about their excessive use. She
F appears eventually to have stopped complaining about what was going on and continued working with the others, although, in her view, things did not in fact improve.

Code A was a senior nurse and only one grade lower than Code A She did not start work at the GWMH until 1998. She was new to palliative care and had a difficult working relationship with Code A She ran the ward when Nurse Code A was away and she describes Nurse Code A as "an excellent nurse but her word was law". She, Nurse
G Code A did not feel that the analgesic ladder was being properly adhered to. She describes how on Dryad ward it became standard practice to double the dosage if it was deemed that the patient needed a higher dosage of opiates. She was troubled by the fact that it appeared that Code A would prescribe opiates and then hand responsibility over to the nurses.

As I said, the GMC will call number of nurses and you will have to analyse their evidence carefully. Some of the evidence may be founded on self-protection or even upon misguided
H loyalty. What may matter to your inquiry, however, is to look at whether there is evidence

which actually supports the administration of opiates or, in many cases, the lack of evidence as to why opiates were in fact administered or increased.

One of the allegations made in respect of every patient and which has in very large substance now been admitted to relates to the very poor quality of the notes kept by Code A In the cases that you are going to be looking at, there was a lack of a proper note of the first assessment by Code A and a lack of reassessment notes or a proper diagnosis or a treatment plan. The administration of opiates was regularly increased with only a nurse's note to show it. Code A s explanation to the police was in short that she was too busy to make a note and she had to decide whether to look after the patients or make the notes about it. She said in one of her statements:

> "I was left with a choice of attending my patients and making notes as best I could or making more detailed notes about I did see but potentially neglecting other patients."

The GMC does not accept that to be a legitimate approach. Unless a proper note is made, assessing the patient on admission, and when there are significant changes in their state of health, then it is very likely, we submit, that the treatment of that patient would be adversely affected. With no proper notes of assessment, there will be no baseline or benchmark from which to work. Other medical staff will not know what the finding and the diagnosis was. The treating doctor may not remember what the state of health of the patient was when at first assessed. Nursing staff will not be able to track the patient's progress, nor will they know the appropriateness or not of administering analgesia. Nursing staff may not appreciate when a patient is opiate naive, nor might they understand the significance of that in setting the first dose. Good notes are, we say, a critical element in the patient's care. In this case, the notes in relation to each of these 12 patients were terribly inadequate and that itself may have led in some cases to failures in patient care.

Let me say something about the paperwork which you are going to receive before we turn to the first patient, Patient A, Code A

There are individual files – you will see them arranged behind me – for each patient. What we have done is to restrict the notes that you are going to receive really for the sake of the management of this hearing, to a lever arch file each and many of those lever arch files are not even full. We have put into each file only those documents which we think are immediately relevant to your consideration. However, we have – as far as I am aware – all of the patient notes available should more documents become relevant. So these, when they are handed out to you, are going to be used, we hope, as working files. If Code A or his team or you as a Panel decide that you need to see more then more is available, but we think that we have it about right. We have retained the original pagination.

As you will know – I know some of you are experienced Panellists – dealing with medical notes can be a nightmare because they are not ordered chronologically; even nursing notes themselves within the nursing notes may not be ordered chronologically. So what Code A Code A sitting next to me has done, we have prepared a chronology that you will find at the beginning of each of those bundles so that we hope you will be able to find by reference to each day where the relevant notes are. As I say, if you feel that you are missing something – and I have no doubt that there will be errors in copying, and that is no criticism of those who sit behind me – obviously please just let us know and we will provide the relevant paperwork.

I can just tell you this: if we were to try and give you all of the notes for each patient frankly you would simply be subsumed in paper and neither side think that that would help you.

There are further files: one is a file containing the reports of Code A and I am going to address you about that once I have finished opening, because we are going to invite you to receive Code A 's reports in advance of hearing the evidence.
I know that that is resisted by the defence but that is an argument that we will have in the future. I think it is more sensible for me to finish my opening so that you know the size of the task in front of you before you make a decision about that application.

A final file contains the statements produced by statements produced by Code A when questioned by the police.

It may have become apparent to you already that there have been a number of investigations into what went on at this hospital. There was a substantial police investigation as well as an investigation by the Commission for Healthcare Improvement.

When Code A was interviewed by the police she made no answer to the many hours of questions which were put to her about what had happened on those two wards. Instead, Code A chose to draft a series of statements which she provided to the police in advance of her interviews. Those statements are themselves, we would submit, self-serving in the sense that they are drafted by Code A or by her lawyers and they were never tested under questioning by a police officer. Nevertheless, it is proposed that you should receive those statements as her account at the time of her actions. But they must, as I say, be regarded as self-serving statements and you will have to wait and see whether or not Code A chooses to give evidence so that in fact she can be tested upon those accounts or not.

Most recently there was a coroner's inquest which looked into the deaths of a number of the patients, about whom you will be hearing. There was a degree of publicity about that inquest and, again, can I say this: that if you have heard anything about that through the press or Internet you will no doubt well understand that you should ignore anything that you have previously read or heard. All that matters so far as your consideration of these charges is concerned is the evidence you will now hear put before you by both sides. The findings of those other hearings and inquiries are at this stage of your proceedings completely irrelevant to your considerations, except in so far as you may of course hear witnesses being cross-examined upon the evidence that he or she may have given in the course of other enquiries. So that is how it may come into these proceedings; but other than we would frankly invite you to ignore them.

I am now going to move on to Patient A. I am just going to pause because I know the Panel is stopping early today and I just wanted to ask administratively how the Panel wanted to play, it as it were. We can keep going; you might decide that you want to take a break slightly early, have a short lunch and then carry on until 2.45 or perhaps you were not intending to take a break.

Code A The Panel do require to rise today at 2.45. It was our intention to take a break for luncheon but I think that provided those who assist us are content for it to be shorter that would assist to some extent in making up time, and I think that we are also scheduled to start somewhat earlier tomorrow morning.

Code A: We were not told that.

Code A You produced a schedule of witnesses that has your first one here for 9 o'clock tomorrow.

Code A That is simply because we are asking all the witnesses to be here at nine just in case.

Code A As a Panel we are quite content to sit at nine tomorrow morning to catch up a bit further. So far as today is concerned, if we work on the basis that we take a 30 minute luncheon break we can fit that to your own estimates of where you are going to be. So we can either go somewhat earlier now before you start Patient A or, depending upon how long you expect to be on Patient A, we could go after.

Code A I am slightly less than a third of the way through my opening at this stage. I would have thought it sensible perhaps to take a break now and then that will give us about an hour and a bit to deal with as many patients as I can without rushing. I can carry on if you require me to, but this might be a convenient point.

Code A It is important that we keep everybody sharp so that what you say does not fall on deaf ears, as it were. We will break now, ladies and gentlemen, for 30 minutes.

(Luncheon adjournment)

Code A Welcome back. Code A

Code A Before I move on, could I take you back to Panel bundle 1 and to tab 3, on page 6, because I think on reflection I should have dealt with this in slightly more detail. Page 6 has the heading "Prescribing for the elderly".

> "Old people, especially the very old, require special care and consideration from prescribers.
>
> Elderly patients are apt to receive multiple drugs for their multiple diseases. This greatly increases the risk of drug interactions as well as other adverse reactions."

Then to the right hand side of the page, under "Adverse Reactions" and below "Hypnotics":

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

Over the page again – and this is where I cut myself short, frankly because I was not dealing with the right point, but I was, and I want to come back to it – page 7, under the heading "Guidelines":

> "First always question whether a drug is indicated at all.
>
> It is sensible policy to prescribe from a limited range of drugs and to be thoroughly familiar with their effects on the elderly."

A Then this:

> "Reduce dosage. Dosage should generally be substantially lower than for younger patients and it is common to start with about 50 per cent of the adult dose. Some drugs should be avoided altogether."

And I think I did in fact deal with the rest of that.

B Just then to introduce you to the rest of that document, at page 8 you will find the heading "Opioid analgesics" and:

> "Opioid analgesics are used to relieve moderate to severe pain ..." Repeated administration may cause dependence and/or tolerance, but this is no deterrent in the control of pain in terminal illness, for guidelines see Prescribing in Palliative Care."

C We have looked briefly at that.

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

D I am not going to go through each drug but you will see that morphine is dealt with, and under that heading of morphine on the right hand side you can see diamorphine, dihydrocodeine and methadone.

Over the page, page 9, under the heading "morphine salts" you will see under "contra-indications" – and I think this is really under the heading opioid analgesics:

E

> "Avoid an acute respiratory depression, acute alcoholism."

Then again you can see the side effects below that. Then on the right hand side you can see that the BNF deals with Oramorph. Again, I am not going into detail; it is simply to point those out to you.

F Then to page 12, please, because you will hear about fentanyl. Fentanyl is to be used, it says, for chronic intractable pain due to cancer.

> "Cautions; contra-indications; side-effects: see under morphine salts."

We have already looked at that. Fentanyl, about which you are going to hear, commonly comes on a patch which can be applied to the skin where a patient either cannot swallow or

G cannot for any reason be injected.

Page 15, you will find at the bottom left hand side of the page hyoscine hydrobromide, about which you will be hearing, which is for dry secretions.

That is all I wanted to draw to your attention in that document.

H

I am going to turn to start dealing with Code A who is Patient A, and I am going to ask that you be handed Patient A's notes, please. (Same handed) This will be, I hope, C2.

Code A Yes, indeed; we will mark that exhibit C2, ladies and gentlemen.

Code A We will keep a running tally, of course, and then provide you in due course with a schedule of exhibits.

Code A That would be very helpful.

Code A It may be useful to take the chronology out and staple it. We have deliberately left a lot of room on these pages, both within the body of the text, and you will see on the right hand side there is a specific column for comments. We have kept the chronology as anodyne as possible, for obvious reasons, so that it can be agreed in its present form by both sides. However, as I say, there is room here for you to add such comments as you think fit. When you come across a document that you think is relevant please obviously make a note of it and then this will become in due course, when you come to consider your determination at the end of the factual stage of the proceedings, a fairly core document to which you will be able to refer back.

You can see that we start with Patient A, with Code A as far back as 1992. But in fact at page 4 you will see on 5 January 1996 it shows that he was in fact admitted to Dryad Ward on that day, 5 January; and it was set out in general terms the drugs that he had been receiving prior to his transfer. Then over the page, page 5, Code A has done as best he can in setting out the medication which was prescribed by Code A

This gentleman was 82 years old when he was admitted on that date, 5 January 1996, to Dryad Ward at Gosport War Memorial Hospital. He had previously been admitted on 13 December 1995, and you see that at the top of page 3, to Mulberry Ward, which, as you have heard, was an elderly psychiatric ward and he was then under the care of Code A

Code A unfortunately, suffered from long term depression and mobility problems. He was at the time of his admission to Mulberry Ward verbally aggressive and was not mobilising well.

On 3 and 4 January he had been assessed first by Code A and then by Code A who recorded, so this is just before his move to GWMH, that he was completely dependent upon nursing case, he had a urinary catheter in place, he had an ulceration on his left buttock and hip and low protein in his blood. Code A indicated that she would transfer him to the GWMH to a long stay bed. It was thought realistically that he was unlikely return to a residential care home. He was noted to be very depressed.

Code A commented that she felt he had lost the will to live. He was transferred on a Friday, which was 5 January 1996. Code A made a short entry which you will find at page 196. Can I ask you to concentrate on the typewritten page numbers at the centre bottom of each page? You will find other pagination, but it is always going to be the typewritten pagination in the centre.

May I mention straightaway that these records are all difficult to read. This afternoon we are going to use the time, because we have finally got hold of the original patient records on Friday, although we received some of them today, in order to see if we can get better copies of these.

Code A One thing that would help, if the originals are going to be recopied, if they could be copied using a magnification of whatever, 25 per cent. Presumably in the page that we currently have that is a true size?

Code A I think actually that is ---

Code A That is a reduction?

Code A I think it was taken off the microfiche.

Code A If we can get up to a full page that would certainly help.

Code A We are going to do obviously what we can. The entry reads, if you look at the top first entry:

> "Transfer to Dryad Ward from Mulberry. Present problems immobility, depression, broken sacrum..."

Which we understand means that the skin around the sacrum was broken:

> "...small superficial areas on right buttock. Ankle dry lesion, both heels suspect. Catheterised. Transfers with hoist. May need help to feed himself, long standing depression on lithium and sertraline".

On Tuesday 9 January Code A noted that the patient's right hand was painful and he had increased anxiety and agitation.

There is an entry on 10 January by Code A It is very difficult to read, but you will see "depression" and then underneath those five lines you will see "for TLC', which we understand to mean "tender loving care". Code A appears to have seen the patient prior to the administration of a prescription for Oramorph later that day. That prescription is indicated on the drug chart at page 200. That is, as I understand it, to be Code A 's prescription for Oramorph 5 mgs five times a day. There is also an undated prescription for 40 to 80 mgs of diamorphine which you will see underneath. It is very difficult to see the 80; you can probably make out the 40, to be given over a 24 hr period subcutaneously. It is likely that that prescription was written out on 10 January at the same time as the Oramorph prescription because it appears to have been superseded the following day on 11 January when Code A wrote another prescription for diamorphine.

If we go over the page to 201; this time the dose that she wrote out was for a variable dose between 80 to 120 mgs to be delivered "SC" subcutaneously together with midazolam of between 40 to 80 mgs. Code A describes this first prescription for opiates by syringe driver as a "proactive" one.

Two doses of oral Morphine appear to have been administered on 10 January. That became a regular prescription for the next five days.

Of the higher prescription on 11 January, which you have in front of you, Code A said this:

> "I would have been concerned that although it was not necessary to administer the medication at that stage, (the patient's) pain, anxiety and distress might develop significantly and that appropriate medication should be available."

Code A has considered that prescription on 11 January. In his view a variable dose in these circumstances of diamorphine between 80 and 120 mgs was poor practice, it was potentially hazardous and the lowest dose, in other words 80 milligrams, was still inappropriately high because it amounted to a four-fold increase in the opiate dose that the patient was already receiving orally. His view is effectively the same so far as the midazolam is concerned. His expert opinion is that these prescriptions ran a high risk, if administered, of producing respiratory depression and potentially coma.

No diamorphine was in fact administered until Monday 15 January. But it was then started at a lowest rate, which was 80 mgs. Midazolam at a rate of 60 mgs was also started. I will just pause for a moment because I see the Code A looking for 15 January. I hope you can go in the chronology to page 6. You will see at the top, 11 January, the prescriptions that were written out. Then on 15 January, as the drug charts indicate, diamorphine 80 milligrams administered, hyoscine at 40 micrograms – that is to dry up the secretions and midazolam 60 milligrams were administered.

The only note that appears to give any justification for that medication is a nursing note, page 208, which I would invite you to turn up. Right at the bottom you will see that this date, 15 January:

> "SB [seen by] Code A has commenced syringe driver at 0825, diamorphine 80 milligrams, midazolam 60 milligrams and hyoscine."

The dose of midazolam, both prescribed by Code A and that administered was excessively high. An appropriate starting dose for a frail older man, as this patient was, if given subcutaneously and if justified at all, would have been in the region of 10 milligrams over a 24 hour period rather than a range of 40 to 80 as prescribed by Code A and 60 milligrams actually administered, particularly in light of the fact that diamorphine was started at the same time. Both of those drugs will have a depressive effect on the vital functions.
The lowest dose of diamorphine prescribed and administered was also far too high given that the patient had, until that point, been on only effectively 30 milligrams of oral Morphine over a 24 hour period the day before. The equivalent dose, even if it were necessary, should have been one of around 15 mgs, increasing only if the patient was still in pain. The midazolam was excessively high according to Professor Ford. There was no explanation for it in the notes and no assessment to justify it.

On 16 January Code A added haloperidol to the mix. A nursing note records that the patient was agitated but that may have been a reaction to the Morphine being administered. There should in any event have been we say a reassessment.

A If I can take you to page 190, going back to the drug chart. I am turning to 17 January so if you want to turn up your seventh page of your chronology. On the 17th Code A again increased the dose of diamorphine, this time to 120 mgs, and midazolam to 80 mgs. You can see that at the top of the page, page 190. I will just pause while people get to that. You will see to the right that there is the date January in the top row. Underneath you will see columns indicating 17 January, 18 January, 19 January. Just taking 17 January as an example, underneath that you will see a time, I think it is 10.30. We will have to get a better copy of
B this, but it appears that the dose of 120 milligrams of diamorphine and 80 milligrams of midazolam were given from the 17th onwards, and that is by way of syringe driver. The patient was hooked up, as it were, to this permanent 24 hour dose.

Code A says that the increases were made on the 17th because the patient was tense and agitated. If we go to page 210 we will see that recorded at the top, not in a note that Code A made, but a note that the nurse made:
C

> "Seen by Code A, medication increased 0825 ..."

Code A I think it is 0830.

Code A "...as patient remains tense and agitated, chest very bubbly."

D Right at the bottom of that you will see that the patient remains distressed on turning. That is the only indication of any pain.

Although the oral Morphine early on prescribed by Code A may have been justified by reason of the pressure sores from which the patient was suffering, there is nothing else in the notes to reflect why such a dramatic increase in the use of opiates was thought to be necessary by Code A The patient was not noted to be in any particular pain although he
E was agitated at times.

No clinical assessment seems to have been conducted before the prescription of major opiates was written. The high point, so far as an assessment is concerned, is the note that you have looked at on 17 January:

> "Seen by Code A Medication reviewed and altered.'

F

Then on 18 January there is noted by Code A and this page 198. If you look at the top entry:

> "Further deterioration, sc [subcutaneous] analgesia continues, difficulty controlling symptoms, try Nozinan."

G On 18 January Code A prescribed that new drug, Nozinan, at 50 mgs. That is a sedating drug which is used to control terminal restlessness and agitation. A note the previous day on the 17th made prior to administration of that drug recorded that the patient appeared to be 'more peaceful', that is at page 210, and it is difficult to see what justification there was for adding another sedative to that mix that the patient was already receiving.

It appears that on Saturday 20 January, a day when Code A would not have been working,
H a Code A was consulted. You will find his notes on page 198. He in fact increased

Nozinan from 50 mgs to 100 mgs but he stopped the haloperidol was apparently on a verbal order. If you look at the entry for 20 January 1996 you will see at the bottom of that entry in brackets "(verbal order)". It appears that Code A from whom you will be hearing, did not attend the patient. This appears to have been done over the telephone. His reason for doing so was that Staff Nurse Code A expressed a suspicion that the haloperidol may be causing a side effect and she was concerned and he was concerned about the interaction of the drugs which the patient had been prescribed. It appears realistically that he was pursuing the regime initiated by Code A that between 17 and 23 January the daily syringe driver was filled with 120 milligrams of diamorphine and 80 milligrams of midazolam. Those drugs in conjunction with one another and with the haloperidol which Code A had prescribed by carried, according to Code A a high risk of producing coma and respiratory depression.

This patient died Code A days after 20 January, on Code A

Code A may say that she was in fact performing regular assessments. If that is so, she made no note of them. It is difficult to see how she could assess the needs of the patient on subsequent occasions when she had no assessment baseline from which to work. An assessment with no note is clinically relatively pointless for the purposes of the future management of the patient, unless of course the doctor is able to remember every patient that she is dealing with. We have to bear in mind that this was a doctor with a regular GP practice, who was spending half an hour in a morning that this hospital.

Code A is very critical of the note keeping, as I have indicated, in relation to drug charts as well. At one stage in this case there were three active prescriptions for diamorphine and, in addition, there were two actively running prescriptions for haloperidol, which obviously would have put the patient at risk of serious harm had they been administered.

The infusions of diamorphine, midazolam, haloperidol and then Nozinan, in Code A 's view, very likely led to respiratory depression and shortened Patient A's life, although he was in fact expected to die in the near future. The death certificate, which you will find right at the back of the bundle, behind a tab, and we have done this for every patient, recorded the cause of death as bronchopneumonia, which I think is the first time that illness has been mentioned anywhere in the notes. That deals with the moment for Code A and you can put his notes away.

Now I was not going, unless it proves necessary, to provide you with all of the patient notes at this stage. If you want them, of course you can have them. You now have a feel as it were for what you are going to see in the patient notes and in due course you will have them. What we are going to do, certainly on our part, is to invite you to take the patient notes in advance of hearing the witnesses. You will have the chronology, which will guide through the patient notes, and so you will have a good idea, I hope with my opening and the transcript of my opening, of the history of each patient. There as it were – when we have days when we have fewer witnesses than others – will be plenty of reading, if I may say so to do, and lots of homework.

Patient B was a lady called Code A and she was born in Code A She was 83 years-old when she was admitted to the Royal Hospital Haslar, and that was on 5 February 1996. It followed a fall at home where she lived alone. She was registered blind but in fact I think was partially sighted. Following her fall, she was x-rayed. No bone injury was found but

A there was concern that she might have suffered a CVA, a cerebral vascular accident or a stroke, and she had pain in her left shoulder and abdominal pain. According to Code A Code A she made good progress. Some weeks after her accident, on 22 February, she was transferred to the GWMH Daedalus ward for rehabilitation and hopefully for return to a rest home. In fact she died two weeks later on Code A

B Upon transfer, she was seen by Code A On the 22nd, the day of her transfer, she noted that the patient had leg ulcers, she was incontinent of urine and suffered from insulin dependent diabetes Mellitus. She prescribed dihydrocodeine, which as I am sure many of you will know is a powerful synthetic opioid based painkiller on the second level of the analgesic ladder. Code A notes that there was no assessment of the patient's pain, nor of her neurological function. There should have been a clinical review but there was not, or at least none that was properly noted.

C On the 24th, two days later, there is a nursing note that patient's pain was not being controlled by DF118 or dihydrocodeine and that she had a sacral sore. She was commenced, by Code A on morphine, 10 milligrams twice daily. Two days later Code A noted that the patient's bottom was very sore and she needed a Pegasus mattress. She wrote: "Institute [subcutaneous] analgesia as necessary". She wrote out prescriptions that day for morphine sustained release tablets at 20 milligrams, twice daily, thus doubling the dose that the patient had thereto been on, and diamorphine at a variable dose as required of between 80 to

D 160 milligrams and 40 to 80 milligrams of midazolam plus hyoscine. A normal conversion dose would have started at 10 milligrams diamorphine, not 80. That is if she had been receiving, as she appeared to, she had been receiving 20 milligrams a day up to that point.

None of those medicines which she prescribed were in fact administered but, of those prescriptions, Code A is very critical. He describes them as "not justified, reckless and potentially highly dangerous". Even the lowest dose of diamorphine would have

E amounted to a fourfold increase in opiates.

Code A s explanation in her police statement was that this was proactive prescribing for pain relief, in case the patient experienced uncontrolled pain. She says that she would have seen the patient on 28 February, 29 February, as apparently there was that year, and 1 March, but appears to have made no note about any assessment that took place. Then 2 March and 3 March was a weekend.

F

On the following Monday, which was 4 March, the notes, as you will see, record that Code A increased the slow release morphine prescription from 20 milligrams twice daily to 30 milligrams twice daily. Her next entry on 5 March was that she noted that the patient had deteriorated and was not eating or drinking. She noted that the patient was in "some pain, therefore [she wrote] start SC analgesia".

G A nursing note records that the patient's pain was uncontrolled and the patient was distressed. Nurse Code A whose note that was, explains that she would have been relying on the night staff in order to make that entry and the dose was authorised by Code A

The syringe driver was commenced by the nurses at 9.30 that day, 5 March. It was started with diamorphine at 100 milligrams and midazolam at 40 milligrams over a 24 hour period, which doses were allowed for by Code A s prescriptions for diamorphine between 100 and

H 200 milligrams over a 24 hour period. Her prescription for midazolam was between 40 and

A 80 milligrams, which, Code A says, was necessary to relieve the patient's pain and distress. An equivalent dose to that which the patient was already receiving orally but now to be given subcutaneously would have been in the range of between 20 and 30 milligrams per 24 hours. So even though the nurses were in fact starting at the minimum dose prescribed by Code A even that was over three times greater than the previous dose of opiates. If the intention was to control the patient's pain by increasing the dose, then a 50 per cent increase, at most, might have been appropriate. Code A describes the prescribing by Code A B as "reckless and dangerous".

The following day, 6 March, Code A notes that the SC, the subcutaneous analgesia has commenced and that the patient was now, as she put it, comfortable and peaceful. She also wrote:

"I am happy for nursing staff to confirm death."

C

A nursing note says that the patient was seen by Code A that day, 6 March, and the medication other than through the syringe driver was discontinued as the patient was unrousable. Given the dose of diamorphine to which she was then being subjected that is perhaps not surprising.

Code A states that the description of this patient as being comfortable and peaceful D was more likely to reflect the reality that the patient was by that stage in a drug-induced coma. Code A the patient died. In Code A 's view, the administration of the subcutaneous diamorphine and midazolam led to the patient's deterioration and contributed to her death.

In respect of each patient, as you will have noted in the heads of charge, Code A is charged with prescribing drugs in such a way as to create a situation whereby the patient could be E administered drugs which were excessive to their needs, and that such prescribing was inappropriate, potentially hazardous, and not in the patients' best interests. It may be thought to be relevant specifically to those charges that there is evidence in this case that, in some of these cases, excessive drugs were indeed administered and the hazard did indeed arise. Additionally, in Code A 's view, when the patient's condition deteriorated, there was a duty upon Code A to consult with her consultant colleagues as to the best approach to future treatment. It is for that reason, that specific criticism, that you have heads of charge F which relate to the failure to consult colleagues, which has been admitted in each case now by Code A

I am now going to turn to Patient C, who is better known as Code A was 87 years-old when she was admitted on 6 February 1998 to the Queen Alexandra Hospital, having experienced what is described as a general deterioration over a five day period and complaining of nausea and reduced appetite. A suspected malignant mass was seen in her G chest. The notes recorded on 12 February that she should be managed with palliative care on Charles Ward, to which she was transferred on 19 February. On 23 February 1998, she was diagnosed as being depressed and suffering from possible carcinoma of the bronchus, ischaemic heart disease and congestive heart failure. She was plainly not at all well but she does not appear to have been in any pain.

She was transferred to GWMH on 27 February 1998, according to Code A 's note for H continuing care. Her Barthel score was 0 to 2, which meant that she needed help with all of

her basic bodily functions. The Barthel scoring system is a method of assessing a patient's ability to cope with their daily living requirements. You will hear about this document again. If you could take up bundle 1 please, and go to tab 7, we put one into the miscellaneous bundle. This is actually a Barthel index relating to Code A You will see at the top the patient's name, the Barthel ADL index, which I think is Activities of Daily Living. The total score that is available as it were runs up to 20. So if a person is fully able to look after themselves, they will get a Barthel score of 20. If they need assistance with everything, they will get zero. This patient, as you see, scored 9 because she needed some help so far as her bladder was concerned, she was incontinent, but she had occasional accidents concerning her bowel movements. Her grooming, she could look after herself. She needed some help with her toilet. She was independent in feeding herself. She had major help to transfer, in other words, I take it, to move out of bed, but, her mobility, she could walk the help of one person; she scored 2. She needed a bit of help with dressing but she could do some unaided. She could not do stairs and could not bath herself. So she scored 9. That gives you an idea.

This patient, Code A who we are dealing with now, her Barthel score was I think 2, which meant in effect that she needed help with all of her basic functions.

A note made by Code A the duty GP on 28 February, records that this patient felt confused and lost but was not in any pain. She was distressed and she was given thioridazine and a small dose of Oramorph, two and a half milligrams, to help her.

We move on to 2 March, so this is the week after she had been admitted to the GWMH on 27 February 1998. On 2 March Code A suggested the use of adequate opioids to control fear and pain. A fentanyl 25 microgram patch was started that day, as well as a small amount of diamorphine, 5 milligrams given by an injection. As we have looked at already, fentanyl is a very powerful synthetic opioid which comes on a patch, which can be applied to the skin. It is useful in circumstances where it is difficult for any reason to inject the patient. By its nature, its effect is less immediate but may be longer lasting and the effects remain long after the patch is removed and that may be significant.

That patch was the equivalent, according to Code A of about 90 mg oral dose. Her drug prescriptions up to and including this point are in fact approved of by Code A who regards them as a reasonable response to the patient's anxiety despite the lack of pain, although, he says, the fentanyl patch is very likely to have caused the patient to become very drowsy.

The following day, the day after the fentanyl patch had been applied, there was a rapid deterioration in the patient's condition, with her neck and both sides of her body being described as "rigid". On the same day Code A prescribed diamorphine with a variable range from 20-200 mgs daily and midazolam at 20-80 mgs daily by syringe driver. There is no note that the fentanyl patch was removed or directed to be removed. That syringe driver was commenced at 10.50 in the morning with 20 mgs of each drug and Code A the patient was pronounced dead.

Those prescriptions of diamorphine and midazolam were in Code A 's opinion not justified.

Her deterioration, as it was noted on 3rd, could have been as a result either of a stroke or an adverse reaction to the fentanyl patch which had been applied to her. However, there was no

A indication that the patient was at that stage in any pain. The drugs would be expected to result in depression of the level of consciousness and respiratory depression. He says that the prescriptions were not consistent with Good Medical Practice and the analgesic ladder was not followed.

Patient D, better known as Code A was born in 1916 and she was 81 years old when she was admitted on 31 July 1998 from the Addenbrooke Rest Home to the
B Queen Alexandra Hospital Portsmouth Philip Ward which was within the department for elderly medicine. She had had a fall and she was refusing fluids. She was severely dependent and had a zero mental test score when she was transferred to GWMH Daedalus Ward on 6th August 1998. The nursing notes reveal that she was for "assessment and observation and then decide on placement". A further note reveals – "pain at times, unable to ascertain where".

C Code A assessed the patient on 10 August 1998:

> "Barthel 2/20, eating and drinking better, confused and slow. Give up place at Addenbrookes. Review in one month. If no specialist medical or nursing problems discharge to a new home'.

That presumably would have meant a continuing care bed within the NHS.

D

An entry on 17 August in the nursing notes records that there had been a deterioration over the weekend and the Code A had agreed that active intervention was "not appropriate". Then this note is made: "To use syringe driver if patient is in pain"

There is in an undated prescription – and a number of the prescriptions by Code A were undated – written for this patient by Code A for between 20 and 200 mgs of diamorphine
E and 20-80 mgs of midazolam per 24 hours and by syringe driver. That prescription must have been written on or before the 20 when a syringe driver was started.

On 20 the syringe driver was started with 30 mgs diamorphine and 20 mgs of midazolam. Prior to that point this patient had not been receiving any analgesic drugs but Code A Code A who visited her that day did notice that she appeared to be in pain. But having said that, in this case it is difficult to see how the analgesic ladder was being applied
F because the first drugs used were opiates at a relatively high level for an opiate naïve patient.

The next entry in the notes by a doctor is Code A, by Code A, who writes:

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

G

A nursing note of the same day records that the patient is "comfortable and pain free". But on that day the patient's Code A recalls Code A looking in, looking at the patient and saying, "Any time now." And at 6.30 pm that day the patient's death was confirmed. So within Code A effectively of the syringe driver being initiated the patient was dead.

H

In Code A 's opinion there was nothing to justify the use of a syringe driver in this case – milder analgesics could and should have been tried first. A medical assessment was required before prescribing those drugs when the deterioration was apparent.

The variable range prescribed by Code A was poor practice, very hazardous and in Code A 's view unjustified.

So far as the notes are concerned, the only acceptable medical note was that made by Code A on 10 August and that was during the entirety of the patient's stay at the GWMH.

I am going to turn now to Patient E, Code A . She was born in 1907 and she was 91 years old when she was admitted as an emergency via the A & E department at Haslar Hospital on 29 July 1998. She had fallen on her right hip which was then painful. She was found to have a fractured neck of femur. Surgery by way of hip replacement was performed very promptly on the 30 July.

On 3 August she was seen at the Haslar by Code A He found her to be confused but pleasant and cooperative. He took the view that despite an element of dementia, as he thought, she should be given the opportunity to be remobilised and with that in mind he organised her transfer to the Gosport War Memorial Hospital.

Between Code A 's assessment and transfer on 11 she had an episode on 8 August when she was recorded as being agitated and she was calmed down with drugs, using haloperidol and a drug called thioridazine.

Code A remembers that she made a good recovery after the operation and was soon up on her feet and walking, albeit with the use of a Zimmer frame.

On Tuesday 11 August she was transferred to Daedalus Ward at the GWMH. By that stage she was fully weight bearing and walking with the assistance of two nurses. She was continent but needed total care with washing and dressing. The purpose of her admission appears to have been rehabilitation.

Code A 's note on admission was this:

> "Impression frail hemi-arthroplasty, not obviously in pain, please make comfortable. Transfers with hoist, usually continent, needs help with ADL (Activities of Daily Living) Barthel 2. I am happy for nursing staff to confirm death."

Code A describes this note as revealing a much less proactive not to say pessimistic attitude towards this patient's potential rehabilitation. Code A 's failure to recognise the patient's rehabilitation needs may have led to subsequent sub-optimum care for this unfortunate patient. Code A also says that she was, in his view, in pain from her hip but if that is so that was not recorded at the time and the notes on 12, the day after her transfer, state specifically that the patient did not seem to be in pain.

On the day of her admission to Daedalus Ward Code A wrote a prescription for a variable dose of between 20-200 mgs of diamorphine together with 20–80 mgs midazolam to be administered via a syringe driver. Fortunately none of that prescription was in fact

A administered at that time, although the midazolam was administered at a later stage when the patient was re-admitted to the hospital for reasons I will come to.

Code A also prescribed oramorphine 10 mgs on 11 which was administered on the morning of the patient's admission. That prescription Code A regards as inappropriate in the circumstances and may indeed have precipitated what followed.

B The following night on Wednesday 12 the patient was very agitated, possibly as a result, of course, of her new surroundings at a new hospital, but potentially also as a result of the commencement of opiate analgesia and she had to be settled with a dose of haloperidol. Code A describes her as agitated and he ascribes pain as being the cause of that agitation but he does not appear to have made a note to that effect. The patient's Code A visited Code A on the day after her admission, i.e. on 12 and was very surprised to find that Code A was unrouseable. She remembered that up until her transfer to GWMH – in C other words, when she was still being cared for at the Haslar Hospital – Code A had been enjoying three meals a day.

On 13, Thursday, she was found on the floor having fallen from her chair. That fall may well have caused, it appears, a dislocation of her repaired hip and that undoubtedly would have caused the patient pain. Code A who visited her that day, remembers this being obvious and that Code A was weeping and calling out. And the staff at the GWMH at D first instance seem to have thought, wrongly, that this was as a result of the patient's dementia.

The following day, 14, the patient was assessed by Code A who noted that sedation and pain relief had been a problem and that the patient was very sensitive to Oramorph and the patient was referred to the surgeons at Haslar again and a further operation was undertaken. Again, once she was at the Haslar she appears to have recovered well from that operation and E there are no complaints about her treatment there.

Three days later, on Monday 17 August she returned to the GWMH and the transfer unfortunately appears to have been performed inappropriately. It appears that she was transferred – and this is not laid at Code A s floor – without the use of a canvas sheet, which would have supported her body; and in fact it looks as if at one stage certainly she was transferred with a normal sheet which put too much pressure on her hip causing it further F damage and pain. The decision appears to have been by Code A not to send her back to the Haslar Hospital again.

On that day Code A wrote out a further prescription for a variable dose of 40-200 mgs of diamorphine. The patient was then dosed with 40 mgs of diamorphine but at that stage, given that the patient was indeed in pain, Code A takes the view that the dosage, although high, was not unreasonable.

G

On the Tuesday 18 the patient was recorded by Code A as being "in great pain" and was then put onto a syringe driver on the direction of Code A She was dosed with 40 mgs diamorphine, 20 mgs midazolam and 5 mgs haloperidol and that dosage continued until her death.

The expert's view is that midazolam which had in fact been prescribed back on 11, should H not have been added to the cocktail of drugs that she was in fact given after her second return

to the GWMH because the combination of drugs was likely to lead to respiratory depression and coma.

Code A s explanation in her police statement was that it was being used as a muscle relaxant to assist her movement and to make her as comfortable as possible. Code A recorded on 21:

"I think more peaceful, needs hyoscine for rattly chest."

And at the patient died Code A

As you will have seen, the focus of the charges in respect of this patient, who undoubtedly had an extremely unfortunate experience in any event, is upon the original prescription by Code A back on 11 August but before the patient had her second fall and dislocated her hip. That prescription was, say the GMC, unjustified and dangerous and indeed allowed for the administration of midazolam to the patient at the end of her life of which Code A is critical.

Code A is most critical of that early prescription where there was little or no indication that the patient was in any pain at all. And in the last days of her life it is accepted that certainly there were indications that she was in pain and did require pain relief by opiates but there is a lack of suggestion or evidence that the patient was in pain when she first arrived at that hospital.

Indeed, when Code A was interviewed by the police and made her statement, she indicated that the patient did not appear to be in pain. Indeed, immediately prior to her arrival at GWMH the patient had not been on regular analgesics at all and the only tablets that she had last taken was two tablets of cocodamol, but no indication that that had not been sufficient to deal with any pain that she was also suffering.

So the expert is of the opinion that it was simply inappropriate to start the patient on opiate medication before trying milder analgesics.

The decision immediately on her arrival at hospital to prescribe subcutaneous diamorphine, haloperidol and midazolam was inappropriate, reckless and placed the patient at serious risk of respiratory depression and coma if they had been administered. The administration of the midazolam in the last days of the patient's life when added to the other drugs was unjustified and inappropriate. That administration would appear to have been upon Code A s direction and it was her prescription.

I can deal perhaps with one further patient before the break, if that is convenient.

Code A By all means.

Code A This patient would be Code A who is in your charges as Patient F. She was born in Code A and was aged 84 when she was admitted to the Royal Haslar Hospital on 5 August 1998, also suffering from a fractured neck of femur following a fall at home. She was operated upon the same day and she was transferred to the GWMH two weeks later, on Tuesday 18 August, the same day in fact as our last patient was put on to her syringe driver.

A One of Code A who saw her on the weekend prior to her transfer on the 15th and 16th describes her as being 'very lucid' and 'up-beat'. She was mobile with a Zimmer frame and she could wash her top half independently but she did suffer from leg ulcers, angina and breathlessness. One of the last notes made by Code A Code A Royal Haslar Hospital before she transferred on 18 August was "well, comfortable and happy. To GWMH today." That patient died Code A days after her admission on Code A

B Her Barthel score on admission was 9 and so she was able to wash and feed herself but she needed help getting dressed and some help with walking. Her Barthel score was recorded at the Royal Haslar before her transfer.

Code A 's note on admission to the GWMH recorded the history of the fall and she gave her a Barthel score of 6. Her note then reads:

C "Gentle rehabilitation. I am happy for nursing staff to confirm death."

Nurse Code A for one was surprised when she saw that annotation in this patient's notes. The patient was started on Oramorph and 5 mgs was given to her just after lunch on the day of her admission. The nursing notes record that the patient had two sacral pressure sores and ulcerated legs.

D That night the patient became anxious and distressed, she was in a new hospital obviously, and she wanted someone to sit with her. She was given 10 mgs of Oramorph instead. The following day, the Wednesday, 19 at 11.50 Nurse Code A describes how she administered the patient with Oramorph oral solution 10mgs in 5mls. That drug is of course a pain killer. The patient was complaining of chest pains which were not radiating down her arm.
In Nurse Code A 's words she was just continuing the prescription which had been started the night before. She was unable to comment on any pain that the patient was suffering. That

E may be an indication of the regime to which nurses had become used and which was unfortunately pursued.

In her police statement Code A claims that she reviewed the patient on the morning of 19, in other words the Wednesday, but made no note about it. She says that she was concerned that the patient was going to die shortly and wanted to be sure that she had appropriate pain relief for the pain from her fractured hip and her sores, and also from her anxiety and distress.

F Either on 18, or more probably on the following morning 19, the day after her admission, Code A prescribed her a variable dose of diamorphine, so this is following the Oramorph, at a range of 20 to 200 mgs, and midazolam 20 to 80 mgs over a 24 hour period. The prescription is undated but we know that it was administered at 4 pm in the afternoon on the 19th. The Syringe Driver contained 20 mgs of diamorphine and 20 mgs of midazolam.
Nurse Code A made an entry in the notes that the patient's pain was only being relieved for

G short periods and that the patient was very anxious.

On the following day, the Thursday, the diamorphine was doubled to 40 mgs. Nurse Code A noted that the patient was still suffering some distress when moved. Code A Code A went to visit her on the 20th. She had been a regular visitor to Code A up until that point and she noted a marked deterioration and a dramatic decline.

H A day later on the 21st those drugs were increased again to 60 mgs each, so 60 mgs diamorphine and 60 mgs midazolam, at 0735. Code A says that she may have been

A unaware of that increase but she would in any event have approved it. The patient's death was recorded at Code A

Code A is critical of all of Code A s prescriptions. On the night of the 18th, on the day of her admission, it is unfortunate that the response of the staff to the patient's agitation was to provide her with a dose of Morphine when she simply wanted someone to sit with her. In the alternative, if no one really was available, a dose of temazepam would have calmed the
B patient.

The lack of clear instructions as to what the Morphine was to be used for may explain why it was given for distress and anxiety when there was no indication of pain. It is not an appropriate first line treatment for stress or anxiety; indeed Morphine can in fact promote or exacerbate exactly those symptoms.

C There is no indication from Code A why she thought it right to prescribe either the diamorphine or the midazolam and there appears to have been no adequate assessment of the patient. If there was an assessment there was no note made of it.

The reality is that the patient deteriorated very rapidly after the commencement of the syringe driver and there was no medical assessment as to why that was happening. It may well have been due to the sedative effects of the opiates that were being automatically injected into her
D body. The reaction to the patient's deterioration was to increase the quantities of the opiates she was receiving.

It is likely that this patient died, not from her illness, but as a result of the combined effect of the drugs in her system. That deals with that patient.

Rather than move on to the next patient, could I deal with a matter of housekeeping? I am
E very grateful to Code A who has agreed, because I think we both think it is sensible, that you should have in this case the witness timetable. With his agreement I am going to pass that out to you. The purpose of giving it to you first of all is so you can see who is being called, who is being read, and who we hope to call as a live witness. It will also give you an idea of the schedule.

When there are gaps in the days, if we run out of witnesses, you will have to blame me. It
F has been extremely difficult. It is always extremely difficult to try and get these things absolutely right. Of course I do not know, and I would not ask, how long Code A is going to be cross-examining any particular witness. Let me pass those schedules out and then I will make a comment or two if I may about them. (Same handed)

Code A This is the timetable?

G Code A Yes, this is the witness timetable. We, the GMC, are proposing to try and keep to this as closely as possible. You will see that tomorrow is a relatively light day because we did not frankly how much argument there was going to be today, and indeed there is still an argument that we are going to have about Code A 's reports.
Can I just indicate so far as tomorrow is concerned, the only substantial witness that we were going to have after Code A who I think will not be very long, is Code A who is
H Patient B's son. I am afraid we have had an email, literally over lunch in our 30 minute break, from his doctor to say that he, on Friday I think, he suffered from chest pains. His

A doctor at the moment has not advised that he attend. I am afraid that we have not been able to react to that. We will in fact have legal matters to deal with tomorrow in any event. Tomorrow may or may not be a light witness day.

Then if I can just take you through, you can see that we are proposing to call the patient/relative witnesses for each patient in order except, as you will see, when we get to Patient K who is at the bottom of page 2. The reason for that is that that witness, Code A
B Code A can only give evidence that day and can only give evidence by way of video link. I will have to make an application to you as a Panel to receive her evidence in that way. That is why we have dealt with the evidence in respect of Code A out of time.

Then you will see that we get back on track, as it were. Can I then take you to page 5? You will see that there are various witnesses that I can read, if we can agree some reading with Code A Other witnesses will be called. I hope there will be a measure of agreement as
C to what can be read from statements and what cannot.

At page 5 you will see that we are calling the nurses, those nurses who we are calling, in a group. The reason for that is that, as I have indicated, many of these nurses deal, as you will see from the middle column, with a multiplicity of patients. To try to call them in respect of each patient would make, I think, your task and probably mine impossible.

D Then over to page 6, you will see we are calling the doctors and consultants as a group. We are now on day 14 and day 15. Then finally on day 16, which will be at the start of the fourth week of these proceedings, we have a witness who is the Code A Code A and then we have Code A

Code A is going to start giving evidence on 30 June. Could I ask you to note that in the comment column you will see that he is not available I am afraid on 1 July? If we find
E we are in the middle of his evidence I will have to ask you not to sit although I expect you will have plenty to do by that stage of the proceedings.

If we stick to that timetable, which on some days is going to be light, we will finish the GMC's case certainly within five weeks, and probably within four. If we manage to do that we, I think, will be doing relatively well given the timeframe for this particular case. Could I ask you first of all not to put undue pressure, as it were, on us if you do find that we have
F days when we have fewer witnesses not to try and bring witnesses forward. Ultimately we are going to come unstuck if we try to do that.

Could I also say this: tomorrow, because we are going to have probably going to have a shortish day, we can of course sit at 9 am if you wish to, but we will need to have breaks? I say that because when you rise you will appreciate that both teams of lawyers will continue working. As you, sir, know well, and certainly your Code A will know well, in order to
G keep a case like this running there is a great deal of paddling to be done under the water and so I hope you will give us time to paddle, as it were, to make sure that the case stays on course and we will try and complete the timetable, as indicated.

Code A In the circumstances it does not look as though there is a particular need for us to start at 9 tomorrow as it seems fairly inevitable that it will be a shortish day in any event. Shall we revert to the normal sitting time tomorrow of 9.30 with the breaks as and
H when you need them?

Code A I would be very grateful. There is only one matter we will have to deal with which may take a bit of time and that is this argument whether you should receive Professor Ford's reports in advance. I think Code A is preparing a skeleton; we are drafting a skeleton to decide that. That is the only legal matter I think that remains that we have put before you before we start the evidence.

Code A Very well. Thank you very much indeed. We will rise now, ladies and gentlemen, and return tomorrow morning at 9.30 am. Thank you.

(The Panel adjourned until Tuesday 9 June 2009 at 9.30 a.m.)

**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Tuesday 9 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 TWO)

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)

# INDEX

A Code A Good morning everybody. Code A ?

Code A I was about to move on to deal with Patient G, who is Code A Code A was 79 years old when he was admitted to the hospital, to Dryad Ward, on Monday 21st September 1998 under the care of Code A to whom he was known. He had been admitted to the psychiatric ward, Mulberry Ward, some months earlier, on 21st July 1998, when he was depressed and tearful, and since 27th August that year he had B been living in a local nursing home known as 'The Thalassa'.

He had been seen at the Dolphin Day Care Hospital by Nurse Pamela Gell, where he was found to be very frail, with a large necrotic sacral sore. He was depressed, he suffered from dementia and he was diabetic. Code A decided that he should be admitted to Dryad Ward for treatment of his sacral ulcer, and she wrote on the day before his admission – and in due course when you have these notes you will find it at page 644 – she wrote that he was to be C admitted to Dryad Ward for treatment of his sacral ulcer; he was to be given a high protein diet, and Oramorph if he was in pain. Code A notes that the nursing home was to keep his bed available for him to return for at least three weeks, but his prognosis was described as being 'poor'.

The day after that note, Code A saw him on the day of his admission, on 21 September, and she made the following note:

D

"Transfer to Dryad Ward. Make comfortable, give adequate analgesia. I am happy for nursing staff to confirm death."

It appears that she prescribed Oramorph 2.5 to 10 mg as required, and diamorphine at a variable dose of between 20 mg and 200 mg, and midazolam between 20mg to 200 mg, and she wrote out that prescription, it would appear, on that very day, even though in fact the E prescription was undated. Really, it seems, as soon as he arrived at Dryad Ward, or soon thereafter, he was given Oramorph 5 mg at 2.15 in the afternoon, and then 10 mg at 8.15 in the evening.

I say that the prescription was undated, but it has to be presumed to be the 21st because he was in fact also put onto a syringe driver on that same day, at ten minutes past eleven that night, to deliver opiates to him automatically.

F

Code A 's explanation for her prescription, to the police, was that she was concerned that the Oramorph might become inadequate in terms of pain relief.

The patient's Code A went to see him on the Monday of his admission, so before the syringe driver had started, and he found him to be cheerful but complaining that "his behind was a bit sore". The patient was started on a syringe driver that G night at a rate of 20 mg diamorphine and 20 mg midazolam; and according to Code A 's notes the other drugs he had been on, co-proxamol and senna, were not given because the patient was being or about to be sedated. The notes reveal that the patient remained agitated until approximately 8.30 in the evening, and they also reveal, frankly, that the patient had been behaving pretty offensively. However, the driver was not commenced, as I say, until ten past eleven that night, and by that time, before the driver was commenced, the patient was described as 'peaceful'. That may well have been as a result of the Oramorph kicking in, as it H were. So it is hard to glean, at least from the notes what caused the commencement of the

A syringe driver. Code A states that although the patient was peaceful, it was not certain that he would remain that way.

Two days later, on Wednesday 23rd , the medication was increased to 20 mg diamorphine but 60 mg midazolam. A note made by Nurse Hallman records that he was seen by Code A on the 23rd, he had been chesty overnight, and so hyoscine was added to the driver. That note is at page 868 of the records.

B His Code A was informed of a deterioration and he asked if it was due to the commencement of the driver. He was informed that the patient was on a small dosage, which he needed. Code A saw Code A again that day, two days after he had last seen him, when he described him as being cheerful but complaining that his behind was a bit sore, and when he saw him, now on the Wednesday, he found Code A Code A to be unconscious, and he was shocked by the difference in his condition. He was

C so concerned that he asked for the syringe driver to be stopped so that at least he could have a conversation with Code A but this was denied.

He insisted, apparently, on a meeting with Code A who informed him that the patient was dying due to his bedsores and that it was too late to interrupt the administration of the drugs. Code A says that she reassessed the patient on a daily basis; but if she did, she failed to make any notes about it, and she refers in her police statement to the doses the patient

D received as "small and necessary".

On the following day, Thursday 24th, the midazolam was increased to 80 mg, and on the following day after that, the 25th, the diamorphine was increased to 60 mg. That followed a further prescription from Code A dated Friday 25th now for a variable dose between 40 mg to 200 mg diamorphine and 20 mg to 200 mg of midazolam, so the lowest dose of the diamorphine had gone up.

E On each occasion that the dose was increased, Code A claims in her police statement that she "anticipates that the patient's agitation might have been increasing".

The following day, Saturday 26th, the diamorphine was delivered to the patient's body at a rate of 80 mg, and the midazolam at a rate of 100 mg. That of course was well within the variable dose that Code A had prescribed. The patient died Code A apparently,

F according to the death certificate, of bronchopneumoniA

The first prescriptions on the day of his admission written out by Code A are described by Code A as "highly inappropriate" and "reckless", particularly in light of Code A s assessment, as you will recall, from Haslar, that he should be prescribed intermittent Oramorph if in pain. There is no doubt that the patient would have been in pain from his sacral sore, but there was no indication prior to him getting to the GWMH that the patient

G have been unable to take any medication. The prescription written by Code A which allowed the nurses to administer the diamorphine and midazolam was undated but, as I say, it must have been written on the day of admission because it was administered that night, and was for a dose range of between 20 mg to 200 mg diamorphine, and 20mg to 80 mg midazolam. It was, according to Code A poor management to prescribe those drugs to an elderly frail underweight patient – I think the patient at this time weighed about 68 kg – and it created the hazard that the combination of drugs could result in profound respiratory

H

depression. You will recall the guidance, or course, in the *BNF* about reducing the dosage for elderly patients.

The increases on the 23rd and thereafter are described as inappropriate and dangerous by Code A He also expresses the concern as to whether the nursing staff would have understood how long it takes for the opiates delivered through a syringe driver to take full effect, which in this case would have been between 15 and 25 hours. So it appears, in fact, in the records that they were being increased before they would have the full effect in the original dose.

As his condition worsened, in all likelihood, we submit, as a result of the drugs which were being administered to him, there was apparently no assessment to discover the cause – or at least none that was recorded. Code A admits that she did not seek advice from a consultant, as she could, and we say should, have done.

The various dose increases without explanation is described as very poor practice. Even if that was being done independently by the nurses, Code A we say, had created the situation where that had become a possibility.

The administration of 100 mg midazolam and 80 mg diamorphine would produce respiratory depression and severe depression of the consciousness level.

In addition to all of this there is no note that the patient was provided with food or fluid during the period following his admission until his death Code A days later, and that is despite the note from Code A that the patient was to be provided with a high protein diet. The very opposite seems to have occurred.

The cause of death, given as bronchopneumonia, can occur as a secondary complication to opiate-induced respiratory depression.

Let me turn to Patient H, better known as Code A

Code A was 75 years old when he was admitted to Queen Alexandra Hospital on 21 September 1998. He had sustained a fracture of his humerus bone following a fall. Whilst at the Queen Alexandra Hospital he was given relatively small doses of morphine for pain. On assessment his Barthel score was 5.

On 7 October it was noted that he did not want to go into care but wanted to return home. He was seen by a Code A who was a Code A in old age psychiatry. She noted that he had been a heavy drinker during the previous five years, and she thought he may have developed early dementia.

The following week, on 13th October, which was a Tuesday, he was assessed by his consultant physician at the Queen Alexandra Hospital, Code A who found that he needed both nursing and medical care, and that a short spell in a long-term NHS hospital would be appropriate. Code A felt that he would remain at risk of falling until fully mobilised and he thought that the patient's kidney function should be reviewed. He prescribed his patient frusemide, which is a diuretic, and for pain relief he prescribed paracetamol. The patient could, according to the doctor, have stabilised or alternatively he could have died quite quickly.

A

The patient was visited on the day of that assessment, 13 October, by Code A who remembers him on the day before his transfer to the Gosport War Memorial Hospital sitting up in bed and having a joke. On his discharge from the Queen Alexandra Hospital he was taking paracetamol and codeine as required for pain, but he had only required four doses of codeine over the five days prior to his transfer. He was a heavy man, weighing some 93 kg.

B

On Wednesday 14 October, the day after his assessment by Code A he was transferred to Dryad Ward for continuing care. Code A noted on his admission that he needed help with his daily living activities, his Barthel score was 7, and he lived normally with Code A He was continent, and the plan was for further mobilisation. She also noted – and this may be significant – that he had alcohol problems. He also had congestive cardiac failure.

C

Code A has noted that there was no record of any symptomatic medical problem at that time. His blood pressure was not taken, nor was there any clinical examination. It is important to note in respect of this patient that he was not admitted for palliative care but for rehabilitation.

Code A saw him on the day of his transfer to GWMH, and indeed

D

travelled with him in a minibus which was used for that transfer. She remembers him being lucid that day and being able to hold a conversation.

The nursing note at GWMH on the day of admission recorded that the patient had a long history of drinking and LVF – which is left ventricle failure – and chronic oedematous legs.

On the day of his admission into the GWMH Code A prescribed him Oramorph 10 mg in

E

5 mils, 2.5-5 ml, four–hourly despite the fact that in the days leading up to his transfer he had only been on codeine for pain relief. That prescription for Oramorph was administered twice that day, once in the afternoon at 1445 and again in the evening at a quarter to eleven at night.

The following day, the 15th, he was administered 10 mg every four hours. That was given, according to the nursing notes, because he was complaining of pain in his left arm. Up until the stage of his admission to GWMH his pain had been controlled by codeine and

F

paracetamol, and Code A regards that very first prescription of morphine at that stage to have been inappropriate. Code A saw him that day, the 15th, and describes how Code A Code A was in "an almost paralysed state".

On Friday 16th the patient was seen by Code A who noted that the patient had deteriorated overnight, and he was for active nursing care. Code A describes him as being almost in a coma and unable to speak.

G

Later on the 16th, on the Friday – so this is just two days after his admission – it was noted by Nurse Code A that his chest was very bubbly, and a syringe driver was commenced with 20 mg diamorphine and 400 mcg hyoscine. That was on the basis of a prescription written by Code A which may have been written, according to Code A on the day of admission. That prescription was for a variable dose of diamorphine, between 20 and 200 mg over a 24-hour period – almost, you may think, the standard dose for Code A That was,

H

according to her police statement, one of her 'proactive' prescriptions for pain relief.

A

There appears to have been no re-examination by Code A prior to that prescription being administered by the nurses. Indeed, from her police statement it appears that Code A was actually away on the day that the syringe driver was started.

It is quite possible, according to Code A that the morphine the patient had been receiving via Oramorph that was the cause of his deterioration.

B

The following day was a Saturday, the 17th. His secretions had increased and the hyoscine was increased to deal with them. In the afternoon the dosage of diamorphine was increased to 40 mg, and midazolam was started at 20 mg.

The date of Code A 's prescription for midazolam at a variable dose between 20 mg and 80 mg is unclear but it must have been obviously on or before the 17th, the date it was

C

administered. There was no record made of the reason for starting the midazolam, and at the time the notes suggest that the patient was in fact, as it is put, "comfortable". Code A views the use of midazolam in these circumstances, together with the diamorphine, to have been highly inappropriate.

No consideration appears to have been given by Code A or by the nursing staff to the real possibility that the reason for the patient's deterioration may well have been the infusion of

D

the cocktail of opiates which he was receiving automatically through a syringe driver. The prescription of continuous subcutaneous diamorphine is not an appropriate treatment for a diagnosis of myocardial infarction and heart failure in a patient who is otherwise pain-free.

A particular issue with this patient is one that I have mentioned, and I will come back to, which was his previous chronic alcoholism, which had been noted by staff and appears to have been known to Code A

E

The use of opioids in patients with liver disease as a result of alcoholism has to be very carefully monitored, and preferably not used unless required to deal with severe pain. If he was in severe pain, then a low dose of morphine would have been a more appropriate response.

On the night of Saturday 17th and into the morning of the 18th, that dosage was continued but

F

in the afternoon of the Sunday it was increased again, from 40 mg to 60 mg diamorphine and from 20 mg to 40 mg of midazolam. During none of this period was there any note made by either nurses or doctors that the patient was in pain, though there were many notes that the patient was deteriorating.

At 20 to 12 on Code A the patient's death was recorded. That was four days after he had entered that ward at Gosport War Memorial Hospital. It was recorded that he

G

had died from congestive heart failure. Code A is of the view that the cocktail of drugs is highly likely to have led to respiratory depression and/or bronchopneumoniA

Patient I, better known as Code A was 92 when she was admitted to the Royal Haslar Hospital on 19 March 1999, following a fall in which she had broken her hip. Prior to her fall, she had been living at home and caring for herself. According to her medical notes, she had been active and in good health. The fracture was described by an orthopaedic

H

surgeon called Code A who has examined her notes – he did not treat her but he has looked at this case post these events – as a "relatively complicated" case.

At the Haslar she had initially been given three doses of 5 mg morphine over 20 and 21 March; so in the two days immediately following her fracture. That morphine had resulted in hallucinations; so she plainly had an adverse reaction to morphine – and that is not an uncommon side effect, apparently. A note was therefore made by the anaesthetist, "nil further opiates". She was operated upon on the 20th, when a right dynamic hip screw was inserted. The only other analgesic prescribed for her, apart from the morphine, which was stopped on the second day, was paracetamol.

She appears to have had post-operative complications by way of bleeding, and a haematoma developed and she had a painful hip. Code A reviewed her on 23 March and noted that she was still in a lot of pain and that was proving a barrier to mobilisation.

She was transferred three days later, on Friday 26 March, to Dryad Ward at the Gosport War Memorial Hospital. However, prior to her transfer, when she was still at the Royal Haslar, she had become mobile. She was walking short distances with a zimmer frame and with the assistance of two nurses. She was continent, but not at night, and her only analgesia when she was discharged from the Royal Haslar was paracetamol.

Code A made a note on her admission, at page 27 of the notes when you get them – "Past medical history, nil of significance; Barthel", and then there is no score; "Not weight-bearing; tissue paper skin; not continent; plan, sort out analgesia". Code A prescribed her Oramorph on the day of her admission – 10mg in 5 ml, 2.5 mg four times a day.

A note by a nurse asserts that the patient had complained of a lot of pain, and oral morphine was administered on 26, 27 and 28 March, and then discontinued because the patient was vomiting it. That, you may think, was consistent with her reaction at the Royal Haslar Hospital. She was given co-dydramol as an alternative.

On the 27th, although it was a Saturday, Code A believes that she reassessed the patient, although, if she did, we cannot find a note of that. On the 27th she had increased the Oramorph from 10 ml four times a day to 20 ml four times a day. As I say, the care plan also records that the patient was experiencing pain on movement.

If pain was uncontrolled by less powerful analgesics, then those prescriptions were appropriate, according to Code A However, there is no note, as I have said, from Code A recording her assessment or her reason for prescribing as she did. And the patient should not have been in severe pain unless something had gone wrong with the hip repair, which should then have required reassessment.

The fact that Code A has recorded that the patient was not weight-bearing is not consistent with the notes at the Royal Haslar, and is either inaccurate or indicates that there had been a change in the patient's mobility. That in itself should have triggered a reassessment. A nursing note some days later, on 4 April, records that the wound was oozing serous fluid and blood, and the wound was redressed.

Going back to 31 March, Code A had then prescribed, to replace the Oramorph, 10 mg of morphine sulphate to be given twice a day. A week later she was seen by Code A and he

A suggested that there may have been a problem with the hip screw and said it may be that that was causing the patient's problems. He requested that an X-ray be arranged. Unfortunately that was never actioned.

That day, 6 April, Code A increased the dose of morphine by slow release tablets to 20 mg twice daily. In her police statement she reveals that she would have seen the patient that morning but made no note about it. The review by Code A therefore, was the first noted
B review since that patient's admission on 26 March, 11 days before.

A note by Code A of the consultation with Code A reveals that Code A had been incontinent a few times but was insistent about not going into a care home. There was in that note in fact no mention of pain. The prescription issued by Code A for slow-release tables on 6 April was administered until 11 April, which was the Sunday. On the Sunday, the patient was described as being very drowsy but still in pain if moved. She was by then, of
C course, effectively on 40 mg of morphine per day.

The following Monday, the 12th, Code A prescribed diamorphine by syringe driver at a variable dose between, as usual, 20 mg to 200 mg over a 24-hour period, as well as 20 mg to 80 mg of midazolam, and there is no note of any further assessment by her.

Those prescriptions are described by Code A as "reckless and inappropriate". The
D patient was already described as "very drowsy" and any dose over about 30 mg subcutaneously would be highly likely to produce coma and respiratory depression.

In fact the dose administered by Nurse Code A either because of her own calculation or under Code A 's direction – we do not know – on 12 April, was 80 mg of diamorphine and 30 mg of midazolam. Those doses that were administered were well within the variable dose that Code A had prescribed, but in fact were much higher than the dose of morphine that the
E patient was already receiving and extremely dangerous. The equivalent subcutaneous dose would have been 20 mg of diamorphine, without the midazolam. Nurse Code A could not explain why the patient was administered such a large dose and she in fact thought that the dose was only 60 mgs when she was asked about this.

When Code A noticed that the patient was receiving such a high dose of diamorphine, 80 mg, he reduced it. He cut it in half, down to 40 mg, but in fact the patient died the following day.
F In Code A 's view, the drugs that she was being administered were in fact a direct contributor to this patient's death.

Code A the orthopaedic expert, raises concerns in relation to the lack of response to the patient's pain, which should have prompted the doctors to look for a possible orthopaedic explanation for her symptoms, instead of simply prescribing her ever-increasing amounts of analgesiA No review of that sort was ever done.
G

The charges on this occasion therefore reflect specifically the lack of assessment by Code A given the patient's condition on entry onto the ward. Criticism is also made of her prescription on the 12th and the direction to administer such a high dose on the same day.

I am moving on now to Code A who is Patient J. Code A was born in Code A and so he was 67 years old when admitted to Dryad Ward on 23 August 1999. He was
H very obese; he was suffering in both of his legs from oedema, in other words swelling. He

A also suffered from venous hypertension, atrial fibrillation, and he had poor mobility. He had a low Barthel score and, frankly, he was not a well man.

How he had got to Dryad Ward was because some weeks earlier he had suffered an accident in his bathroom at home. It had taken two ambulance crews to get him out of his bathroom and he was admitted Anne Ward at the Queen Alexandra Hospital on 6 August. On 8 August it was noted that he had very severe sores on his sacral area and the annotation was made in
B his notes on two occasions, "not for 555". That apparently meant that he was not to be given resuscitation in the event of a life-threatening event. Eventually, however, according to his Code A he in fact made a good recovery in hospital and he looked better than he had for years.

He was, on 23 August, transferred to Dryad Ward for recuperation and rehabilitation. When he was assessed on Dryad Ward by Code A the problems recorded were obesity,
C arthritis in both knees, pressure sores. His mental test score, however, was good, there being no significant cognitive impairment. His Barthel score was at 6, but Code A remembers this patient as having the worst pressure sores she had ever seen.

Code A believes, according to her police statement about this patient, that she must have reviewed him on the morning of the following day, Tuesday 24th, but made no note about it. On 24 August, a drug called Clexane was prescribed, which he received to reduce the risk of
D a DVT, as well as temazepam. That Clexane may in fact have caused quite severe problems later on; in particular, a gastrointestinal bleed, from which the patient was to suffer. The following day, on 25 August, he was found to be vomiting and passing fresh blood through his rectum. Again, there is no note of any review by Code A though she thinks she performed one. Because of the symptom of passing fresh blood through his rectum, Code A was contacted and directed that Clexane, which was an anti-clotting agent, should be stopped.

E

Code A recalls visiting him with friends on or about the 25th or 26th – so the Wednesday or Thursday after his admission on the Monday – and she met Code A for the first time. According to her, Code A took her into a room and told her bluntly that Code A Code A was going to die and that she should look to herself now. Code A was very shocked and surprised.

F On 26 August, Code A made this note: "Called to see. Pale, clammy, unwell. Suggests ?MI" – which I take to be myocardial infarction. "Treat stat diamorph and Oramorph overnight. Alternative possibility GI" – gastrointestinal – "bleed but no haematemesis", which I think is vomiting of blood. "Not well enough to transfer to an acute unit, keep comfortable. I am happy for nursing staff to confirm death". There was no note of pulse, blood pressure, or any other indication of a clinical examination. However, on that day, Thursday 26th, Code A appears to have given a verbal order to give diamorphine
G intramuscularly, which was injected that day. She also prescribed Oramorph, 10 mg in 5 ml four times a day, which was administered daily thereafter from the 27th until the syringe driver was commenced three days later, on the 30th. The syringe driver was therefore effectively commenced seven days after his admission.

There is also an undated prescription written by Code A for a variable dose of diamorphine of between 40 mg and 200 mg and midazolam, 20 mg to 80 mg. She said in her police
H

A statement that she wrote that prescription out on the 26th and we accept that may well be right; but she says that she had no intention that it should be administered at that time.

The following day after the prescription on the 26th, on the 27th, the patient is noted to be in discomfort, particularly when his dressings were changed. Code A claims that she would have reviewed him, but made no note of it. The syringe driver was commenced on Monday 30 August, which was a bank holiday. It was commenced at the rate of diamorphine 40 mg
B and midazolam 20 mg. There is no note from Code A about that and she is not sure if she would have been there, because it was a bank holiday. It therefore seems that the syringe driver may have been started at the discretion of the nurses, and the amount of opiate to be administered was within the range set by Code A and indeed at the lowest dose for diamorphine, because her lowest dose was 40 mg. Code A believes the nurses would have spoken to her before starting it, but there is no note of that recorded.

C Those same doses were administered on Tuesday 31 August, when it was also noted that he had passed a large amount of black faeces, which was an indication of a significant gastrointestinal bleed. The following day, Wednesday 1 September, the diamorphine was increased to 60 mg and the midazolam to 40 mg and then, later the same day, up to 60 mgs; then the following day there were increases again.

On 1 September, Code A visited him and he did not wake up throughout the visit. Code A s
D Code A remembers that Code A deteriorated once he was in the GWMH and that he appeared to be "spaced out". She describes the change as "dramatic". On Thursday, 2 September, diamorphine was increased to 90mg and the midazolam was increased to 80 mg in 24-hour period.

Code A who was a nurse, said that she could not imagine such an increase taking place without the authority of a doctor. Code A says that she would have reviewed the
E patient, but made no note about it. She said this in her police statement: "I anticipate again that (the patient) would have been experiencing pain and distress." If that is so, you may think it is very surprising that no note was made about it. The patient's Code A sat in throughout the second and he was unconscious throughout the day. On Code A Code A at ten to two in the afternoon, Code A days after admission to the ward, the patient died.

F In Code A s opinion, the patient's death from a massive gastrointestinal bleed was contributed to by the Clexane he was prescribed, but it was stopped the following day, and it was also contributed to, in his view, possibly by the opiate induced respiratory depression. It is important to note that this patient was not dying, nor expected to die, prior to his deterioration on Dryad Ward from 26 August. He had pressure sores, but those were treatable and he has been transferred or recuperation and rehabilitation. Before deciding that the patient should not be transferred to an acute unit, which Code A did on the 26th, she
G should have had further discussion with a senior consultant colleague. That is reflected by the charge which has been admitted.

Her assessment of the patient was, according to Code A inadequate. Her verbal order to administer diamorphine was inappropriate. There was never Panel order to administer diamorphine, inappropriate. There was no proper explanation for the doses of subcutaneous diamorphine or midazolam. There is no explanation for the dramatic increase in the
H

quantities of those drugs being administered and the dose ranges were inappropriate and hazardous and unjustified by the assessment of the patient's condition.

Code A Sir, may I rise to make one thing clear? I do not think my learned friend meant to put it in quite the way he did. It might have been thought that he was suggested it was admitted that Code A should have consulted a colleague. That is not the way it is put in the charge. It is admitted that she did not; not that she should have. I understand why my learned friend put it that way, but I want to make it clear that the admission does not mean an acceptance by us that she should have, in those circumstances.

Code A Can I move to Patient K, better known as Code A was an 88-year-old lady when she was admitted on 9 October 1999 to the Queen Alexandra hospital with an episode of acute confusion. Her problems are summarised by the letter, by Code A who is a Code A in old age psychiatry, which you will find at page 29 of your bundle. She is described as being confused, disoriented and sometimes aggressive. She had a medical history of treated hyperthyroidism and chronic renal failure. She was independent and was able to wash, but she did tend to her herself lost.

She was transferred from the Queen Alexandra Hospital on Thursday 21 October 1999. There was a referral date, which you will find at page 21, written by Code A geriatrician, who had seen her two days earlier and stated that she was alert and could stand, but was unsteady on walking. She was increasingly confused and had been aggressive until she got to know the staff.

Code A 's note on admission on Thursday 21st stated that she was for continuing care. She needed help with all her daily living needs, but she had a Barthel score of 8. The plan is described as "plan get to know. Assess rehabilitation potential possibly for a rest home in due course."

On 25 October and 1 November there are further entries by Code A indicating that the patient was continent, but mildly confused and wandering during the day. She was suffering from renal failure, but was still physically independent, although she needed help in bathing.

Two weeks later, on Monday 15 November, there is a note that she had been aggressive on the ward. She had needed an injection of a drug called Thioridazine to calm her down. Code A was one of the nurses who helped look after her and she recalls the specific aggressive incident when the patient had grabbed a nurse, would not let go and kicked out at Code A saw her on his ward round that day, but that was the last time he saw her. He noted that there was not a single entry on her clinical notes since the last time he had seen her two weeks before. He made a full examination of her. Her heart, chest, bowels and liver were all normal, but her legs were badly swollen. He wanted the patient to be seen by Code A the psychiatrist, and he made a note to that effect.

Three days later on Thursday 18 November, the patient was seen by Code A who was one of Code A s team. Arrangements were being made to transfer her to an old age psychiatric ward, presumably Mulberry, for assessment and management. However, that same day, when she was seen by Code A who was making those arrangements, she was described as confused and aggressive and Code A prescribed a Fentanyl patch for the patient. As I have explained, Fentanyl is an opiate which is applied in this case to the skin by patch. There was no indication in the notes as to why Code A thought it appropriate to start the patient on

A opiates. There is no reference anywhere in the notes to this patient being in pain. Code A in her statement to police about the patient stated that the patch was "an attempt to calm her, to make her more comfortable and to enable nursing care."

The timing may be of some significance. The patch was apparently applied on the 18th at 09.15 in the morning. Those patches can take up to 24 hours to become fully effective, and they remain in the system – the effect of the drugs remain in the system – for between 12 and
B 24 hours after the patch has been removed.

A note made by Code A the following day on Friday 19th indicates there had been a marked deterioration overnight, the patch of course having been applied 24 hours earlier. Code A wrote on the 19th: "Today further deterioration in general condition. Needs SC [subcut or subcutaneous] analgesia with midazolam. Son aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death."
C

Code A prescribed that day diamorphine at a rate of between 40mg to 80mg and midazolam between 40mg to 80mg. In addition, at 8.30 on the 19th, the patient was given injection of Chlorpromazine, 50 mg, prescribed by Code A following an incident in which the patient is suggested to have been aggressive with nurses. Chlorpromazine is a tranquilliser and 50mg is, according to Code A at the upper end of the normal range of the dose. An hour later a syringe driver was started by the nurses that day, Friday, at 9.25 in the
D morning. It contained, as Code A prescribed at the lowest dose, 40mg of diamorphine and 40mg of midazolam. The fentanyl patch was still on the patient, and it seems it was not removed until about three hours later at about 12.30, according to the notes. There is no record anywhere in the notes that the patient was at any time in pain. At this stage, therefore, on this Friday morning, this patient had in her system Fentanyl, Chlorpromazine, diamorphine and midazolam.

E It is very difficulty to understand why anyone would have thought it appropriate to start this patient on anything less than the minimum dose of midazolam, even if the patient was complaining of pain, which she was not.

The syringe driver was kept replenished for the next two days at those dosages. Code A wrote in her police statement: "This medication (diamorphine and midazolam) was prescribed at 09.25 and was administered with the sole intention of relieving the patient's
F significant distress, anxiety and agitation which were clearly very upsetting for her." Code A again says that she had been making daily weekday reviews of this patient, but accepts that she failed to make a note of any of them, and that she greatly relied on daily reports from the nurses in charge and their nursing note entries. The patient died Code A days later on Code A

Dealing with the diamorphine and midazolam prescription on the 19th, Code A can
G see no justification for it. Even if the patient had been in pain, for which there is no evidence, the starting doses were excessively high. An appropriate starting dose might have been 10 or 20mg, if the patient was in pain, but not double that and not when coupled with Midazolam. Neither, in Code A s view was the Fentanyl justified. This regime of opiate medication has, according to him, every appearance of being given to keep the patient quiet, which would not be an appropriate use of opiates in this setting. In his view, the drugs administered are very likely to have led to respiratory depression and coma.
H

Patient L is Code A was 73 years old when admitted to the Royal Haslar Hospital on 26 April 1999, after experiencing chest pains and collapsing. She was found to have suffered a stroke, as a result of a cerebral infarction. She was looked after for several weeks, but she did make a substantial recovery.

On Thursday 20 May – so about a month after her stroke – she was transferred to Daedalus Ward but she was, according to records, in a very poorly condition. She died Code A days later. The criticism by the GMC of Code A 's care of this patient hinges around her immediate prescription upon entry on to the ward on the 20th of Oramorphine, diamorphine and midazolam, in the usual variable ranges. This is not a case, the GMC accepts, where this particular unfortunate patient was likely to recover or leave hospital. The only note by Code A was on 20th, on the day of her admission, 20 May. The second note was made by nurse Code A which recovered her death on Code A There was a recorded conversation with Code A on the 21st, noting that he was anxious that medication should not be given which might shorten her life.

On the day after her admission a syringe driver was started with 20mg diamorphine and 20mg of midazolam. Code A 's entry makes no mention of the patient being in pain and contains no record of any physical examination of the patient. In Code A 's expert opinion, there is no evidence that Code A undertook a Code A of the patient, although it is right to say that the patient had previously complained of chronology abdominal pain, but treatment, in his view, with opiates would not have been appropriate at that time. In addition, he says, the doses were again far too wide and the dose of midazolam particularly excessively high.

As already indicated, Code A is critical of the quality of Code A 's note-making. She failed to note assessments of the patient's condition, if she was making them, she failed to make notes about important decisions relating to treatment and prescribing. She made few, if any, notes about why she regularly increased the dosages of her prescriptions. The GMC submit that failing to make appropriate notes in relation to assessments on admission to hospital is particularly serious, because it leaves other treating medical personnel in the dark about what the baseline condition of the patient was upon admission. It left her, Code A with no notes that she could rely upon to assess properly whether the patient's condition had improved or worsened. In view of the complete lack of notes, it has to be inferred, we would submit, that no assessments were being properly performed before opiates were prescribed.

The reality in this case, as you will have gleaned from this opening, is that the prescription of very large doses of opiates appears to have become a matter of course at the Gosport War Memorial Hospital for the patients under Code A 's care. It is our submission that the patients' best interests were not being served. The prescribing by Code A was, on occasion, we say dangerous, inappropriate and left far too much to the discretion of the nurses, however experienced they were. Patients were overdosed with opiates, so much that they became unresponsive.

That is all I say about the background facts to this case. As you will appreciate, this is an old case. So for that reason, we are working under the old rules, which means also the burden of proving the charge is, as usual, upon the General Medical Council, but that the standard of proof in this case is the criminal standard. In other words, before finding any of the heads of charge which have not been admitted proved, the Panel would have to be sure that Code A had acted in the way alleged.

I have given you already the witness schedules, so you know what is planned for those. What we are doing at the moment is working backstage, both last night and this morning, to try and improve on the quality of the notes in the bundles. As you will have seen in Bundle A, the notes are very poor. I can only say that we have been trying for a long time to get the original notes, both from the police and the Trust. Those turned up on Friday of last week, and some more I think are due today. So it is not through lack of effort, as it were, to try and get these things sorted out. We do, however, have a set of notes for Patient A. We have the same pages as you have in your copies, but they are larger and better copies. We will hand those out, if we may. They have been repaginated. We invite you to get rid of the old pages and perform the replacement exercise yourself. We are happy to do it, but you may have marked the notes and it would be inappropriate for us to see those. It may take a little while to do it, and apologies for that.

We then need to address you in relation to Code A s reports. Both sides have prepared skeleton arguments, and it may be useful if you were to read those skeleton arguments in advance of hearing our various submissions about whether you should or should not receive Code A s reports, and that might be an appropriate moment for a short break.

Code A Are we going to do the bundle work prior to the ---

Code A Yes.

Code A How long do you anticipate that will take?

Code A They are being brought in right now. I would have thought it would take you five or ten minutes or so to do it.

Code A Perhaps we will do that before the break, then, and we could perhaps take with us the skeleton arguments and incorporate that into the break so that you have a longer period, rather than us coming backwards and forwards.

Code A Yes. (Documents handed)

I am sure I do not need to talk you through it. The pages are paginated at the bottom, and they simply replace the pages which I hope you have.

Code A They are very much clearer; that is excellent.

Code A We will also hand in our skeletons, then can we leave the room to you?

Code A Once we have the skeletons, you are absolutely free to go. How many pages are the skeletons running to, Code A?

Code A Not very many. Mine is four, and I think Code A s is rather shorter.

Code A Let us say we will resume at ten past eleven, please.

Code A May I say that when you receive the skeleton argument on behalf of Code A there is a typo on the second page. It will be apparent – the third line, it says "... unusual for a GMC Panel to receive an expert's" – and the word "report" has been left out, I am afraid. The reading will make it obvious, I think.

Code A Thank you, Code A

(The Panel adjourned for a short time)

Code A we have updated our bundles, and we have all read the skeleton arguments.

Code A Thank you very much. Sir, this is our application, so perhaps I should start. I can be very short, because you have seen the reasons why we want to put Code A 's reports in. Can I just show you what physically that would mean; it is not a lever arch file but it is a fairly full ring binder. What Code A has done is that first of all he made a report to the Hampshire Constabulary back in 2001, and those reports were in relation to five of our patients. He then wrote what I have referred to as a generic report, which is a general introduction to the analgesic ladder and opiate medication, and an explanation of the various drugs which are mentioned in this case and their inter-reactions. Then he has dealt afresh with each of our 12 patients, setting out briefly their history of events, the medication that was prescribed to them once they were on Dryad ward, when it was prescribed and when it was administered, and the effect of that administration, and his criticisms. So that is what we are encouraging you to receive.

There is no specific rule that we are aware of either that says that you cannot receive it or that says you can receive it. It is a matter for you, of course, to control your own process. We are not trying to circumvent anything or go behind anything by doing this. Obviously in due course you will hear from Code A . If, as a result of evidence during the case, Code A has changed his opinion, you will be in a good position to appreciate that.

Can I deal with the defence skeleton argument briefly. Specific criticism is made by Code A and Code A in the fifth paragraph that Code A 's reports which we are encouraging you to receive are based upon various documents which include medical and nursing records, but also statements taken by police officers. Then they say:

> "Many of the witnesses, from whom statements were taken by the police, had concerns as to the accuracy and completeness of those statements. Many nurses, due to give evidence at this hearing, gave evidence at the inquest hearing ... Their evidence differed ... from the contents of their statements ... It will be obvious that there is a serious risk of prejudice if the panel were to see the reports from Code A Code A based upon partial and inaccurate statements taken by police officers."

As a result of that criticism I have reviewed Code A 's reports this morning. What Code A in fact has done is he has relied – although it is right to say that he has received certain statements, in producing his reports he has actually relied, as far as I can see, and I will be corrected if I am wrong, entirely on the records, which are not challenged. He has relied on the records, and he has relied on the referral letters – in other words everything contained within the patients' medical files. Again I will be corrected if I am wrong, but

A I have not seen a single comment upon, for instance, a nurse's statement or a patient's statement; that is not how he has done his reports at all.

So we would submit first of all that although he may have had other statements, he has written his reports based entirely on the medical records, the accuracy of which is not challenged.

B Being pragmatic, being realistic, there could in fact be no objection if I were to read to you as part of my opening the entirety of Code A 's reports. It would probably take me about four hours to do; it would not be produced to you in a very convenient form, although I suppose ultimately you would have the transcripts which you could refer to whenever you wanted to.

My opening has already been based of course in large part on Code A 's reports, so we
C do not understand on this side of the room what prejudice can actually in truth arise. If Code A makes concessions and changes his view as a result of evidence heard before you, you will be in a very good position to identify that that has happened.

The end of that paragraph, paragraph 5, reads as follows:

> "There could be no valid objection if Code A gave his opinion based upon the
D evidence that is actually given during the GMC hearing: but it would be quite wrong for the Panel to consider his opinion based on what he thinks the evidence is going to be."

As we have said, he has based his opinion so far on the notes, so if evidence does change his opinion you will know that. You are not a jury, if I may say so, you are an experienced professional panel, and you should be treated as such. You are well able to ignore what is
E irrelevant but to take account of that which is relevant.

This is simply a tool to assist you to follow and understand the evidence that you are going to hear. I will not repeat the complications of the evidence; it is quite apparent from my opening, where I have given you a very light touch, as it were, of some of the evidence that you are going to hear. But there are complications about this case, particularly when we get to the medical staff, who will be dealing with a variety of patients.

F

So our submission in essence is that this is simply a tool which will assist you to follow the case, to understand the evidence that you hear, and we do also rely on the point that is made in the skeleton – we do not want to get to the position of having no reports, hearing the patients, hearing the medical staff – the doctors, the consultants, the nurses – then hearing from Code A and saying "Well, I wish I had asked this witness that, because I would have done if I had known that this was referred to in the report". This will give you the
G advantage of being able to clear up any matters as you wish to, as the evidence proceeds. So in our submission it would be appropriate for you to receive the reports, with the caveat that ultimately it is the expert's opinion as he gives his evidence on oath before you that actually matters.

Code A Thank you very much, Code A ?

H

A Code A Sir, this application is strongly resisted. In our submission it is extremely unusual, if not unique, that the GMC should be able to present to the Panel in advance of any evidence an expert's report which is contentious. It may very well happen that, by agreement between the parties, documents can be placed before the Panel – for example, an expert's report on some matter where there is essentially no dispute. But here these conclusions are disputed.

B May I also make this clear: there is no problem about the Panel having before it a factual history set out in a particular way – chronologically would obviously seem to be the most sensible thing. But what is attempted here or is being attempted is to put before the Panel in advance of any evidence the opinions of Code A – that is the crucial thing. It so happens – and this may be a matter for debate – that the way that Code A sets out the history with regard to individual cases – a narrative of the history without comment – is not actually particularly easy to follow. That is no criticism of Code A he is entitled to C compile his reports in any way he likes. But, for example, he will have a section dealing chronologically with what the nursing notes say, and he will have another section dealing with what other records say. They do not lie side by side in the sense of slotting in chronologically. So actually in terms of trying to follow the series of events as they happened, Code A 's reports may not be in the most helpful format.

But that, with respect to my learned friend's argument, is not the point. I make it absolutely D clear now that if my learned friend and his team wish to put before the Panel a chronological narrative history with regard to each patient, if you like, fleshing out the chronology you already have with regard to prescriptions, then there would be no objection. So that is not the difficulty; that is a matter for my learned friend to decide what he does in terms of presentation of the case, and we are not in any way resisting or seeking to object to anything which assists the Panel in having a useful – to use the word my learned friend used – tool for following the evidence. But that is not the point with regard to Code A It is his E opinion which is being expressed in this report that is something which should not be in documentary form before the Panel at this stage. It is unique, in my submission.

I have enquired of those who assist me, and they are unable to think of a case in which they have been involved where the Panel has in advance a contentious expert report, and indeed, as I understand it, my learned friend is seriously suggesting to the Panel that Code A 's contentious report should be looked at before you get to each individual patient. What in fact F is happening is my learned friend is saying "Here is my case. When you look at Patient A, this is my case expressed by Code A . That is not fair, it is not balanced, and it is completely contrary – I do not think I am putting it too highly – completely contrary to the normal way in which these cases are conducted.

It is unnecessary, too, for the reasons I have already indicated, and it carries with it real risks that the Panel would have in front of it a contentious document which may influence the way G in which the Panel, consciously or unconsciously, approaches the evidence with regard to a witness. The important thing above all – and again I am not putting this too highly – the vital thing in this case is that the Panel decides the case on the evidence.

Code A 's report, just like that, is not evidence. What the Panel will be hearing is what he has to say, and there will be no difficulty, since his evidence, apart from anything else, appears at the end of all the factual history you have heard – and you have heard from other H doctors before him. His evidence coming at that stage, this Panel will be very familiar indeed

with the history with regard to the patients. You will have seen the records, you will have heard the witnesses who dealt with patients having given evidence. It is not a case where you will not be able to follow the evidence if you do not have Code A s report – particularly his opinion.

One has to ask the question rhetorically: why should the Panel have the opinion of one witness before the witness has even given it in evidence in documentary form so it will assist you with regard to the evidence? It is exactly the same as if my learned friend Code A were to say "I've opened the case to you" – his job being in opening the case to you to present the case so that you can comprehend the nature of it, and what it is you are going to have to deal with – "I've opened the case to you, and when we get to each individual patient I am going to make a further speech to the Panel to say what it is our case is with regard to various matters". I do not think my friend would even contemplate making such an application, and I do not think – no disrespect, because it is a matter for the Panel, of course – but I cannot see any Panel conceivably allowing that to happen. That is the reality of what my learned friend is actually seeking to suggest in terms of this procedure.

The important and critical features, apart from the fact that the case has to be decided on the evidence – I cannot stress that enough, and Code A s report is not evidence – he is the prosecution case. The GMC are inviting you to have in front of you a document, before the witness has said a word in evidence, which sets out their case.

The objection to this application, if sustained, as I submit it should be, does not shut out from this Panel one single word, one single issue, one single matter in terms of evidence. You will be hearing from Code A in detail when he gives his evidence.

May I turn, sir, briefly to our skeleton argument, and I am not going to read through every word of it. We have set out obviously at paragraph 2 that he is a highly contentious witness. For the members of the Panel to receive his reports would be unnecessary, inappropriate and likely to be highly prejudicial to Code A We endeavour to support every one of those objections in the skeleton argument, and where a course is being proposed for which there is no particular foundation in the rules, and which is in my submission, unique – or maybe I will call it highly unusual, as we cannot actually establish, I suppose, that it is unique – in such circumstances the Panel would obviously want to give full weight to the objections raised by the defence.

Paragraph 3 of the skeleton, which was written before my learned friend actually had opened his case, sets out that the fact of the matter is that his opening address, which he has now completed, which was really quite detailed, and must have made it very clear indeed to the Panel what the issues were, or what the matters were that you were going to have to deal with – that having been concluded, there is no need for a further opening speech if there are any deficiencies in what Code A has already said.

The further point is made in the skeleton – and I think perhaps it is of great importance in considering the nature of this application – the Panel already have in front of them documents to assist them in following the evidence. It may be that further documents can be put in which relate to the narrative or the history which will again assist the Panel. Opinion at this stage is irrelevant, unnecessary in terms of the evidence, and does not assist the Panel to follow the history with regard to individual patients.

The fourth paragraph – again I am not going to repeat every word of it – makes the point that in criminal proceedings it would be unheard-of for a jury to see an expert's report in circumstances like this. It would be wholly inappropriate for the Panel to see an expert report based, like Code A 's, on statements of witnesses due to give evidence. It is quite inappropriate, and we set this out as a basic proposition, for members of the Panel to take an expert report when they retire to consider their findings. What you will be considering is the evidence given by Code A not any document that he prepared months, if not years, ago.

May I just say this about the witness statements: it may be that my learned friend is right, that he does not specifically refer to a witness statement. I am not going to trouble with that kind of detail; but what Code A says in relation to each one of the patient cases he is expressing an opinion about, he says – and I will just quote from one of them: "This report is based on my review of the following documents: medical records of Patient A, statement of Code A with regard to Patient A, witness statements of" – and then lists eight or nine witness statements. That is what his report is based on. Whether he cites passages from them or not is, with respect, neither here nor there. But all of those pieces of material that he has relied on go to assist him in forming his view – a view you will be hearing in evidence. That is the important thing. You do not need to have his views in advance of any evidence.

Apart from anything else on that point, may I say this? Code A , with all due respect to him, has very sensibly, very properly, indicated to you with regard to each patient what it is that Code A criticises. He has set it all out. I do not think that the Panel, even if it does not possess super powers of recall, can have any doubt at all that Code A is saying, "These doses of drugs were inappropriate, were too high and administered at the wrong time". That is basically what it is. We will be able to go into the detail when we hear the evidence further.

I am not going to repeat the other paragraphs in our skeleton; may I just turn back to the skeleton my learned friend Code A put before the Panel? He set out the position with regard to what the rules say – or really what they do not say – because you will in fact hear all the evidence. I am not going to go through his paragraphs 2, 3, 4, 5, 6 and 7 because none of those apply. I am not criticising him for setting them out, but none of them actually apply to the situation we are now in.

In relation to his paragraphs 8 and 9, however, when one looks at the reasons that are put forward, may I just say this? "The scale and complexity of the case makes it necessary...." With respect, it does not make it necessary for the Panel to have contentious opinion before it. There is a very sharp division between a part of Code A 's report which might assist in terms of being a tool for the Panel to use – that is, pure, uncontentious narrative – and his contentious opinion.

The issues that will have to be dealt with will have to be dealt with patiently and carefully and will all be clear, as we hear the evidence in the case. The figures, for example, will all be set out before the Panel. They can all be put onto a separate chronology, if necessary, and can all be put into a separate document – without causing the problems that this proposed course envisages or involves.

"The Panel will be assisted enormously in following the case, understanding the patient notes and the evidence of Code A in reaching its conclusions." With respect, not with

regard to Code A 's opinions. My learned friend Code A has made clear what his case is.

"If the Panel clearly understands the matters subject to criticism by Code A in advance of the other evidence commencing, the Panel can ensure that all potentially relevant evidence is adduced from the witnesses." Again, with respect to my learned friend, it is extremely difficult to see how that makes any sense at all. The Panel will be able to ask witnesses questions if my learned friend Code A has not presented his case adequately in chief. I am sure that he will not fail in any sense to present his case properly. The Panel will have heard cross-examination in appropriate cases from me or from or from Code A The absence of Code A 's report does not prevent the Panel asking any questions it wants to. If, in the unlikely eventuality that a member of the Panel should think "Oh, I wish I'd asked that question", then the witness can be called back or the witness can, by agreement, be asked the question and the information relayed to the Panel. To suggest that that possible problem warrants taking this wholly unusual, wholly exceptional course, is simply not justified.

Similarly in relation to the last parts of the skeleton. Again, I am not going to go through all the detail because I think the points I have already made cover all of those circumstances. It comes down to this. If the Panel needs a tool to assist in following the evidence, or putting the evidence together comprehensively in terms of its narrative, uncontentious history, then by all means let there be such a document produced. I am sure that we could do it. It can be done, if necessary, patient by patient, putting the whole thing there in a chronological sequence. Not contentious opinion, which the Panel will decide upon at the proper time – which is when Code A gives his evidence and is cross-examined on it.

Sir, those are my submissions on the point.

Code A Thank you. Code A ?

Code A May I reply very briefly? In relation to the last comments that Code A was making about Panel questions, I have to confess that I have rarely sat down after examining a witness without there being at least one Panel question. That is the nature of these types of inquiries. It does not mean that the barristers have not done their jobs. There are normally Panel questions, because things arise to Panels that would not necessarily arise to the mind of a lawyer.

I do ask if it is conceded that, at the time that Code A comes to give evidence, the Panel can then receive his reports. My learned friends might think it is unique; it is not unique. Panels very often ask to see the reports. If it is a simple report, I, as a prosecutor, normally resist that; but if it is a complex case, a Panel is often in the position of being presented with a report before the expert gives evidence or at the time that the expert gives evidence, so that they can follow the course of the evidence. If that is right, I simply do not see why you cannot receive it at an earlier stage.

Finally, this. My learned friend says that I would not dream of reopening my case, as it were, in advance of each patient. That is absolutely right. However, these proceedings are intended to work and, of course, you have the transcript. I think that we have all just received the transcript of my opening. I have little doubt that when we get to Patient D or E, if you have forgotten what the essential case is in relation to that patient, you will take up the transcript and have a look. There is nothing to prevent your doing that and indeed there is

every reason why you should do it. If you find that a useful tool, then in a similar way we would say Code A 's reports will be a useful tool, with the caveat that we have already indicated. That is my response.

Code A Sir, may I simply deal with that one point which has been raised? It is new in terms of the argument and it will take me only a moment to deal with it.

If my learned friend wishes to provide the Panel with Code A 's report when we get to his evidence, then that is the appropriate time for him to apply and for the argument to be addressed. It may be that circumstances will have changed by then. Who knows? But if that is what he seeks to do – and it may have been done in other cases in those sorts of circumstances – then the proper time is to deal with it then, not before any evidence has been heard.

Code A I will now ask our Code A for his advice.

Code A Before I give my advice, I wonder whether the Panel might wish to confirm with Code A that it is in no way intended that the reports will go in as evidence; that they are to go in as an aid. I think that is important and perhaps it could be clarified.

Code A Sir, I can confirm that straight away. Yes, they are not intended to be the evidence. Professor Ford giving evidence on oath will be the evidence.

Code A This is of course an application that the reports referred to go in at the outset of the case, before any evidence has in fact been heard, and that is all that you have to consider at this stage. You have obviously read the skeleton arguments of counsel in relation to this.

Code A wishes you to have the reports, as you have just had confirmed, not as evidence but as an aid to assist you with the complexity of the case and so that you can raise with any witness at the appropriate time any relevant issue mentioned in his written reports by Code A Thereby the GMC no doubt seeks to avoid having to recall witnesses after has given his evidence, and those are the main advantages put forward by the GMC.

Potential prejudice to the defence of putting the written reports before you is stated by Code A Code A and Code A to be this. The factual basis of an expert's opinion will derive in very large part from what he has read in the formal witness statements or in other material, but any expert, before he gives evidence to you, is likely either to have sat in and heard all the evidence or, more probably, to have read the transcripts of the case so far. This means that, by the time he gives live evidence to you, the expert may have revised or changed entirely his views set out in the written reports. If you had never had the written reports, you might never have known this, although you would of course have heard the GMC open the expert evidence in the case. If you do have the written reports before you, you may be tempted, say the defence here, to second-guess the expert and give undue weight to the written views in the report, even though that is not evidence at all and the expert has changed his views anyway.

It can always happen, of course, that the evidence of a witness varies from that in his statement, but in this case the defence state that there are particular reasons why you should

anticipate such variation. First, they say many of the witnesses have expressed concerns about the accuracy and completeness of their witness statements. Secondly, they say evidence has already been given at the inquest earlier this year, and that evidence did, in the case of many nurses, materially differ from the accounts given in their witness statements.

Even if the expert reports are based on medical records rather than witness statements, it is of course possible that the expert would change his conclusions, having heard the actual evidence. I hope that is a fair summary of the various arguments.

I advise you as follows. First, on the face of it, rules 50(1) and 50(2) in the old rules – which I think you have before you – might appear to offer some assistance to you. Rule 50(2) has not been directly referred to, of course. My advice is that it does not in fact assist you in this case, because it refers to documents in themselves admissible: maps, and so on, and matters of record. That is not the kind of document that we are looking at here.

What about rule 50(1), which is set out on the first page of Code A 's skeleton? My advice is that you should be careful about concluding that this rule assists you. Why? The reason is this. That rule clearly deals with the admissions of documents as evidence. In fact, the proviso refers to documents being tendered in evidence. Here, of course, the GMC is not seeking to put the reports before you as evidence in the case but as an aid.

Secondly, I advise you that it can be said that you are a professional Panel, well able to set to one side irrelevant or prejudicial material; but I advise you that, as a matter of good legal practice, such material should not be placed before a Panel if it can be avoided.

Thirdly, as you have heard, if you receive copies of Code A 's reports at this stage those reports are not evidence. The only evidence of Code A you can take into account will be his oral evidence. It is important that you remember this and that you consider whether your receipt of Code A 's written reports at this stage might in fact muddy the waters in this respect, to make it harder for you to come to a reasoned decision. On any view, you would at the end of the evidence have to perform a disentangling exercise, separating in your minds the content of the written reports from what Code A actually said in his oral evidence.

Fourthly, as I have said, the GMC wishes to avoid having to recall witnesses in the light of further questions you might have wanted to ask had you had the expert's written reports before you. That is understandable and commendable, but it is of course open to the GMC to set out the views of their expert in their opening to you and, if a particular issue with a particular witness is flagged up in the expert's report, highlight that to you in their opening. You may think that that is what Code A has done. Of course, you will shortly have a full transcript of that opening.

In addition, when a witness is actually called, both counsel will no doubt ensure that the witness is asked everything that they think is relevant. That really is their – counsels' – responsibility, not yours.

Fifthly, I advise that you should look with care at any analogies, particularly in relation to criminal law, drawn to your attention by Code A It is of course important that you make up your own minds about the relevance of any analogies, but I do say this. If one looks at paragraph 3 of Code A 's skeleton, referring to a transcript used by a jury to follow the pre-

recorded evidence of a witness, bear in mind that that is a situation in which the jury simply has a record of the evidence which is actually being given, at the time that it is being given. In relation to paragraph 4 and the permitting of a witness statement to be exhibited, bear in mind that Code A is not submitting to you at this stage that the reports should be formally exhibited, to show inconsistency or consistency. Indeed he cannot, because the expert evidence has not yet been given.

In relation to paragraph 6 and the drawing up of schedules and so on, no one doubts that all this can be done by consent, as frequently happens. The issue for you to decide is whether it can be done without the consent of the defence.

Sixthly, my advice to you is that there is no clear and identifiable legal authority for the putting of these reports before you. I advise you that, in criminal proceedings, a report from an expert who is himself going to give evidence would at the outset not go before a jury unless the defence consented.

If Code A and Code A were to consent here, of course, it would be a different matter but they object, as they are perfectly entitled to. Because I am unable to point you to any clear and identifiable legal authority for the course proposed by Code A I am unable to advise you that it is a course open to you to take.

Even were I wrong about that, and even were you to take the view that the reports are evidence and therefore that rule 50(1) and the discretion do apply, I would not be advising you that your duty of making due inquiry into the case before you makes its reception desirable. You would in any event have to consider whether the admission of the evidence would have such an adverse effect on the fairness of the proceedings that you ought not to admit it.

This is clearly an important matter and the Panel should consider its decision in camera and should also consider whether to provide written reasons for its ruling. That is my advice to the Panel, Code A

Code A do you have any observations on the advice just proffered?

Code A: Only this in relation to rule 50. We accept that rule 50 refers to material tendered as evidence. As we have said all along, we are not tendering this as evidence; we are tendering this as a tool in order to assist you. We therefore accept it may well be that rule 50 does not come into play.

Code A

Code A I have nothing to say, thank you.

Code A We will now go into camera to consider our decision. I would not anticipate at this stage that we would have anything for you before the luncheon break. At this stage, therefore, I will say not before two o'clock, and we will attempt to update you on our progress.

STRANGERS WITHDREW BY DIRECTION FROM THE CHAIR
AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

DECISION

Code A the Panel has heard submissions, supported by written skeleton argument, from both yourself and Code A in connection with your application for the Panel to receive reports prepared by the GMC's expert witness, Code A before it hears evidence from witnesses and before Code A himself is called to give evidence. You have submitted that it is not your intention for the reports to be received as evidence at this stage of the proceedings, rather that the reports be regarded as a tool to assist the Panel when hearing the evidence of other witnesses.

Code A strongly resists your application on Code A s behalf. He submitted that it is unnecessary for the Panel to receive contentious reports prior to hearing the evidence of the author, and that if the Panel were to receive the reports at this stage there would be a real risk of the panel being influenced by the opinions expressed in Code A s reports which were of necessity written before any oral evidence has been heard.

The Code A advised the Panel that:

- Rule 50(1) of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules of 1988 does not apply, as that rule refers to documents as being "tendered in evidence." Your application seeks to put the reports before the Panel not as evidence in the case, but as an aid.
- The Panel is a professional Panel, well able to put to one side irrelevant or prejudicial material, but that, as a matter legal principle, such material should not be placed before a Panel if it can be avoided.
- The copies of Code A s reports are not evidence. The only evidence of Code A that the Panel can take into account will be his oral evidence, and the Panel should consider whether Code A s written reports might muddy the waters and make it harder for it to come to a reasoned decision. The Code A cautioned that at the end of the evidence the Panel would have to perform a

disentangling exercise, separating the content of the written reports from what Code A actually said in his oral evidence.

- There is no clear and identifiable legal authority for putting these reports before the Panel. In criminal proceedings a report from an expert who is himself going to give evidence would, at the outset, not go before a jury unless the defence consented, which in this case they have not.
- Were the Panel nonetheless to conclude that the reports are evidence and that it had discretion to receive them under rule 50(1) of the Procedure Rules, the Panel should then consider whether its duty of making due inquiry into the case makes reception of the evidence desirable. Further, if the Panel considered that the admission of the evidence would have an adverse effect on the fairness of the proceedings, it ought not to admit it.

While the Panel might have found some value in the early reception of the reports, and while it is well able to put to one side irrelevant or prejudicial material, the Panel nonetheless accepts in its entirety the advice of the Code A The Panel has concluded that in the absence of consent from Code A on behalf of Code A it would not be appropriate to receive the reports at this stage. The Panel therefore rejects your application.

The Panel would, however, welcome an agreed fuller chronology in relation to each patient which incorporates the specific criticisms which are made by the GMC in respect of Code A and the Panel will allow you time to prepare such a document, should you wished to do so.

Code A: Thank you for that indication. I am not going to ask for time now. As the case proceeds we will consider how best we can flesh out the chronology that you have.

Can we then start by calling evidence? If you go to your witness list, the first witness is Code A who is the Code A That witness is not available to attend, but I am told by Code A that there is no objection to her being read. I wanted to clarify whether the agreement is to her being read as agreed evidence, or whether it is agreed that she can be read because she is unwell and therefore falls within one of the categories of section 166 of the Criminal Justice Act.

Code A May I assist on that point? It seems to me, in the circumstances, there is no difficulty with treating her evidence as agreed evidence. The Panel will also hear that this lady attended the inquest. It refers to another witness and not this lady. It does not affect what I am saying. My respectful submission is that the Panel treat this as agreed evidence.

Code A That is most hopeful. Before you read her, Code A, one thing that the Panel feel would assist it is for us to, at this stage, invite you to withdraw for a few moments while we all read that part of your opening in the transcript that relates specifically to Patient A We would do that on each occasion that there is a movement towards a new witness. We have already identified the pages concerned. Some of us have already embarked on the process but we will need probably another five to 10 minutes to achieve that.

Code A As a matter of housekeeping, I know that Panels sometimes request the statements of witnesses who are being read to them, and we could certainly do that in this case. Can I suggest this? Because you are going to be getting a full transcript of the proceedings and we are happy (certainly towards the end of the GMC's case) to provide you with a full index of every day, you will be getting an index for every day, but we can provide you with a cumulative index, rather than having two bundles to refer to rather than one, we suggest you stick to the transcript. It also means that if there is any editing to be done with witness statements, you do not need to trouble about that; you simply hear the relevant evidence being read to you. We are in your hands. We can provide you with statements if you wish, but in the circumstances perhaps you may feel it is unnecessary. Perhaps at some stage you could indicate.

Code A The Panel have indicated that they are quite happy to proceed on that basis, Code A

(After a short break)

Code A While we are waiting, Code A, if I can tell you and Code A that the Panel have refreshed our memory of the opening in respect of Patient A. We will follow this course, if we may, throughout the procedure. So you will never go straight from one patient to another; we will always need a break to read up again.

This is the statement of Code A Her statement to the GMC was made on 3 June of this year. She exhibits a police statement, and that is how most of these witnesses will be giving evidence. She simply says in her GMC statement that she exhibits a copy of a witness statement dated 8 November 2004. She confirms that she has been given the opportunity to add or amend to it, but she does not wish to. Her statement, dated 8 November 2004, reads as follow:

> "I am Code A of Code A, born Code A who died in the Gosport War Memorial Hospital on Code A
>
> Code A was born in Hemel Hempstead. He had two sisters; one who died as a result of an ectopic pregnancy whilst in her twenties to thirties, and the other who died of cancer in her late fifties.
>
> Code A was a submariner in the Royal Navy. Whilst in Canada he met and Code A Code A They had Code A and the family came to England in 1947. My parents had Code A is the eldest and I have a Code A Code A
>
> Code A suffered from severe depression for a great deal of his life. He made

A several attempts to end his life and had to be admitted to hospital for treatment. He was admitted to Knowle Hospital, Wickham, on a number of occasions through the Sixties, Seventies and Eighties and received ECT treatment.

Code A was physically a very strong man, and it was mainly due to his strong constitution that his attempts to end his life failed.

B Code A retired from the Navy after 22 years' service and worked as an instructor at the Nautical Training School, on Training Ship Mercury on the river Hamble. Code A Code A loved sailing and he enjoyed his job, but when the Training School closed he seemed to lose his purpose in life and withdrew into himself.

Some time around 1993 to 1994, Code A was admitted to Alverstoke Ward at Knowle Hospital. He was very depressed and had no motivation. Code A had
C been caring for him at home and the strain this placed on her was giving concern to Code A s psychiatric nurse, Code A and his social worker, Code A (whose surname escapes me). Because of this, a decision was made that Code A would be discharged to a rest home.

Code A left Knowle and went directly to Hazeldene Rest Home where he lived until he was admitted to Mulberry Ward at the Gosport War Memorial Hospital.

D

Code A became progressively worse whilst at the nursing home. He would not socialise with any of the other residents, who were predominantly women, remained in his home and rarely spoke to anyone. He was not rude; he just would not initiate any conversation. He would be the same when the family visited. He stopped eating and drinking properly and was eventually admitted to Mulberry Ward, which is a psychiatric ward at the Gosport War Memorial Hospital.

E

Code A continued to deteriorate mentally and physically. He did not respond to treatment. He seemed to have given up. The nursing staff on the ward were excellent and took great care of Code A The family visited regularly. Code A and I would take it in turns to take Code A in to visit Code A

After a period of time, Code A told us Code A had a chest infection. She
F informed us that the clinical team had considered and rejected treating Code A with ECT (electro convulsive therapy) because of his physical condition. She told us that there was nothing more that could be done on Mulberry Ward, and that he was going to be moved to Dryad Ward. I knew that Code A was not eating or drinking. He would lie in bed all of the time and ignore everyone. He believed that he had Parkinson's Disease. I understood that Code A was going to Dryad Ward for
G terminal care. This was never actually said to me, but my knowledge of the type of patient that Dryad took led me to believe this.

I visited Code A regularly with Code A and as a family we watched as Code A died through what I would describe as self-neglect. He had become extremely frail and just seemed to have lost the will to live. I remember asking the nurses if he was in any pain and if he had any pressure sores because he was immobile. The nurse told
H me that Code A s skin was breaking down and that he cried out when the nurses turned him. I remember that morphine was mentioned to me for pain relief, but I

A cannot recall if I was told that Code A was already receiving it or was going to receive it. I knew that his body systems were breaking down and that he would have been uncomfortable. I was not alarmed by the thought that Code A was being given morphine. I considered it to be appropriate care. The nurse turned him regularly and I recall that he had a blister on his ear. Code A was spoken to about the use of a drip and was kept informed about Code A s condition and how grave it was. I have no recollection of ever seeing a drip used in relation to Code A so I assume that Code A B Code A was referring to a syringe driver. The family acknowledged that invasive or aggressive treatment would be inappropriate in Code A s case. By this I mean to force-feed him or use ECT to try and lift his mood. I remember that it seemed to take Code A a long time to die. I expected him to die as he was in a dehabilitated state, was not eating or drinking and had a chest infection.

C Code A died on Code A His death was certified by Code A and his cause of death was given as bronchopneumoniA He was cremated at the Porchester Crematorium on 30 January 1996.

I have been asked if I ever spoke to a doctor during the time Code A was in Dryad Ward. I did not speak to a doctor as I was kept fully informed of Code A s condition by the nursing staff. Had I felt that I needed to speak to the doctor, I would have taken the necessary steps in order to do so. Code A s GP was Code A D who had a very good understanding of my father's condition and was very supportive of Code A

I think it is pertinent to mention that I am a retired qualified mental nurse, having nursed the elderly mentally ill for most of my career. The time of Code A s admission to Mulberry Ward and subsequently Dryad Ward I was the Code A Code A of the Phoenix Day Hospital within the Gosport War Memorial E Hospital."

That concludes her statement.

Code A Thank you, Code A

Code A : The next witness is one who I will now call, Code A You may wish F to get Patient A's files available to you.

Code A , Affirmed
Examined by Code A

(Following introductions by the Chairman)

G Q Is it Code A
A That is correct, yes, sir.

Q Can you bring the microphone a bit further towards you?
A Yes.

Q Are you a self-employed GP?
H A I am, sir, yes.

Q Your practice I think is the Forton Medical Centre, Whites Place in Gosport, is that correct?
A Yes.

Q Does that mean in fact that you practise with Code A ?
A Yes, I have been practising with Code A for the last 15 years, since 1993.

Q You must keep your voice up. This is a very big room and we have air-conditioning.
A I have been in practice with Code A and her former partners and present partners since I joined the practice in 1993.

Q Can we take it that she was there before you?
A Yes, she was.

Q I am not going to ask you a great deal about your medical training. I think you registered with the GMC in August 1982; I think in 1985-1986 you took a post as senior house officer, domiciliary care of the terminally ill, at a hospice, is that right?
A That was a domiciliary care job with St Joseph's hospice in Hackney. The consultant was Code A and subsequently whilst I was seeking a practice after completing my general practice training, I returned there over the course of a year to work as a locum quite frequently, both in domiciliary care and in hospice care, with in-patients at the hospice, in 1992.

Q I want to ask you particularly, please, about your involvement with a patient whom we know as Code A I can see that you have brought a file in with you. Have you marked up a file for your own purposes or are you happy to use an unmarked file?
A I have marked some of my statements where I can see question marks that are relevant to my memory of the case.

Q Right, I understand that. Do not worry about that for a moment. In relation to the bundle of patient notes, have you marked one up or are you happy to use the clean bundle, which is to your left?
A I am happy to use the clean bundle on the left.

Q Could I ask you to take that up, please, and I was going to ask you to turn to page 189 and I will then ask you some questions about it. Before we examine the entries on that page, we know, just to fill you in with the background, that this patient was admitted to Dryad Ward on 5 January 1996 – yes?
A Yes.

Q We also know that he was prescribed various drugs by Code A and I am not going to ask you in relation to those. We know that on 15 January he was started on a syringe driver, and that appears to have contained diamorphine – and is it hyoscine?
A Yes.

Q And midazolam. Then I think we get to 20 January, where we see a note in relation to Nozinan. Can I just ask you this: up to 20 January 1996 had you had any dealings with this patient, as far as you know?
A No.

Q So presuming for a moment that you did do something in relation to the patient on 20 January, this would have been your first contact with him?
A I may have known that the patient was there from doing ward rounds when I was on duty prior to that time, but if the patient had not had any medical problems at the time, I would not have been required to make entries into the notes at that time.

Q When you talk about doing ward rounds when you were on duty, what duties did you have in relation to the Gosport War Memorial Hospital?
A As a partner in the practice, the practice had an agreement with Code A that when Code A was not on call for the practice, that the GP on call for the practice would take on the responsibility for care of the patients at the Gosport War Memorial Hospital.

Q So if she was unavailable you would come, as it were?
A In effect Code A I suppose, subcontracted her responsibilities to the War Memorial to the practice, and the practice subcontracted that responsibility to whoever was the duty doctor at the time, and that doctor might in turn subcontract that to a deputising service if they were on duty.

Q All right. Let us deal with how you came to be telephoned, I think, on 20 January. What role were you performing on that day when you were telephoned by, I think, a nurse at the hospital?
A 20 January was a Saturday, a weekend, and I would always undertake my own on-call duties at weekends and at night, so I was effectively duty doctor for the practice and covering patients at the War Memorial Hospital.

Q Right. Could we have a look, please, at what happened on 20 January? Do you have a recollection now of these events? It is a very long time ago.
A I have a reasonably clear memory of the clinical questions that were being raised, although I do not have very much memory for the patient himself.

Q You may want to keep a finger in page 189 but also go for these purposes to page 198, which is a record I think made by a nurse and then by you; but perhaps you can help us. At page 198 do you see an entry on 20 January, first of all?
A Yes, I do. That is my writing – that is my signature. The writing above that is Code A 's writing, dated 18 January 1996.

Q Just dealing with 20 January, you say "my writing and my signature". There is no signature under 20 January, is there?
A There does not appear to be so, no.

Q But that is your writing?
A That is my writing, yes.

Q How did you come to make that note?
A I had been called by the staff nurse to come and see the patient, to arrange for an alteration in the medication. The staff nurse, which was Staff Nurse Code A I think, was concerned that Code A had become more agitated and very restless, and she was concerned that there was a paradoxical side effect with haloperidol which at high doses could

A cause significant agitation to develop in certain patients. She wanted me to review the dosage of haloperidol or consider other medication that could be used.

Q Is that, may I ask, an effect of haloperidol on its own or is it the effect of haloperidol when mixed with other drugs?
A The side effect with haloperidol is listed in the palliative care book that we have reference to, as specific to haloperidol.

B

Q So your first contact would have been what – a telephone call from Nurse Code A ?
A That is correct. Nurse Code A I think would have been recharging the syringe driver at about 3.45 that afternoon, which is when the driver was always being recharged, and that is when it would have been noted that Code A 's symptom control was not so good.

Q Can I then take you back, please, to page 189, and ask you to assist the Panel. As we
C work through this case we will probably get more adept at reading these and understanding them, but perhaps you would be able to assist us at this stage. We can see first of all that there is a prescription under the heading "As required prescription" for – is it Nozinan 50 mg?
A Yes, that is Nozinan 50 mg to be given in a subcutaneous syringe driver over a 24-hour period, the starting date on 18 January 1996, which correlates to Code A 's note on 18 January 1996 on page 198 noting a further deterioration in Code A 's condition and
D symptoms. So that would have been added – she has written there "Try Nozinan". It says "Further deterioration, analgesia" ---

Q "SC", I think.
A "Subcutaneous analgesia", I think, I cannot read that word. "Difficulty controlling symptoms. Try Nozinan".

E Q Just going back to page 189, you told us it was "SC" and you are right, but I just wanted to make sure we all understand why. We can see under the word "Drug (approved name)", "Nozinan 50 mg", and then underneath that on the left we see "Route", and is that "SC"?
A Yes, it is. It is subcutaneous in 24 hours.

Q So that is the indication, as it were, that it is to be delivered by way of a syringe
F driver?
A That is correct.

Q Then to the right of that we can see the date, 18 January 1996; then is that Code A 's signature underneath?
A Where it says "Signature", you have ' Code A ' underneath, just above the space saying "Special directions". The timing of the dose being given is signed by the
G administrating nurse.

Q Can we just look at the timing then. If we look to the right of "50 mg" we can see a number of columns. The heading for the first is "Date", and then we see "Time", then we see "Dose" and then we see "Given", and then it repeats itself a number of times across the page. So the date on this occasion, two days before you came into the picture, as it were, is 18 January 1996.
H A Yes.

Q The time is 15.15.
A Yes.

Q The dose is 50 mg.
A Yes.

Q Then there is an initial.
A There is, yes.

Q Is that likely to be a nurse?
A That would be a nurse's initial.

Q Right. So is that an indication that on 18 January at a quarter past three in the afternoon a nurse would have loaded up a syringe driver with 50 mg of Nozinan among the other drugs that she was using?
A Yes, it is.

Q That is very helpful. Thank you. Then if we look below that we can see another date, which I think is 19 January. Again, 1500.
A Yes. The date is a little obscure, because the milligrams bit of Nozinan covers the "19", and it does not show; but it would have been in different coloured inks, I think. So that is 19 January 1996.

Q That is another 50 mg of Nozinan being put into a syringe driver at 1500 hours?
A Yes.

Q So these are 24-hour drivers, are they?
A They are, yes.

Q We can see that on the 18th Nozinan is put in, as it is on the 19th, at about the same time of day.
A Yes.

Q Then we move to the 20th. If that dose of 50 mg of Nozinan had just continued, would we simply see further date entries below that?
A Yes.

Q Tell us then, please, what happened on the 20th.
A I was called to see the patient, and I was advised that he was becoming agitated, that it might perhaps be the haloperidol that was causing the increased agitation. I agreed with Staff Nurse Code A that that seemed quite likely; and in view of the fact that Mr Pittock was already being prescribed Nozinan and haloperidol, which do have a broad overlap in their therapeutic effect, I felt it would be reasonable to reduce the number of different medications in the syringe driver in order to firstly avoid any problems in the mixing of drugs; and secondly, to consolidate the prescription into a more simple form.

Q So what did you do?
A I suggested that the haloperidol should be stopped, and that the Nozinan should be increased from 50 to 100 mg, bearing in mind that the sedative effect of haloperidol would

have been removed from the driver, and so any sedative effect of Nozinan 50 would have to be increased to compensate for that change.

Q What was the purpose of the Nozinan in this mix?
A The purpose of the Nozinan from Code A 's note is simply to control symptoms of agitation and distress, that it was felt Code A was suffering at the time. Nozinan, to my knowledge, has mainly used as an anti-emetic, to counteract a side effect of diamorphine which acts on the emetic centre of the brain; but it also has broad sedative properties which have a calming influence of patients who are distressed by their symptoms.

Q Anti-emetic meaning stopping a patient feeling sick?
A Prevention of sickness and vomiting.

Q It may be helpful then to look at page 190, to see what other drugs this patient was receiving.
A This is part of the same prescription chart. Diamorphine and midazolam would both have some sedative influence, in addition to pain relief and allowing muscle relaxation.

Q Did you go in and see the patient on this day? We can see the words "verbal order". What does that indicate to us?
A I went in to see the patient because I would have had to see the patient in order to countersign my prescription, which was written by the nurse.

Q When we see on page 189 the words "verbal orders", does that mean you would have given the order over the telephone first and then gone in to see the patient?
A That is correct.

Q Why would you need to go in to countersign?
A It is standard or proper practice that, where a verbal order is given, the nursing staff are allowed to take the verbal order and carry out the order, on the understanding that the doctor, having been called, will come and see the patient. This would particularly apply if, for example, orders were made to change CD drugs.

Q Controlled drugs.
A Controlled drugs.

Q Because if you are authorising the prescription of a controlled drug, that has to be written out by the prescribing doctor, I think.
A I believe that, with controlled drugs, unless the drug is actually written on the chart by the doctor, the nurse cannot give it and cannot take a verbal order for that. So in order for verbal orders to be administered, the prescription for a controlled drug might well need to be pre-written into the chart, if it is anticipated that changes in medication might be necessary when the doctor is not in the hospital.

Q How long, may I ask you, did it take you to get from your practice into the hospital? What is the geography of it?
A On a Saturday I would be covering, at that time, a range of patients between Lee-on-Solent and Gosport and, going north, up as far as Fareham.

A Q I just want to stick at the moment to the distance between your practice and the hospital. Not on this particular day that you had to go in, because you may have been all over the area, I suppose.
A Yes.

Q But to get from your practice to the hospital would take you how long?
A By car, with no traffic, I would think it would take about ten minutes.

B Q In terms of mileage, what does that mean?
A It is about two miles.

Q Going back to page 189, you have explained why you gave this prescription of 100 mg. Did you stop the haloperidol at the same time?
A Yes, I did.

C Q At the time that you did this did you believe that Nozinan had been continuously administered to the patient?
A Yes, I did. I think there is actually an error in my statement in this respect, which I have reviewed. My statement indicates that, after looking at the prescription with Code A I had noted that Nozinan 50 had not been placed in the syringe driver on 20 January, and that it was therefore my belief perhaps that Nozinan was not in the mixture
D when Code A was showing greater agitation. But in fact he would of course have been on the Nozinan that had been placed in the mixture on the 19th, because it would have been continuing through until 1545 on the 20th, when the syringe driver was recharged.

Q Let us just pause about that. It may not matter but, just to be absolutely accurate about it. If we go to page 190, it looks on the 20th – and please tell us what the true picture is – as if the syringe driver was not actually re-loaded until, is it 1800 hours?
E A This shows that the syringe driver was re-loaded initially on the 20th at 1800.

Q So that is rather after the 24-hour period has expired from the previous syringe driver?
A There is a crossed-out bit just above 1800, actually, at 1530. I am sorry. If you look on the 20th, there is a re-loading noted at 1530, where diamorphine, midazolam, hyoscine and haloperidol are all re-loaded into the syringe driver. But, yes, the Nozinan was not re-loaded at that time. So there would have been a period, I suppose, of an hour perhaps after that.
F I am not entirely certain the exact time when I was called to see the patient after the re-loading, or whether it was at the time of re-loading. I would be uncertain exactly at what point I would have been called.

Q What does the crossing-through of the entry at 1530 signify?
A That signifies that the syringe driver that was running at that time has been taken down and disposed of, and then re-loaded at what looks to be six o'clock. I think six o'clock
G would have been the time when it was re-loaded with Nozinan 100 mg, which, if we look at the prescription detail on page 189, was commenced at six o'clock in the evening.

Q And it would not have troubled you that there was a few hours' break, if that is what it was?
A I am not certain whether there was a few hours' break there or not. I cannot remember whether I was called at three o'clock or whether I was called perhaps at
H

A five o'clock, but it is possible that there might have been an hour or two when Code A did not have the Nozinan 50 mg in his driver.

Q I just want to understand this. Again, I am not seeking to make any point about it but I just want to understand it. These are 24-hour drivers. Are they exactly 24 hours or are they approximate?

A No, there is always a certain amount of overage available. If an emergency arises and B it is not possible for one reason or another to change the driver at the exact 24-hour period, there would be three or four hours of additional available drug to continue running.

Q So even though we see that the last time Nozinan was put into the driver was at 1515, that actually would continue unless that driver is stopped?

A It would, yes.

C Q If we go over to the 20th, we see that at 1530 a new driver was actually started.

A It was, yes.

Q And then crossed through.

A Yes.

Q When that new driver was started, it appears that Nozinan was not included.

D A It does, yes.

Q So there would be a period – it may not matter – when Nozinan was not being injected into the patient's body.

A There would, yes. I am uncertain how long that would have been.

Q I totally understand that. How many syringe drivers, from your understanding of E these notes, were in fact working with this patient?

A When I first spoke with the nurse, I was concerned that it might have been just one; but, reviewing the notes, I have seen from a nursing Kardex note that there were two drivers running, and this would have been proper practice because they would normally not place more than three drugs in one syringe driver, in order to avoid any interaction or precipitation problems.

F Q But you cannot tell from this, the notes that we are looking at, how many syringe drivers there are?

A No.

Q Could I then take you to page 198? We have looked at your note briefly on 20 January as being "unsettled" on haloperidol and syringe driver. You took that from the nurse – yes?

G A Yes.

Q "Discontinue and change to higher dose Nozinan, increase Nozinan 50 mg to 100 mg in 24 hours (verbal order)" and then, underneath that, do we see your writing again? "Much more settled" – this is on 21 January.

A Yes.

H Q What is the note? "Quiet breathing"?

A A It says, "Quiet breathing, respiratory rate 6 per minute, not distressed; continue".

Q At any stage, either on 20 January or 21 January – when you must have seen the patient to make that note, presumably?
A Yes.

Q Was the patient awake, as far as you know?
B A No. The patient was not awake on either of those because, when I went in on 20 January, the changes to the syringe driver would already have been made on my verbal order and, by the time I came in to see the patient, the effect of those changes would have already taken place.

Q And the effect would be?
A Would have been to settle the patient, who was distressed prior to the change and, it
C would appear from my note, became un-distressed and was able to sleep or relax.

Q I understand that, but the effect of the drugs that this patient was being administered would be that he was asleep at the time that you saw him.
A Yes.

Q On both occasions.
D A Yes.

Q And I do not think that you had any other dealings with this patient.
A No, I did not.

Cross-examined by Code A

E Q Code A as you will realise, I am asking questions on behalf of Code A Just in relation to what you were saying about your note with regard to 21 January and the respiratory rate of 6 per minute – that is what I want to ask you about.
A Yes.

Q That is slow, but you would have borne in mind at the time that he was under the influence of diamorphine which was being administered?
F A That is correct.

Q And therefore that would have been expected.
A That is correct.

Q But you would also have noted whether his skin colour suggested excessive respiratory depression?
G A Yes.

Q You have not noted that; so we can take it that that was not present.
A That was what I stated to the police in the original inquiry: that whilst I had made a brief note about the respiratory rate, the fact that I have noted the respiratory rate indicates that I did have a concern as to whether he might be over-sedated or overdosed with medication, and the fact that I have not written anything to that effect would indicate that I
H was happy that he was not inappropriately dosed at the time.

Q I was going to add that, of course, from your note we can see that you have said, "continue" at the end of your note for 21 January, on page 198.
A Yes.

Q Meaning that you were happy with the regime he was under at that time in terms of the medication and that it should continue.
A My concern for Code A was that he had been admitted with distress and agitation, and that the purpose of treatment was to relieve his distress; that he appeared to be comfortable and not in distress but at the same time he was not in any physiological stress either.

Q Had you been unhappy with any other aspect of the medication he was receiving, you would have pointed that out and done something about it?
A I would have made further changes to his medication regime and then reviewed him again at a later stage.

Q The senior nurse whose name you have mentioned, senior nurse Code A was somebody who in your view had extensive personal experience of palliative care, including a knowledge of different drugs and their specific side effects?
A Yes.

Q Would it be right to say that that was your view as to the knowledge and experience of other senior nurses in that hospital?
A Yes, it was.

Q In general terms, Code A is it right you felt that the nurses in Gosport War Memorial Hospital were doing their job well and had particular experience and expertise?
A I did, yes.

Q Would it also be right to view the situation as being this in terms of reliance on nursing staff: that when you came in to see a patient, maybe on call or somebody whose case you did not necessarily already know very well, you would find yourself naturally very reliant on what was said to you by the nursing staff as to what they observed of the patient's condition?
A Many of the patients would be unfamiliar to me, as would be their history. Many of them, because of their medical condition, would have extensive, very large sets of notes, and these notes would require enormous amounts of time to go through to gain an accurate impression of what the patient's condition and treatment plan was; so nursing staff could be relied upon to fill me in on a lot of that detail.

Q Would it also be the case, with your trust as a result of your own experience in the nursing staff, that you would take note of *their* view as to the condition of the patient?
A That has been my practice in all areas of medicine where I work with nursing staff.

Q It may be just a matter of common sense, because you may be seeing a patient just by way of seeing them in a snapshot way at the time you have to come in to try to deal with whatever the problem is, whereas the nurses, of course – not every nurse is there 24 hours – but the nursing staff in general are seeing the patient for hours each day and are observing a whole series of things which the snapshot approach cannot observe.

A A Yes, that is correct.

Q That is putting it very broad brush, but just so we can have the picture. In general terms, did you find that if you were called in to deal with or treat a patient with whose case you were not already yourself familiar – in those cases did you find that the notes that you did have available to you were sufficient for you to make a judgment about what was appropriate?

B A I never had any difficulty with judging the situation with patients.

Q You would have not only the notes if you needed to look at them, any clinical assessment that might have been made, but you also had the assistance of the nursing staff and what they could tell you.

A There is access to nursing Kardex notes, medical doctors' notes, other medical letters in the notes and, in general, where a lot of these patients were in for quite long periods of

C time, very often the notes would relate to crisis intervention. On days when the patient was in a stable state, there may not be a note but that would usually just involve a line, for example "in status quo" or "continue with treatment".

Q Because in effect there was nothing to note specifically?

A There would be nothing to add to the patient's needs at the time.

D Q You have told us about your own out-of-hours cover, just so we can get the general picture – and I am afraid you are the first medical witness we have heard so far, so I am using you to cover a bit of background information – you were doing your own out-of-hours cover and that would mean, would it, in general terms at this time, that you were on call one night a week – something like that?

A Something like that. There were six partners in the practice at that time, and myself and Code A would cover our own on-call commitments. The other partners in the practice

E were in the habit of contracting a deputising service, usually between the hours of ten and seven each night when they were on duty.

Q In terms of your cover in this aspect, something like one weekend in five would you be on call?

A About that, yes.

F Q Just very roughly.

A Yes.

Q You yourself had done some palliative care, had you not, in your training?

A Yes, I had.

Q Is that specifically the hospital in Hackney you were mentioning?

G A Yes, it was. But palliative care is an aspect of most areas of medical practice, both in hospital and in general practice.

Q Yes, I was going on the way it was put in your statement. I think that you have probably already covered it. You said that you were at St Joseph's Hospital in Hackney as a senior house officer/registrar in palliative care.

A Yes.

H

A Q That, I think you told us, was 1992.
A In 1992 I had completed my general practice training and was seeking a job in general practice. It took about a year to find a suitable job and during that year I was taking on various locum posts in the area in which I was living at the time. I lived at that stage in the East End of London. Having previously worked at St Joseph's Hospice they knew I was there and would contact me when they needed assistance.

B Q May I just ask you a little bit about Code A ? Somebody, I think you can confirm, who worked very hard?
A Yes, indeed. Very hard. When I first came to look at the practice in Gosport, I was shown round the Gosport War Memorial Hospital by Code A who showed me the wards, the wards where she worked, and indicated the nature of the work that was involved and asked me if I was happy to take on that kind of work. I stated that I would be very happy to take on that kind of work. It was the kind of general practice hospital which I would value
C the opportunity to work in.

Q Would it be right, in terms of the practice generally to regard her as the most experienced practitioner in terms of palliative care generally?
A Very much so, yes.

Q You would also, no doubt, have become very familiar with her practice in terms of
D palliative care.
A Yes, I was.

Q Obviously, if you were on call and were required to attend the hospital, you would see records that she had made and you would also see what her prescribing practice was.
A I was fully aware of her prescribing practice.

E Q I want to ask you about one aspect of it. It may be that in the course of this hearing different people will use different expressions. I am going to use the expression for the moment 'anticipatory prescribing'.. I think that is something you touched upon earlier on. You were aware obviously that Code A practised that in terms of patients at Gosport War Memorial Hospital.
A Yes, I was. I regarded it as a very necessary practice.

F Q I would like you to flesh that out. What is the difficulty and what justifies doing that?
A Well, when a patient requires a CD drug to be given, nursing staff are not allowed to dispense or administer that drug unless the drug is actually written up in the notes by the doctor themselves. They are not allowed to give or to write in a verbal order for a CD drug into the notes. It is allowed, to write in non-controlled drugs, but diamorphine and morphine in particular, they cannot write this. So if you have a patient who is in great distress, or who develops acute symptoms, who requires reasonably urgent administration or initiation of pain
G relief or other medication to relieve their distress, that drug needs to be written up and ready in the ward, so that it can be given. This is a particular problem if, for example, a patient becomes unwell at a time when you are already engaged in seeing another patient elsewhere out in the community; in which case, there might well be a delay of an hour or two perhaps before you can actually go in to see and deal with that patient. So I regarded it as an essential practice to allow the adequate care of patients in the wards, and I did not see any problem with that.
H

A Q Putting it very broad brush, to prevent them suffering unnecessarily whilst waiting for a doctor to arrive to actually prescribe something.
A I think that is an essential part of this type of practice.

Q Did that also mean that such anticipatory prescribing might on occasion justify a dose range?
A Yes, it does.

B Q As opposed to a specific dose. Can you explain the purpose and point of that? Why a range, as opposed to a specific amount?
A Some of these patients might, for example, already be on oral morphine products, and therefore would not be naive to the effects of morphine and would need to initiate on higher doses of morphine in the syringe driver. So if a patient, for example, was taking oral morphine, 10mg, five or six times a day, you might well need to start that patient on maybe C 80mg or so diamorphine in the pump. Otherwise it would not be sufficient to cover their symptoms, if you started at a lower dose. In fact, in general practice, where we have patients self-administering drugs, it is absolutely standard practice to instruct patients about how they can adjust and use their medication.

Q So they are given a range themselves.
A Patients may be advised on ranges of drugs they may take in order to reduce D symptoms, if they need them. These are untrained persons, and it would be seem natural to me that trained staff, such as nurses, can be trusted to help administer appropriate doses of drugs, with the direction of a doctor, if they wished to consult of that matter.

Q Again, it comes back to that being something which you would approve and which you would practice, as long as you could trust your nursing staff.
A Yes.

E Q We may be going into this other topic that I am about to ask you about in more detail with other witnesses, but it may help, if you can give us part of the picture. As time went on – because you are starting in 1993, if I remember correctly?
A Yes.

Q As time went on through the Nineties, would it be right to say that in terms of patients F at the Gosport War Memorial Hospital there was an increase in workload?
A Yes, there was.

Q What was the cause of that, as far as you judged it at the time?

Q I think it was seen that the War Memorial Hospital provided a very good service for management of patients who were at a stage of end-of-life care where, through general G physical deterioration and decline, these patients had reached a point where it could be anticipated that they would never be capable of rehabilitating back to an ability care for themselves; where they were suffering distressing symptoms, or were unable to express their needs. And in those circumstances, a facility was necessary to offer what was, in effect, a hospice management for these patients.

H

A Q Obviously in the District General Hospital, whatever category of hospital we are talking about apart from the Gosport War Memorial Hospital in this sense, there was a pressure on bed. It is inevitable, yes?
A Yes.

Q And a perfectly understandable desire perhaps that patients who had been treated, let us say, in Queen Alexandra Hospital (by way of example), as soon as it was possible for them
B to be transferred, because the hospital did not see itself as needing to provide immediate care as a result of an operation, say, they would be looking to transfer patients as early as possible.
A I think that certainly happens. When you have pressure on beds, you develop wards which specialise in different areas of care, and it might be felt perhaps that the management of a patient who is beyond medical or surgical treatment is not best managed on a ward where the psychology of the ward is geared towards producing an improvement or a cure. In those circumstances, the quality of care of the patient it is felt might be improved by moving to a
C ward where there is a philosophy of palliative care rather than intervention.

Q Did that sometimes mean that patients were discharged – and I just take Queen Alexandra Hospital as an example – from such a hospital? Some patients might be discharged before, in an ideal world, they were quite ready?
A I think in terms of before the patient or their relatives were ready to accept the nature of their condition perhaps, yes. I personally feel that occasionally patients would be arriving
D at Gosport War Memorial having been, or their relatives having been, given the expectation of rehabilitation rather than continuing care. And those expectations may have been partly driven by staff at outlying hospitals who were unfamiliar with the exact nature of the type of conditions and physical conditions, that we were actually dealing with at the War Memorial.

Q So in some cases, leading to rather higher expectations of what was realistic than was actually the case?
E A This is partly complicated, because there were also long-term rehabilitation wards based at the War Memorial. Sometimes it would be unclear to staff at the Queen Alexandra Hospital whether the patient was going to a rehabilitation ward or a long-stay ward.

Q Would you help, in relation to the Gosport War Memorial Hospital, when you talk about rehabilitation ward or wards, what names do we think of as applying, because we will be hearing of different names?
F A Daedalus Ward was what I would regard as a ward where the emphasis was perhaps towards some rehabilitation work. I think Dryad Ward tended to have patients who had a more severe degree of disability.

Q We will be hearing about patients who came to Gosport War Memorial Hospital for slow stream rehabilitation, or something of that kind. They would be likely to go to Daedalus, would they?
G A I think so. I think it would very often be a fairly broad mixture, because it would depend on where the bed availability was between the two wards.

Q It might also turn out to be the case that a patient who was transferred with a hope of progress with regard to rehabilitation might turn out, on arrival or shortly thereafter, to be a case where rehabilitation, realistically speaking, was not on.

H

A That would certainly be the case quite often. Assessment of the patient would often show – or the patient, for that matter, would take a turn for the worse. And in those circumstances, one would have to actually change the direction or emphasis of treatment.

Q Thank you for that by way of background and context. Lastly, may I ask you this about Code A Was she somebody who, in your view and your experience of her, who was wholly committed to the best interests of her patients?

B A I have never had any doubt of that.

Q Thank you. That is all I need to ask.

Re-examination by Code A

Q Just a couple of matters. You spoke about patients being written up in advance, as it

C were; prescriptions being written in advance for patients.

A Yes.

Q Are you saying that happened for every patient who entered Dryad of Daedalus Ward?

A I do not think it would happen to every patient, but I think that any patient where it could be anticipated to be a need, then there would be an advance prescription perhaps written up.

D

Q You spoke about patients who might already be on morphine.

A Yes.

Q Let us deal with those first of all. So this is patients who are on morphine, but taking it orally, is it?

A It may be administered orally or through a patch or something of that nature, but not

E by a syringe driver at the time.

Q Were you aware of the difference in the amounts that should be provided, administered, subcutaneously; in other words, the conversion rate?

A I would be aware of that. There would be a chart for that purpose. The issue there though is that very often, when a patient moves from oral medication to needing syringe driver medication, it is very often due to a deterioration in their condition. And often that

F deterioration might require an incremental increase in the dose in the first place.

Q I understand.

A So the conversion might not necessarily apply. You might deliberately go to a higher dose equivalent.

Q The conversion rate presumably still applies, but you have to bear that in mind when

G you are seeking to deal with the patient's distress.

A Yes.

Q You are not saying you ignore the conversion rate and treat it, as it were, one for one, are you?

A No, I would not treat it as one for one, because they are different drugs.

H Q If a patient is opiate naive, would the range have to reflect that?

A I think it probably would, depending on how severe their symptoms were.

Q You told Code A that in general terms you had never had any difficulty with the notes that you came across on the Ward. Is that right?
A Yes.

Q Can I take it, or would you tell us, have you reviewed any of the notes for any of the other patients that we are dealing with in this case? I think broadly you are aware of them?
A I have not reviewed other patients' notes. I was not involved in any of the specific care of any them that I am aware of.

Q You also said this. You would be very reliant on the information provided to you by the nurses. "Many of the patients would be unfamiliar to me." Yes?
A Yes.

Q You also spoke, or I think perhaps these words were used by Code A that really you would be getting a snapshot of the patients on the occasions when you went into the ward.
A I would, but where I felt that that was not adequate for me to make a clinical judgment I, could make reference to the patients' notes, where I needed to.

Q I understand that, but you were not there, as it were, as Code A was, on a day-to-day basis.
A No.

Q In relation to the patients on Daedalus and Dryad Ward, although the patients might be unfamiliar to you, whose patients would you regard them to be?
A I would regard them to be patients of the Code A in charge, which would be Code A and I think Code A at times. Code A would have knowledge of them, as being the Code A who would deal with many of the day-to-day affairs of their medical needs.

Q Thank you very much.

Code A Doctor, as I had indicated, after Code A had asked questions of you it would be open to members of the Panel to do so, so I am looking now to see. Code A Code A over to your left, is a lay member of the Panel.

Questioned by THE PANEL

Code A Good afternoon, doctor. I am hoping you can help me with some clarification of the questions just asked by Code A You said that you have not reviewed the other patients' details, so you have only concentrated on this one, because this particular patient you were involved in.
A This particular patient I was involved with the care, and the police in the course of their investigations of the Gosport War Memorial Hospital asked me to review the notes of Code A in detail, because I had had some clinical involvement with his care.

Q Just this one?
A Just this one.

Q I think you have just said that you only attended perhaps once a week, or once every other week, or ---
A When I was on duty during the week I would really just be on-call for out of hours, which meant that if there was no request to see a patient I would not go into the hospital. When I was on duty at weekends I would conduct a ward round of the Daedalus and Dryad wards on the Saturday morning to review any medical needs or requests from the staff nurses – the nurses in charge – and I would usually make a telephone enquiry on the Sunday of any needs and go in on the Sunday also to write up any specific needs.

Q I think you have given me the picture of your input into the hospital. Can I just ask you to turn to pages 189 and 190, please?
A Yes.

Q These are administrative records for this patient.
A Yes.

Q You would have seen these administrative records, this record, for this patient, because you actually increased the dosage of one of the drugs?
A Yes.

Q So you would have had access to the other pages and the drugs that had been prescribed prior to that.
A This is actually the third drug charge of this patient during the course of this admission. When he was on Phoenix ward under the care of the elderly mental health team, he would have had a drug chart written up for Phoenix ward. When he was transferred to Dryad ward, the entire chart would have been rewritten as part of that transfer, with all his drugs transferred to the new chart, and his previous drugs would not be included in that. Then subsequently when the number of available spaces for writing in different drugs ran out on that chart, it was rewritten again on 17 January, and the previous chart would have been put away in the notes – filed away in his notes.

Q But you would have seen this? You would have seen page 190?
A I would have seen 189 and 190, because you can see that I have actually signed for the drug, and that indicates that I have looked at the chart.

Q Thank you for that. If you looked at page 190 – and I am not familiar with this chart, so I am trying to read it to the best of my ability – the top reference is diamorphine?
A Yes.

Q And that has been administered on the 17th, with 120 mg?
A Yes.

Q The 18th with 120 mg, and the 19th with 120 – am I reading this correctly?
A Yes, you are.

Q The one below it is midazolam, and that is administered 80 mg on the 17th, 80 on the 18th and 80 – I am reading this correctly?
A Yes.

A Q So when you went into the hospital you saw this. What was your reaction to these figures, to these amounts of drugs?
A They are quite large doses, but I was aware that in spite of those large doses the patient remained agitated and unsettled, and these are drugs which I have used with what I would call a high ceiling, in that if the patient requires a greater dose response – if the patient requires a higher dose, a higher dose may be given.

B Q Right.
A I am aware that prior to this chart, the diamorphine had been written up at 80 mg, so this was increased from 80, which had been the original starting dose, after he had been given oral morphine prior to that.

Q What I am trying to ask you – and it is my fault, I am not putting it well – but I am wanting to know if you saw those, and if those figures alarmed you, or were they the sort of
C figures that you would have been met with at regular visits to the hospital?
A The dose would have alarmed me if Code A had been showing signs of respiratory depression and physiological stress as a result of that.

Q I understand, I am listening to you; I am trying to take a note of what you are saying.
A Patients develop tolerance to opiates, and if they develop a tolerance to those opiates then large doses may be necessary to produce a therapeutic effect. So I would presume that if
D he was still agitated and unsettled on these higher doses, that it would indicate that he had a degree of tolerance to those drugs, which meant that the higher dose was safe to administer.

Q Right. Just bear with me for a second. Can you give me some indication – and I would assume that all patients are different – but can you give me some indication of how long it would take for someone who was an old man – I think he was 80 – for his body to develop a tolerance?
E A Assuming that his clinical condition and his need for pain relief was stable, I would anticipate quite a rapid initial development of tolerance over a period of about one to two weeks. So starting from a starting dose of morphine orally until this point in time, anything between seven to 14 days.

Code A Thank you very much for your help.

F Code A, to Code A's left, is a medical member of the Panel.

Code A Could you turn to page 198 again, please? Just remind me again – it has probably slipped my absolute memory here. When you attended this patient he was unconscious, is that correct?
A When I was consulted about him he was agitated. I asked for changes to his medication to be made, and when I subsequently attended at a later stage, his agitation had
G settled and he was peaceful.

Q Was he unconscious?
A I do not think he was in a coma, no.

Q Was he conscious?
A No, he was not conscious.
H

A Q Thank you. You said to Code A that it was clear from Code A 's entry on 18 January 1996 that the Nozinan was to control symptoms. I wonder if you can just take me through that entry and explain what you mean by that. Rather this: tell me what you understand precisely from that note, bearing in mind that you did not know the patient. And if you can – and this is difficult – if you can divorce your mind from the fact that you have since reviewed all the notes of this patient, what was in your mind on the day when you saw him? How does that note impact upon you? What does it tell you, precisely, that helps you
B manage the patient?
A It states "Further deterioration". The nursing staff had advised me that Code A had become agitated and unsettled. I interpreted that to mean that he was in distress. I did have the habit of reading the notes of patients that I was asked to see, and particularly to read the admission note, which would give information as to why the patient was being treated in the War Memorial, and Code A 's condition noted here was that he had progressive deterioration of his mobility, that he had become completely unable to leave the bed; he had
C become incontinent, he was unable to move easily without assistance, and he had developed bedsores of the sacral area, the buttock area, and these would have been causing him pain. He also had a long history of agitated depression, and a degree of not suicidal but wishing to end his life, wishing his life would end, over a long period of time, and had developed a very aggressive affect with people who cared for him, indicating that he was in a very distressed and unhappy state. So I would have interpreted him as suffering greatly from the inevitable deterioration as a consequence of his age. So "further deterioration" here would indicate to
D me that Code A was suffering gravely, and that he required increased medication to relieve that suffering.

Q I am sorry, this might seem pedantic, but I am just trying to get to the nub of what notes mean in general here. What symptoms does deterioration in this case refer to, and how do you know that?
A My experience of patients ---
E

Q No, sorry, not your experience – this patient, from this note, or from these notes that were available to you on that day.
A It does not specifically state which deterioration we are talking about, whether it relates to pain or cardiac condition or abdominal condition, no.

Q I think you have already alluded to this, that there is a context of care.
F A Yes.

Q And you have alluded to the fact that there are different categories of patient – rehabilitation patient, long-term patient, end-of-life patient. From these notes, as you come in on the Saturday, what can you tell about the category in which this patient lies?
A I would say that this patient lay in the category of end-of-life care. In fact the note prior to this indicates "TLC", which means that the philosophy of care for this patient was to
G relieve distress and suffering.

Q Thank you. So in a nutshell, TLC, would you say, is a commonly accepted synonym of end-of-life care?
A Yes.

Code A Thank you, doctor. Code A is a lay member of the Panel.
H

A Code A Doctor, can you just explain to me, in your evidence, after talking about end-of-life care, you actually said what you see as the essentials of hospice management. Can you tell me what you actually see as the essentials of this hospice management?
A Hospice management is about preserving patient dignity, respecting the patient's needs, respecting the patient's wishes, and reducing the distressing effects of their medical or physical condition and their mental condition also. I think that if a patient is expressing distress, then they should be given the medication they request to deal with that distress. To
B continue, for example, to feed a patient who has expressed a desire not to be resuscitated would be in my opinion tantamount to force feeding, which is an area of medication which we would not condone under any circumstances. So it is about respecting the patient's needs and wishes.

Q Just clarifying with you, in relation to your responses to Code A I understood you to say that this person, through the range of drugs that the person had been given, that he
C actually was unconscious, when you actually went to see him?
A Often, when you see a patient who is in distress, if they are awake they are in distress, and often when you see patients who are suffering from pain they may be on morphine and they may be awake from time to time, and the only memory they have of that time period is of being in pain. So if you have a patient who is in great pain or distress, you have to prevent them from becoming aware of that distress. Otherwise, that is the only memory they have.

D Q What can be the other side effects of the range of drugs that this patient was actually on?
A One of the side effects of haloperidol which we discussed was that the patient might become more agitated, more restless, and this might be an idiosyncratic reaction relating to haloperidol and that particular patient.

Q What was your assessment as to how much the haloperidol was contributing to the
E patient's agitation?
A My feeling was that, if the patient was agitated, we need to give him medication that did not give him agitation; and if we withdrew the haloperidol, the therapeutic effect of haloperidol would have to be replaced by something else – bearing in mind that, although it has side effects, it also has therapeutic effects.

Q I am just trying to clarify here in my own mind, because it seems to me that what you
F are saying to us is that you had to give the patient this type of drugs because the patient was agitated, but at the same time the cocktail of the drugs could have been contributing to that agitation.
A That is a reasonable speculation, but you can also speculate that, without the haloperidol, the patient will also suffer distress because the therapeutic effect of the haloperidol will be withdrawn. So you have to make a decision based on a best guess in those circumstances, and my best guess here was that the patient would be more comfortable
G without the haloperidol and with an increase in Nozinan; so it was a therapeutic decision, based on personal opinion and experience.

Code A Doctor, which came first? Can you tell from the record? Was it the agitation or the haloperidol?
A I have no doubt it was the agitation. There is extensive reference to aggressive, agitated and distressed behaviour from Code A in the run-up prior to this event. He was
H

initiated on oral morphine for that reason, amongst others, because he was in pain from his bed sores when he first arrived on the ward.

Q Would it be fair, in your opinion and experience, to say that the combination of drugs prescribed at the time that you were involved with the care of this patient ran a high risk of producing respiratory depression and potentially coma?
A When I saw the patient he was taking the medication and he did not have respiratory depression at that time; so although there would be a risk with a patient being given these doses straight in – yes, there would be a risk of respiratory depression – but his dose had been escalated steadily as his symptom control required. If medication such as morphine is used to relieve distress, it is likely, if needed in a high dose, that it will probably shorten life, but that is a side effect of the necessity to relieve the distress.

Q My question was would this combination of drugs present a high risk? You have accepted clearly that it is a risk. Would you go so far as to say that it is a high risk of producing respiratory depression and potentially coma?
A I would think there would be a risk of that. I think that is ---

Q What? There is a risk of a high risk? I am sorry, I do not want to be ---
A I am trying to find a way to answer the question in a way that puts it in context. If you take a patient off the street and you give him these doses, there would be a high risk that that patient would develop respiratory depression and would be endangered by that. This patient is already in a situation where they are at high risk of dying because of their medical condition, because of their deteriorating medical condition. In that context, one has to use high-risk management in order to control their symptoms.

Q Was this high-risk management?
A There is a high risk that their life will be shortened by it, yes.

Q In your view, was that a justified risk?
A It was.

Code A Are there any questions, Code A first of all, arising out of those of the Panel?

Code A It should be Code A first of all, sir.

Code A I beg your pardon, yes. Code A any questions arising out of those of the Panel?

Code A Very kind of Code A but no, thank you.

Code A ?

Further re-examined by Code A

Q In relation to your last answer to Code A what medical condition do you say was going to kill this patient?
A He had bed sores. He had extreme immobility, which would place him at risk of orthostatic pneumonia. He had extreme mental distress, which was well documented through

A his admission in Phoenix Ward. But I think the main risk to him of death would be through immobility.

Q Not being able to move?
A His being unable to move, which pre-existed any use of morphine. In fact, I believe his death certificate shows bronchopneumonia, which would have been of an orthostatic type.

B Q You interpreted from the notes "further deterioration" as meaning that the patient was agitated, is that right?
A Distressed.

Q Distressed. But at the time that you come into the picture, do you know the cause of his distress?
A At the time I would not be able to know precisely that. I would have to judge that on
C the basis of his clinical history.

Q You spoke about how a prescriber would have to be aware of the possibility that a patient had developed a tolerance to opiates – yes?
A Yes.

Q You spoke about how a tolerance might develop over, I think you said, seven to
D 14 days. Is that right?
A I would expect tolerance to develop initially very quickly and then gradually to reduce in speed. So one would initially quite quickly become tolerant to a dose of opiate, and the speed with which you develop that tolerance might slow down.

Q I want to understand what you mean by becoming tolerant and what you mean by "quite quickly".
E A Tolerance of opiates occurs, as I understand it, because when your body receives opiates the receptor for the opiate is then blocked, so the body then develops an increasing number of receptors. So the longer for which you are actually on morphine, the more receptors you have; and the more receptors you have, the more morphine you need to cover those receptors, to gain a therapeutic effect. The speed with which you develop those receptors is induced by the morphine; so also, if you need to have a relatively high dose of morphine, you would develop tolerance at a faster rate.
F

Q Do you stick to your original evidence that tolerance might develop over a seven to 14-day period?
A I do not have chapter and verse to that, and that is a purely personal, subjective opinion. I think that the degree of tolerance of the patient is partly determined by the patient's response to the dose. So one's judgment of tolerance is based on how well a patient tolerates a dose. If a patient develops respiratory depression at a dose of 50 mg of morphine,
G then you would stick at that dose. If they do not have respiratory depression at that level, one would be able to go to a higher dose without feeling there was a danger.

Q Yes, I understand that, but the starting point is not the respiratory depression; the starting point presumably is whether the patient is in pain or not.
A The starting point is symptom control, yes.

H

A Q And the reason – just coming back to the questions, I think asked by Code A – you stopped the haloperidol was because of signs of agitation, signs of distress.
A It was because it was felt the haloperidol might be contributing to that.

Q Quite apart from the patient's symptoms. It could have been the drugs.
A A combination is possible, yes.

B Code A Thank you very much indeed, doctor. That brings us to the end of your testimony. We are most grateful to you for coming to assist us with this matter today, and you are free to go.

(The witness withdrew)

Code A Sir, we are about to move on to Patient B. It would plainly be a convenient
C moment to adjourn, if you are going to take the time to read my short opening in relation to that patient.

Code A Yes.

Code A May I mention in passing that we all know there will be a Tube strike starting this evening. I know that counsel can get here on time, but I wonder whether we are
D proposing to start on time?

Code A We are proposing to try to start on time. Some of us are staying up in town; some of us live up here already; but there are others who do require to come in by train. They are anticipating a long walk, on the basis that taxis will be like hens' teeth and bus queues will be enormous. I am told that they are bringing in sensible shoes and will get here as soon as they can. They are aware of the difficulties so presumably they will be leaving
E that much earlier. We cannot be sure what will happen but we will attempt a 9.30 start.

(The Panel adjourned until Wednesday 10 June 2009 at 9.30 a.m.)

F

G

H

**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Wednesday 10 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 THREE)

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)

# INDEX

A Code A: Good morning everybody. I think everybody should be congratulated on managing to make it here on time. Code A, it would be helpful if you could outline your plans for the day.

Code A: We are starting, as planned, according to the witness timetable. I am continuing according to the witness timetable. I am going to read the statement of Code A Code A who is the Code A So far as Patient C is concerned, there are B no witnesses other than the expert evidence which will be given in due course. That will simply mean a review of the notes in due course by the expert and he will give his view, but nothing in relation to Patient C today.

We then move on to Patient D, Code A, and we will be calling Code A Code A We then move on to Patient Code A Your form indicates that Code A Code A is going to be read. She is not, but we are going to call Code A C Code A, who is here and ready to give evidence. Although that is only two witnesses, they are both substantial witnesses and that is all we have for you today.

Code A: So Code A is not to be read, she is simply dropping out of the picture altogether?

Code A: Yes. I take it that you will be requiring a short break in relation to reading the D transcript of my opening in relation to Patients D and, subsequently, Patient E?

Code A: I think that is correct. We have all managed Patient B before the start today, and I think several people have done Patient C as well, but D and E we have not embarked on yet so we would need a few minutes each time for those.

Code A: Can I also indicate that Code A and I have been in E discussion this morning about how best to progress your idea of a fuller chronology and we will be working on that over the coming days to try to produce something rather fuller. We have produced it in the form that it is, a relatively anodyne form, so that it would be acceptable to both sides, but we are both agreed that it would help all parties if we can produce a fuller chronology for each patient, and we will be attempting to do that.

STATEMENT OF Code A, Read

F

May I start by reading the statement of Code A. He starts with a GMC statement in which he simply says:

"I am Code A"

He exhibits a copy of a witness statement dated 19 May 2004 that he made previously in G relation to Code A's care. He says:

"I can confirm that I have been given the opportunity to add or amend the statement."

He amends it in a way that will become clear. He understands his statement can be used for the purposes of these proceedings.

H

A I turn to the statement of 19 May 2004. He describes his occupation as being retired and he says:

> "I am Code A and I reside at an address known to Hampshire Police. I am making this statement about the care that Code A received at the Gosport War Memorial Hospital and her subsequent death.

B Code A was Code A and was born on Code A had a younger brother, Code A who unfortunately died round 1993 or 1994. Code A on 23 December 1934 and I was Code A Code A died in 1989. Code A continued to live alone at the family home which was in Gosport. I took early retirement in 1990."

C He moved to Warsash in order to be closer to her. He makes this amendment, he says:

> "I moved to Warsash from Royston in 1990 to be closer to Code A and then took early retirement in 1991.

Code A was diagnosed as suffering with Diabetes in 1942 and was insulin dependent right from the start. Code A was more than capable of managing her insulin
D and diabetes. Other than diabetes, Code A had slight rheumatism and was partially blind in her later years due again to the diabetes. Other than this, she was healthy and a very strong and independent woman and remained so right up to the day she was admitted to hospital in February 1996. She coped with her housework and washing and was a very family orientated person. She did have a home help and a nurse would attend from her surgery twice a day to assist mum with her insulin regime. Code A belonged to the Forton Road Surgery since she was first married and in the later years
E Code A became her GP. Code A had been taken into hospital on a couple of occasions after she had been become 'Hypo', they would stabilise her diabetes and send sent her home.

In early February 1996 I received telephone call from Code A who was Code A Code A's home help, and informed that she had fallen and been taken to the Royal Navy Hospital at Haslar. Code A was in Haslar Hospital for several days before we
F were told that she had suffered a brain stem stroke which was apparently a very painful type of stroke. However she was sat up in bed almost from the start. She was obviously in pain, not only from the stroke but the fall as well; she had not fractured any bones but had cut her head open bones but had cut her head open. I was shocked to find that she had had a stroke because up to then I assumed it was an incident due to her diabetes.

G Code A remained in Haslar Hospital for two or three weeks and underwent physiotherapy. Her progress was excellent, so much so that the occupational therapist spoke to me about preparing her home ready for her to return to it. Code A was now talking to others coherently and understanding what was being said to her. She was had also learned to walk with the assistance of a frame. The care that Code A had received at Haslar Hospital was excellent in my opinion. On my last visit to Haslar Hospital the physiotherapist was trying to arrange an adjustable walking stick she
H could take with her when she was discharged. He returned shortly and said that she

would not need it as she was going to the Gosport War Memorial Hospital for rehabilitation.

Code A was very coherent at that time and was always checking that we had fed her cat. The cat was a problem for us as she had had it for many years and it would not let anyone go near it except for Code A. We had wanted to sell Code A's house and move her into a warden controlled flat as we felt it would be better for Code A to have constant assistance at hand. Code A agreed with this. The nurses would probably still have had to visit twice a day because of her insulin injections. Code A would not move because of the cat and the cat could not be re-homed anyway because of its bad temperament. Code A also referred to the warden assisted flats at Clarence Square as Barracks and was adamant that she would not move into them.

Code A was admitted to Daedalus Ward at the Gosport War Memorial and was immediately placed in a room on her own. Just after she arrived a nurse came in and conducted a test which I believed was for Alzheimer's. It involved answering a lot of questions like, "What was her mother's maiden name?", and having to remember a word that she was told at the start of the test and repeat it when asked at the end. Code A passed this test with ease.

Staff at the Royal Navy Hospital at Haslar had told me that Code A was just going to the Gosport War Memorial Hospital for rehabilitation. Code A and I attended daily as well as feeding her cat. Within two to three days of being at the Gosport War Memorial Hospital I had an appointment to see Code A I asked when she would be able to go home and said that we needed to know as we would have to get rid of the cat if we were going to get her a warden controlled flat. Code A eplied, 'You can get rid of the cat'. I was stunned with the way she said this. Code A then said, 'You do know that Code A has come here to die'.

I did not know that this was the case. I believed that Code A had gone to this hospital for rehabilitation. I could not believe the cold and callous way that Code A had broken this news to me. It was as if her death had been predetermined. I was that shocked I did not ask any more questions even though I had a number that required answers. On reflection I should have seen this coming because I had asked the same question of Code A on Daedalus Ward and was told that I had better speak to Code A I cannot remember Code A s name because she was a Code A at Northcott House previously and Code A knew and trusted her.

Soon after my meeting with Code A I noticed that Code A had been placed on a syringe driver. Code A had actually said to me on one occasion, "I don't like that thing" and pointed at the driver. I assumed that the syringe driver was for pain, but did not know what drug was being administered by it.

Code A 's health deteriorated quite quickly. On one occasion we visited she appeared unconscious and smelt awful. It was really difficult to be near her because of the smell. I looked at the medical notes and saw that there was an entry stating 'leaking faeces'. Code A was always very proud of her appearance and spotless and she would have hated to be in this state.

About two to three days after this visit, on 6 March 1996, I received a telephone call from the Gosport War Memorial stating that she had died. The death certificate had been certified by Code A BM and gave the cause of death as Cerebral vascular accident and Diabetes Mellitus. We buried Code A at Anns Hill Cemetery.

I am concerned about the rapid deterioration of Code A when she originally went to the Gosport War Memorial Hospital for rehabilitation. I am also concerned about the callous way we were treated by Code A and I cannot help wondering if Code A's death was partly down to go into a nursing home, which was placing a financial burden on Code A's surgery as she had to supply a nurse twice a day.

I am a realistic and accept that Code A was an elderly lady, and at that time was one of the longest standing insulin dependent people. However she appeared to be making a full recovery from the stroke, was alert, lucid and other than a little pain in her shoulder, was not complaining of pain. Code A did not make an issue of the pain in her shoulder, but it was obvious that she was at least a little tender and she did not like people touching it and would ask them to be careful if they got near to it. It was not until her final day that I realised that she was being administered diamorphine through the syringe driver. I was not informed of this by any staff despite visiting nearly every day with Code A"

I have also been invited to read in relation to that particular witness, part of his evidence for the coroner's inquest. I am going to précis it in parts. If Code A or Code A feel I am doing it injustice, they will tell me no doubt, and I can read it. So far as the cross-examination is concerned, I was going to read that in full, and I see Code A confirming that and I will take that course.

Code A was called on Thursday 19 March this year at the inquest before the coroner for North Hampshire. He was sworn and confirmed his name. He confirmed that he was Code A and, effectively, went through the statement I have just read to you. During the course of his evidence, he confirmed that she could not manage her own in insulin because of her poor eyesight and he, Code A, had had to give her injections from when he, the son, was very young. Then the coroner asked him this question:

"The suggestion that will be put forward is that before syringe drivers were used the matters were discussed with relatives: you are saying that did not happen in your case?

A We were – if you look at the notes that came, it looks as though that did happen but chronologically, I do not remember a discussion with Code A until we saw the syringe driver there.

Q Did you not have a discussion with anyone else, any of the nursing staff?

A I did speak to Code A .."

It was confirmed that it was Code A he could not remember the name, but the coroner confirmed it.

"Because she was the lady that actually new my mother because she was in Northcote House and Code A was in Northcote House in Gosport, which is an old people's home and she got very friendly with Code A because Code A was always

visiting, so she did know mother, even though it says she did not, but nobody would talk to me and referred me to Code A and that that is when we discussed the issue of the syringe driver.

Q So it was not until you spoke to Code A that there was any mention of a syringe driver?
A Yes, that is correct.

Q So, you did not discus it with any of the members of staff?
A Both Code A and myself knew what it was, basically because Code A had had an operation and she had had to manage her own pain control through an adjustment control on the driver.

Q You are also suggesting that Code A may have had reservations about Code A Code A going home because of nursing care and having to supply a nurse twice a day, but that had been Code A 's situation before her admission, had it not?
A Oh yes, there was a lot of money being spent on Code A here because the nurses were going there, they were going there whilst we were there. We moved away for a while, the family, and we came back. I was working in North London and they were looking after Code A then, after Code A s death. There was a lot of financial burden on the surgery, supplying her continued, you know, supply of nurses."

He was asked:

"Is there anything else you want to add, anything else that has cropped up over the years?
A Since... It has been a very long time, it is 13 years, so – I am on the other side of 20 so my memory's failing slightly as well but there is one thing if I could mention at this point...."

Then he made a comment about the notes which was to this effect on 6 March 1996.

"There is an entry on the notes:

'Pain...' on 6/3/1996 – Pain well controlled. Syringe driver renewed at 9.45. This is not my writing but an entry was made, it bears my name, but not my signature, along with that Nurse Code A I assume that the entry was Code A s writing and would have been written at the time or shortly after. It was not usual to have two signatures as I was with a qualified nurse. We both had contact with the patient."

The note if you want to have reference to it, is page 1013 on our pagination in Patient B's notes. The note is at the bottom of the page, "Pain well controlled syringe driver renewed at 9.45".

Code A We do not have those notes at the moment.

Code A I am sorry, could I hand up those notes, I do apologise. In fact the page I am going to refer you to is perfectly legible, but this is one of those where some of the pages have not copied particularly well, so I am afraid we are still waiting for the original notes

from the Trust. They have been promised to us today, but we will have to do another exercise as with Patient A.

Code A Perhaps we will receive this bundle and mark it exhibit C3. (Bundle distributed and labelled C3).

Code A The note was at page 1013 and it is right at the bottom. The witness seemed to think there was a false signature, but it is certainly not part of the GMC's case and I am not going to pursue that at the moment. We can see two signatures next to that of Code A and I think it is 'Code A'. The coroner says to him:

> "Two nurses would have signed. You are saying just one of them has signed it?
> A No, what I am saying is that that nurse, when she has gone through those notes to explain them for the purposes of this hearing, or whatever, this has been prepared for, it says there that, 'I did not write it but somebody has signed my signature'."

I think this is a reference to evidence that had been given previously by a nurse. We are not going to go there and I do not think it assists unless Code A wants me to dwell on it.

Code A I can assist because in the transcript it takes it on a little more, the coroner was handed a statement from another witness, a nurse called Code A who explained that she had signed an entry in her name and also the name of the care assistant, the second name is there. So I hope that clears it up.

Code A: I do not think there is any issue. We turn to the cross-examination by Code A Code A It is going to take me a little while to read through this. Can I just ask Code A to confirm that he wants all of it in?

Code A Yes, please.

Code A: Very well.

> "Q Code A I want to ask you about the position of Code A but before I do can I just go through Code A s treatment at the Haslar Hospital. What you told us was that in February 1996 Code A had a fall, yes?
> A Uh-huh.
>
> Q And she was treated at the Haslar Hospital.
> A Uh-huh.
>
> Q Do you remember how long she was there, approximately?
> A It's difficult, we were talking about this ... It was something like two, one – more than one week but not two. There are no records here from Haslar to refer back to anyway.
>
> Q No, I am just asking about your recollection.
> A Yes, my recollection is she had more than a week there but probably not quite a fortnight.
>
> Q Did you go and see her regularly at Haslar?

A

A Oh yes."

Then the coroner interjects:

"Code A: Is it important, because we have got the Haslar records?

Code A I do not think it is important, I am just dealing with recollection. (To the witness) Did you go on your own or did you go with Code A?

B

A Code A came with me on all visits; all visits Code A came with me.

Q Would Code A have gone alone, gone ahead of you to see Code A?
A No.

Q Whenever you went Code A was with you?

C

A Code A was there.

Q Did you go on a daily basis to the Haslar or less frequently?
A I had retired at that time so, yes, we used to go as often as we could. We used to go and feed the cat and then go down to Haslar to visit Code A

Q Would you speak to the doctors at the Haslar as well?

D

A We spoke to the doctors and they said she was doing quite well, basically. Can I just stretch that a little bit? When the physiotherapist was there and the person that was going to look at Code A's house and put handles and things in ---

Code A The occupational therapist?
A The occupational therapist. I walked away from the bed for a while and Code A actually walked down to the toilets with Code A and that's the only time they

E

were on their own together. She walked down and she took her to the toilets, aided, but she took her to the toilets.

Code A I understand, and were there several doctors at the Haslar you were able to speak to about Code A?
A There was a Code A."

F

I think that must be Code A

"which appears on a letter that was sent to the War Memorial Hospital, but of all the others, they were all of naval or military rank and we didn't get to see them too often.

Q All right, but they were there?
A There were lots of them.

G

Q There were lots of doctors, I understand. When Code A was transferred over to the Gosport War Memorial Hospital, how many doctors were there, do you know?
A What, the War Memorial?

Q Yes.

H

A We followed the ambulance down to the hospital.

Q Forgive me, I will ask the question again: how many doctors were there at the War Memorial Hospital looking after the patients, so far as you understood it?
A Code A one.

Q She was Code A s GP.
A That is right.

Q So you knew that at least some of them working there, she was working as a general practitioner. What did you understand was her role at the War Memorial Hospital?
A I understood that her role there was to look after her patients from her surgery.

Q Is that right?
A Mmm.

Q Who was looking after the other patients on the ward Code A was on?
A It must have been other doctors that we weren't involved with. One assumes that there was more than one doctor in the War Memorial at the time.

Code A I think that is the question Code A asked you at the beginning. You were asked how many doctors there were at Gosport and you said the only doctor there was Code A
A The only doctor that we saw.

Code A The only doctor that you saw, and you presumed that there were other doctors seeing to their own patients in Gosport?
A Yes.

Code A The truth, Code A just so you know, is that Code A was the Code A for Dryad and Daedalus Wards, she was the doctor looking after all the patients, not just her GP patients, right?
A Okay.

Q There was a consultant for each of the wards.
A Can I just say one thing at this point?

Q Of course you can.
A Code A was in a room on her own.

Q Yes, but she was one of the wards?
A Yes.

Q She was in a side ward?
A Yes. So the only person I saw in there with Code A was Code A

Q Are you able to tell us how many times you had the chance to speak to Code A Code A during the time Code A was at the War Memorial?
A Several.

A

Q Several times?
A Had a chance.

Q Did Code A 's condition change during the period of time she was there?
A She was – yes, it went down, it went down.

Q I understand.
B A At the time of entering she was very much alert, and she was ---

Code A : You say "alert"?
A Very alert. When this series of questions that the reception nurse, whatever she was, fired at Code A she answered the immediately: "Where are you?" "Gosport War Memorial". The War Memorial was dear to Code A s heart because she was there the day it opened. She knew she was at the War Memorial. She knew who the
C prime minister was. She knew who her member of parliament was; where she lived; where she had been; very fast and she also remembered a word, which I can't remember now because I'm also losing my memory.

Code A What we know is that when Code A was transferred she had ---
A She was going in for rehabilitation.

D Q I understand but she had a whole series of medical problems.
A Diabetes being one of them.

Q Had she been blind for some time?
A Partially sighted, yes.

Q Had she been living alone, with her cat?
E A Yes.

Q And she had had a fall, and she had fallen from the top of the stairs to the bottom of the stairs.
A That is right.

Q That is how she got admitted originally to hospital?
F A Uh-huh.

Q There were discussions, I think, with Code A about what might happen to Code A whether it would be appropriate to transfer her to a rest home?
A Those were prior to her falling down the stairs that Code A came round to see Code A one day and there was a discussion. We went to several places to look to see where we could get Code A in so that she could get some assistance but, yes, there
G had been discussions.

Q What I am suggesting is that there had been discussions when Code A was transferred to the War Memorial Hospital ---"

Then Code A repeated that question.

H

A "Q What I am suggesting is, there were discussions after Code A had been transferred to the War Memorial Hospital about if she improved would it be possible to transfer her to a rest home.
A Mmm.

Q This was long after she had fallen down the stairs?
A This was after she had fallen down the stairs."

B Then that is repeated, I think. Then this:

"Q Yes, and it was at that stage that discussions were being had about what would your mother's future be, what might it be?
A She wouldn't sell her house, basically."

C Again, that was repeated.

'Code A ... (To the witness) I think Code A was very dependent on other people, nursing staff ---
A Uh-huh.

Q --- for her daily needs.
D A Some of the time, yes. She had a home help and she had a nurse visiting twice a day because she had to have an insulin injection night and morning.

Q I understand.
A Except for the days when we went round there regularly, then I did her injection in the evenings.

E Q I am grateful for that: what I was really asking about, and it is my fault for not being clear, is when Code A was at the War Memorial Hospital, I am suggesting that when she was there she was very heavily dependent on people for her daily needs?
A Yes, she was.

Q Yes? She needed a great deal of help from nursing staff.
F A Yes.

Q That is why there were concerns about whether it would ever be appropriate to transfer her away from the hospital into a rest home?
A Yes, I... I am not quite sure when it came up but certainly the fact that Code A had gone there to die cut that discussion down quite a bit.

G Q At the start what was being discussed was Code A s mobility, what her needs were and whether she could be transferred away from the War Memorial Hospital: you agree with that, you are nodding?
A Yes.

Q There were concerns that Code A had about her cat? She was very attached to a feral cat; she got on with it but nobody else did I think?
H A That is right.

Q I think there were concerns about Code A relinquishing the cat; she did not want to let it go, yes?
A Yes.

Q You discussed that with Code A
A Code A said, "You can get rid of the cat".

Q It was affecting what could happen to Code A, is that right?
A Mmm.

Q As her GP and as well as the doctor treating Code A at War Memorial Hospital, Code A knew Code A's circumstances very well, did she not?
A Uh-huh.

Q You have told us that you had several conversations with Code A over the time Code A was at the War Memorial Hospital. Did you have a number of conversations with nursing staff as well when you went to see her?
A We spoke.

Q You knew that Code A was in pain.
A Yes.

Q You knew that Code A was deteriorating whilst she was in the War Memorial Hospital, that is what you have told us.
A Yes.

Q The impression, and I am raising this for you to consider, is that Code A was a rather proud woman about her own appearance and about how she presented.
A (No audible reply).

Q You have told us you read some notes at the end of the bed about Code A leaking faeces.
A Uh-huh.

Q Did she tell you that?
A Did she tell me?

Q Yes.
A Code A was unconscious at that time.

Code A: Can you explore that a little more?

Code A: Are you able to tell us when it was you learned, in relation to Code A Code A's death, that she was leaking faeces?
A When I learnt?

Q Yes.
A The day it said on the papers. I looked at the chart at the foot of her bed and it said – I forget what date it was, it is on there somewhere because I've read it.

Q You suggested that the medical records may not be entirely reliable, so that is why I asked about your memory.
A I saw it – it was fairly soon, maybe the day before she passed away or along that period, when she was really deteriorating."

If you wanted to make a note, the reference that the witness is speaking about is at page 1015 of the notes.

"Q I am not going to go into the detail of the medical records.
A Okay, but that is the only thing we've got.

Code A Sorry, the fact that that came up at a point when Code A was unconscious, so it was fairly near the end?
A Yes, it was.

Code A: (To the witness) Did you know that there had been problems with Code A 's bottom for many days by the time she died?
A No.

Q You told us there was a conversation with Code A when you were told that Code A was dying.
A She didn't say it like that: "Code A s come here to die".

Q What you have told us is you had several conversations with Code A
A Yes.

Q And the words you have put in her mouth are, one, "You can get rid of the cat", and, two, "Code A 's come here to die". I am suggesting that the conversations were a bit fuller than that. It was not just one line from Code A --
A No, there was ---

Q --- on several occasions.
A There were ---

Q I am exploring what it was that Code A said, if you can recall it.
A I cannot recall exactly what she said. All I have done is told the truth as I saw it from that ... I can't remember how many times, and, crumbs, you know you are going back 13 years. She died 13 years ago. It is very difficult to be precise."

Code A agrees with that. Then the witness says:

"A There's been a lot of water under the bridge since then. However, we have often spoken, Code A and I, about that occasion because Code A although it does not say so there, was actually with us. She never saw Code A on her own at any time, because I used to take her to the hospital with me. We only had the one car at that time so I drove Code A everywhere.

Q All right, I am just trying to explore what else you recall of the conversations, the several conversations you say you had with Code A and you are not able to help us?
A No, not really.

Q Do you remember being told that Code A was being given medication for her pain?
A Yes.

Q Do you remember being told that she was being give the use of a syringe driver and that being explained to you?
A I knew she was having treatment for pain but the syringe driver was not there at that time, when we were talking about pain control.

Q You spoke to the nursing staff about this?
A They referred me to Code A. There was Code A referred me to Code A. She would not discuss it.

Q Did you indicate that you were keen that Code A should be pain-free?
A Uh-huh.

Q Anyone would in your circumstances.
A Uh-huh. I didn't want her to have unnecessary pain.

Q Of course, and did you say that?
A We didn't want to accelerate her death either.

Q No, of course not, but was that something you said because Code A appeared to be complaining of pain?
A She wasn't complaining to us a great deal. Code A was – by the notes, she was complaining to the nurses but she didn't actually complain to us a lot at all. We were aware she had a bad shoulder, but she's had a bad shoulder for years, she used to call it her "screws".

Code A Rheumatism.
A Maybe that was aggravated when she fell over as well."

Code A thanks Code A very much. Then the coroner asks:

'Code A One thing I am not clear about: you say that you do not recall any conversation about the syringe driver. Are you saying that that did not take place or that you do not recall it?
A The conversation about the syringe driver was after it was installed; that is what I am trying to say. I don't recall we had discussed it previously, but I knew they were going to try and manage her pain. I mean, you can do that with tablets, you can do it with aspirins when you have got a headache.

Q They can only do that if people can swallow though, can they not?
A She was being fed at that time."

A The witness was then released. That deals with that witness's, Code A s, evidence.

We are now going to move on, passing through Patient C, Code A and we are about to move on to Code A Patient D, and to call the witness, Code A It may be you would like a short period?

Code A Yes, please. Could we have ten minutes? Would you be intending for
B us to receive bundle C today, or will we get it later?

Code A We can certainly have bundle C out now, and perhaps we should also hand out bundle D. It is suggested that we should hold bundle C back because we can update that, and there is no need for you to have it at the moment. Bundle D we can pass to you.

Code A We will receive bundle D now and we will mark that Exhibit C4.
C (Document marked and circulated)

Code A In relation to your exhibit numbering, if we have made C3 bundle B, could I suggest that Patient D is bundle C5 and then you will receive C4 in due course, which will be patient C. That will make it slightly simpler.

Code A Very well. We shall receive in due course the Patient C bundle, which
D we will then mark Exhibit C4, but we have now received bundle D, which we will now amend and mark as Exhibit C5. Thank you.

(The Panel adjourned for a short time)

Code A Thank you, Code A The Panel have had an opportunity to prepare.

E Code A Thank you very much. Could I call, please, Code A ?

Code A Sworn
Examined by Code A

(Following introductions by Code A

F Code A : Is it Code A ?
A Yes.

Q If you have any difficulty hearing me, just say so, and I will repeat the question.
A Thank you.

Q I want to ask you, please, about Code A
G A Yes.

Q Was Code A
A That is right, yes.

Q Now, Code A I think, was born back in 1916?
A Yes.
H

Q 2 September 1916?
A Yes.

Q And I think she had a number of siblings. She was one of six, is that right?
A Yes.

Q She Code A ?
A Yes.

Q And I think she worked until her retirement, and Code A died, and after his death did she move to the Gosport area --
A Yes --

Q -- to live near you?
A -- she came to live with me.

Q Once she had moved to Gosport did she at any stage, so far as you were concerned, show some signs of dementia towards the end of her life?
A She was just starting with dementia and I had her diagnosed while she was with me.

Q Unfortunately, I think that got worse, did it not, progressively?
A Yes, she progressed fairly rapidly but, I mean, I would like to have kept her at home with me and nursed her but I could not make my house safer than what I had already had for her and I thought that the time had come that she could probably get better care in an environment for people with Alzheimer's.

Q Then I think about a year before she died did she go to live at a home called the Code A Residential Care Home?
A Yes, she did, yes. She was in there just a year.

Q Was that a home specifically that was equipped to deal with people with dementia?
A Yes.

Q Did you go and visit her when she was there?
A Yes.

Q Were you still living in Gosport at the time?
A Yes.

Q So would you know the local hospitals? You knew the Queen Alexandra Hospital?
A I did, yes.

Q Did you know the Gosport War Memorial Hospital?
A Yes.

Q I think there came a time in July of 1998 when she was admitted to the Queen Alexandra Hospital?
A Yes.

Q Was that, I think, 31 July? You probably do not remember the dates anymore.

A A It was around that time, towards the end of July, yes.

Q She had, I think, a couple of problems but in particular she had a urinary tract infection, is that right?
A That is right, yes.

Q So she was admitted to hospital. How did she respond to the treatment that she got at
B the Queen Alexandra Hospital?
A She was responding very well. She spent, I think, five days there and that is why they moved her down to the Gosport War Memorial because she was eating and drinking.

Q Since you live in Gosport, you can help us a little bit about the geography. How far is the Queen Alexandra from the Gosport War Memorial Hospital approximately?
A I would say it is about a 25-minute drive if you are using your car.
C

Q And the Royal Haslar, I think, is – do you know where the Royal Haslar is?
A The Haslar is just that little bit further on but I think the War Memorial was for more elderly people that were for replacement and rehab.

Q So she went off to the Gosport War Memorial Hospital. What did you understand was the purpose of her admission there?
D A I was told that she was there just for rehabilitation and for replacement.

Q So, in other words, when you say replacement, so that when she came out she would go somewhere --
A She might have had to have gone to a proper nursing home.

Q Did you understand how long she was meant to be in the Gosport War Memorial
E Hospital?
A I think it might have been three, four weeks.

Q Just tell us about the time that she was at the Gosport War Memorial Hospital. I think she was taken on to Daedalus Ward?
A Daedalus Ward, yes.

F Q Did you go and visit her there?
A Yes.

Q Can you remember how early on in her admission you went to see her?
A When I first went to visit for the first few days she was eating and she was drinking and then I started to go in every day so I saw a gradual decline in her health and she was sleepy, she was not – I do not think she was eating and drinking because of the lack on her
G care plans that some days it looked as though she had not had anything to eat or drink for quite a while.

Q There is no indication that she was on drugs at that stage?
A Not at that stage, no.

Q And so she was deteriorating and could you see that when you went to see her?
H A For the first few days, yes.

Q How often did you go and visit her, can you remember?
A Yes, I was in every day because I was only working just across the road so I used to go in before I went to work and when I finished at eight o'clock.

Q Apart from not eating and drinking so well, can you remember how mobile she was?
A She was not mobile because she was able to walk and after being in there for a few days they were using a hoist on her.

Q So she became less mobile?
A She became less mobile, yes.

Q Did there come a time when you were invited into the hospital for a chat? Did you go and speak to --
A I was asked to call in to speak to I think it was the Code A who said that I had probably noticed that there was a deterioration in Code A and I said, yes, we were wondering why when it was only for rehab and replacement that she was deteriorating really quite quickly.

Q Do you remember what his explanation was?
A He just said that he did not think that Code A would get better and I probably could see that she was going to die in there.

Q Right.
A It was quite a shock and, you know, when you only think that she is going in to be replaced, I think we were all really in a state of shock, yes.

Q I understand.
A I did say that I did not want Code A to suffer but I never once mentioned about any drugs or anything.

Q That was a conversation, I think, with Code A ?
A It was just a short conversation, yes.

Q Do you remember the name, Code A ? Is that the right name?
A I know it was Code A that I spoke to, yes.

Q I think it is agreed but I want to see if the witness remembers. Can you recall whether, prior to that conversation with Code A or whoever – it was a Code A was it?
A It was a Code A , yes.

Q Can you recall whether, prior to that conversation, you had had any meetings with Code A about Code A ?
A Code A 's name was never mentioned and we never met with Code A

Q All right. Did there come a time when you did appreciate that Code A was on drugs?
A I went in one lunch time for an hour or so before I went to work and Code A was really very, very sleepy. After a little while I could see she was flinching in her face and I said to her "Have you got a pain of some sort?" and she answered me and said "Yes". I went

A off to find one of the sisters or one of the nurses and I got told "Somebody will come along and see you in a minute." I think again I had to go and ask and I got told again "Someone will come and see Code A in a minute". It got to almost two o'clock when I had to leave to go across the road to work that I asked again and said that I had to leave. Code A turned up to Code A 's bedside then and he said "We did not know that Code A was in any pain and we will give her something to relieve her. You may find when you come in this evening that Code A is sleepy". I left and went across to work and I phoned Code A up, Code A B Code A and I asked her to get straight down to the hospital to find out what was going on. I was not happy with the care and what was being told about Code A and when I went back across at eight o'clock that evening Code A was totally unconscious and she never regained it.

Q You probably cannot – can you remember the date that that happened? I am going to suggest one to you unless there is objection. It is around 20 August?
C A I am sorry?

Q Would it be around 20 August that that happened?
A Yes, yes.

Q All right. What were you unhappy about? When you said to Code A 'Get down to the War Memorial Hospital", what was it that ---
D A I said I was not happy with who I had spoken to and the attitude "We do not think there is anything wrong with Code A ". When Code A got down there she was told " Code A seems to think" ---

Q Stop there. It is not your fault at all. We cannot hear what other people said to you, we can only hear about your own recollection.
A I just had a feeling that something was not quite right and I was generally worried.
E

Q All right. Did you go back? After Code A had reported back to you, did you go back to the hospital?
A I was back in at eight o'clock that night.

Q What did you find when you got there?
A Code A totally unconscious. She never fluttered an eyelid, she never spoke, she
F was just totally unconscious.

Q Did you make any attempt to rouse her, to speak to her, can you remember?
A I tried and there was just nothing. There was just absolutely nothing.

Q Did you ever speak to her again?
A No.
G

Q Did she die Code A ?
A She died Code A

Q Tell us a little, and if you still find it distressing, I do not want to distress you at all, but did you go back to see her Code A the day that she died?
A I stayed all night. I went back at 8 o'clock that evening and I stayed all night, yes.
H

Q Did they give you a bed in the room or a chair?
A I slept in the chair next to her, yes.

Q Tell us how things went the following day?
A I stayed the following day. Code A came down, we all sat round the bedside. Code A were upset because they were as shocked as what I was that things had rapidly progressed for the worse and that Code A was not going to pull through or come back out.

Q Did there come a time when you left for a period?
A She died about 6 o'clock in the evening, on that evening.

Q Were you there throughout or did you go away at some stage and then come back?
A Code A said, "Why do you not go home, there is no need for you to keep staying, go home, go home". That is all he kept saying, "There is no need for you to stay". The only understanding was that I said, if I went home, it was just to get something to eat and a shower in case I had to stay again that night. He promised me faithfully that if anything materialised with Code A and she took a turn for the worse, he would phone me and I could be back down within a few minutes which did not happen.

Q I think in fact, and this is really something for the Panel, when Code A was admitted to the Gosport War Memorial Hospital, one of the notes that was made on her admission, on page 194, was that, first, you were the next of kin and, secondly, you were to be contacted any time if there was any change in her condition, and you were keen on that?
A Yes.

Q When you came back to the hospital, what did you find?
A I came back to the hospital with Code A and as we were walking down the passage, Code A was stood outside. He saw us walking down, he grabbed an apron, he opened the doors and he went rushing back into Code A 's bedside and, as we walked in through the doors, I went "Oh my goodness", and he said, " Code A has just died, she has just heard your voice, she has just died."

Q I think I can say you must have been distressed about that?
A Yes, very, very distressed because I had, as I, say been there all night and all day, and I wanted to be there when Code A did pass away.

Q I want to ask you about one other matter and that is about syringe drivers. I expect you now know what a syringe driver is?
A I have been a carer for a number of years now and I do know syringe drivers. I do know you would not start someone off, even know that Code A was in any pain, why had she not been given a paracetamol, why had she not been some diamorphine, anything other than a high dosage on a syringe driver because, as I say, at five to two, they did not even know that Code A was suffering.

Q I just want to ask, there is a note in Code A s medical record. I am going to read it over to you, I am not going to trouble you with it but you can look at it if you want. For the Panel it is page 206. This is a note of 17 August, so this is before Code A was put on a syringe driver. The note reads as follows and I will read it as best I can:

"Condition has greatly deteriorated over the weekend.
7.45 pm – Code A seen, aware that Code A's condition is worsening. Agrees active treatment not appropriate and to use syringe driver if Code A is in pain."

I want to ask you about your recollection of that. Can you recall agreeing to a syringe driver?
A A syringe driver has never been mentioned and in fact we never even saw Code A or any other doctor the whole time that Code A was there. The only time I saw Code A was in the morning when she walked into the ward. She ignored me and Code A we might just as well not have been sitting there. She walked round, looked at Code A said, "It will not be long now", and walked back out. That caused Code A great distress. She never said "Sorry", anything about Code A "We have had to put her on a syringe driver for this reason, that reason". A syringe driver had never been mentioned or strong doses of pain relief at all.

Q I will come back to that conversation in a moment. You mentioned that you had been a carer. What was your occupation?
A My occupation was a senior care assistant in a nursing home.

Q How long had you been doing that job prior to this?
A I had only done just done it for the year. That is what I went in to. As I say, I nursed Code A for five years at home and I wanted to take that up when she went into a home. I was working just across the road and I did not then know very much about syringe drivers and we did not have any cause in that year to use them on residents, but now, over the years, we have used them on quite a few occasions.

Q Prior to Code A s death and the use of a syringe driver in her case, would you have come across them at all or not?
A No.

Q The conversation, or the comment, that you remember Code A making when she had a look at Code A can you remember on which day that was, was that on the 20th or Code A the day Code A died?
A I think it was on the Friday morning as Code A because Code A Code A said to me, "Who is that?"

Q I think you were so concerned about the treatment Code A had received that you made a formal complaint to the General Medical Council in 2002?
A I did make a complaint, yes.

Q I am not going into the details of that, but did that reflect what you have been telling the Panel?
A Yes.

Q To come back to the issue of pain, until 20 August you have not recorded, or you have not mentioned, that you were aware that Code A was in any pain?
A Code A was what?

Q Was in any pain prior to 20 August?
A I did not know she was in any pain and the hospital, and all the staff on that ward, nobody knew that she was in any pain whatsoever.

Q On 20 August you noticed her, did you say, wincing or grimacing?
A As I was sitting there, I thought she looks as though she could be in some sort of pain, some sort of distress, I could see by her face. That was the only time she answered me, when I said, "Have you got some pain?" and that was the last word, and she muttered "Yes".

Q At this stage of her life, was she able to converse with you normally or not?
A In some things, yes; some things, because of her dementia, no, but I mean she did lead quite a good, healthy life really. If you looked at Code A you would not have thought there was anything wrong with her dementia.

Q When she mentioned she had some pain, were you able to get from her what the pain was or where it was?
A No, she just very quietly went, "Yes".

Q You mentioned that to nursing staff?
A I said, "I think Code A is in some sort of pain", and that was the only word she said when I asked her, she just said, "Yes".

Q The next time you saw her she was unconscious?
A I went back at 8 o'clock that night and she was unconscious, yes.

Code A Thank you very much, would you wait there.

Cross-examined by Code A

Q I am going to ask you questions on behalf of Code A If you cannot hear me, please say so, but it may be that you can hear me fairly well. What we know of Code A is that she had had dementia for a number of years before she died.
A Yes, about five years.

Q What you told us is that she deteriorated over that time?
A When she was with me I went through quite an aggressive patch with her when she did not want to do anything I asked her to do, because she used to tell me I was a silly bugger. It got to the stage when I was frightened that she might fall down the stairs and I had a stair gate up, but she used to try and climb over it. That was the time then that I thought she would be better, as much as I did not want to and it broke my heart, that I had to put her into care, but I thought she would be safe, well looked after, which she was, when she was at Code A I took her out in the June because the weather was so nice, it was just the UTI, that I got a phone call to say that they were taking her to QA because she was not responding to treatment over that.

Q Code A was in a home. Code A was the name of the home?
A She was just in there for a year, exactly a year.

Q Was she continuing to deteriorate while she was there?
A While she was in the War Memorial, yes.

Q While she was at Code A 's, was she continuing to deteriorate?

A No, she was quite fine. As I say, I had taken her out in the June, we went for a walk round the grounds. She used to sit in their lounge and watch the television. She was quite happy, sleepy or in her own little world. There were other residents there that she sort of got friendly with.

Q What we know is that she got a urinary tract infection?
A She had a UTI infection, yes.

B

Q She went to the Queen Alexandra Hospital and was there for a period of time?
A She was there for about five days, yes.

Q Whilst she was there, she was seen by Code A?
A Yes.

C Q The Panel have this in the records at page 99A. I think, while she was still at the Queen Alexandra Hospital, Code A was assessed by Code A for consideration as to what should happen to her. Were you there for that assessment?
A Not at the time, no. I got a phone call to say that she had made good progress and they were going to move her that afternoon down to the War Memorial.

Q The note suggests that Code A was usually quiet and withdrawn. Would that be
D right?
A Sorry?

Q The note suggests that Code A was usually quiet and withdrawn?
A She was quiet, yes. She was quite happy in her on little world, her own little surroundings.

E Q Is this right, she was pretty dependent on assistance, on people, such as yourself when she had been at home, or nurses when she was in a residential setting?
A Yes. She settled in well, yes she did, she settled in very well.

Q I understand that. My question is, did she need very many of her activities of daily living to be done for her?
A Yes, she was washed and she was dressed, yes.

F

Q I do not know if you are able to comment on this, but it would appear from the note that Code A s assessment was that the overall prognosis, the future for Code A was poor and that she was too dependent to return to Code A the home where she had been for a year?
A I had not spoken to Code A We were just informed that she was coming to the QA for rehabilitation and replacement.

G

Q Who told you that, people at the Queen Alexandra?
A Yes.

Q So whatever Code A s prognosis was, your understanding, is this right, that Code A Code A was likely to get better and have a period of rehabilitation when she was at the War Memorial?

H

A We were on the understanding that she would be placed where she would be cared for for a little bit longer of her life and made as comfortable as she could for what remained of her life.

Q You were not told by any doctors or staff at the Queen Alexandra Hospital, that the prognosis for Code A was poor?
A No.

B

Q It would appear that a decision was made and noted by Code A whilst Code A was still at the Queen Alexandra Hospital, that Code A would not be resuscitated; DNR, are letters that are sometimes used if that is the view of the doctors. Did you know that?
A No.

Q We know that Code A was admitted to the War Memorial Hospital on 6 August and, for those who still have that page open, they will see Code A clerking note at the bottom of the page. Did you meet Code A ?
A No.

Q You were not there when Code A was first seen by a doctor when she got to the War Memorial Hospital?
A Code A 's records and her notes and her care plans were so poor that we did not really know very much of what was going on. We never saw any doctor whatsoever apart from Code A , who was the Code A and the nursing staff.

Q At the Queen Alexandra Hospital, is it right that there were a number of doctors that you could have spoken to during the day?
A I did not have any cause to while she was there.

E Q That may be right, but if you wanted to, would there always have been a doctor at the hospital?
A Yes, I could have spoken to somebody there. When she came down to the War Memorial she was having a cup of tea and she was eating a biscuit.

Q Did you ever ask to speak to a doctor at the War Memorial Hospital?
A I did not, no. That is my regret now that I did not do more than what I should have done at the time.

Q Who were the doctors at the War Memorial Hospital, as far as you understood?
A What?

Q Who were the doctors, as far as you understood?
A Code A but I did not know that until Code A came into the ward that day. As I say, no doctor's name had been mentioned, we never spoke to a doctor, we never saw a doctor and we were never even asked if we wanted to speak to one.

Q You knew there were doctors looking after the patients, did you ever ask who the doctor was or could you speak to them?
A No.

H

Q What you told us is that when she was first transferred to Queen Alexandra Hospital, Code A was eating and drinking?
A When I went down that afternoon, when she was brought back from QA, she was sitting with a cup of tea and she had a biscuit.

Q I was asking when she was at the Queen Alexandra?
A I think she was eating and she was drinking there.

Q I understand.
A Yes, sorry.

Q And you have told me again that when she was transferred to the War Memorial Hospital she was having a cup of tea, certainly, and a biscuit after she had been transferred?
A After she had been transferred, yes.

Q And what you have told us today is that you saw a deterioration over a number of days once she was at the War Memorial Hospital?
A Yes. In fact at times there were not very many people about that we could find to speak to, and sometimes I never saw anybody. I went in one day, and her supper was on the table that she had tried to eat. It was this huge great big thick wedge of cheese that had not even been grated, and you could just see her little teeth marks round it where she had tried to eat it and could not. And her care plans were absolutely appalling. There were some days that there was not even anything written down on them that she had been given fluids, which I would have thought they would have tried to have pushed with her having a UTI. You do try and encourage fluids, but we did not have anything to go by. There was nothing on her care plans. In fact, some days her care plan was found outside somebody else's room.

Q I was asking about her deterioration. Can you tell us what you mean by deterioration over the days ---?
A She was weak. She was very very sleepy and she was very unresponsive.

Q That was long before she was put on any kind of medication for pain?
A That was a few days before, yes.

Q Did you know then, or do you know now, that if elderly patients, particularly patients suffering from dementia, are transferred from one environment to another, that can often precipitate a downturn.
A I know that. I know that they are used to their own little surroundings and sometimes moving them, yes, can upset them.

Q With Code A she was moved twice over the course of less than a week?
A That is right, yes.

Q Looking back now, do you think that that may well be responsible for the deterioration that you saw?
A No. And even if it had have been, why we are here is to find out why she was put on a high dosage of a syringe driver when somebody did not even know, or anybody on that ward knew, that she had any type of pain, discomfort and she was not even, as far as we are aware, given a paracetamol. She was put on a syringe driver that we never even consented to.

A Q Can I remind you of the note that we have already looked at, Code A It is right, is it not, that you did have a number of discussions with nursing staff whilst you were there?
A I was called in by Code A He spoke to me. Then there was no mention of any drugs whatsoever. This is what we want to find out, why we cannot understand.

Q I am going to come back to the note that we have at page 206. It is dated 17 August, so it is four days or so before Code A died. It says, "Condition has generally
B deteriorated over the weekend." That is the note for the morning. The note for 7.45 in the evening: "Code A seen - aware that Code A's condition is worsening." Are you telling us that that was the occasion when you were called in or asked to come to the hospital to see Code A ?
A No. I think it was a few days before when I was called in to be told that she was deteriorating and that I was told, yes, Code A was going to die sooner than later. If my mum had passed away peacefully in her sleep while she was in there, I could probably
C understand that more than being given all these drugs.

Q At this stage, she was not being given any pain relief, was she, on the 17th?
A That she what? Sorry?

Q At this stage, on the 17th, she was not being given any pain relief, was she?
A No.
D

Q But you do not recall that conversation with Code A about the use of syringe driver if Code A was in pain?
A He never mentioned a syringe driver. I was only in with Code A for a few minutes and all he said to me was, "I take it that you have noticed that Code A is deteriorating. We don't think she is going to live very long. She is going to die." And a syringe driver, any form of drug, was never mentioned. He never even mentioned a syringe
E driver when I was in there on that Thursday when I said she was in some sort of pain. All I got told was, "We would make Code A comfortable. She might be a little bit sleepy."

Q Of this deterioration over the week-end that is referred to in that note, do you agree that Code A had continued to deteriorate whilst she was in the War Memorial Hospital?
A I noticed every day that I went in there that Code A was getting weaker, and more and more sleepy.
F

Q I understand. And the next note that we have on that page is one for 21 August: "Condition deteriorating during morning." Is it right that deterioration continued over the next couple of days until she died?
A If there was a deterioration, why did not anybody come round and speak to us that morning, that evening? Why did we not see a doctor? Why did a doctor not explain?

G Q What you have told us is that you did see Code A one morning?
A As I explained, Code A walked into the ward mid-morning. I was there with Code A Code A never said, "Good morning. I am Code A ' We did not know who she was. She ignored me and Code A completely. She walked round the other side of Code A 's bed, looked over at the bed, said, "Won't be long now," turned round and walked back out. And Code A said, "Whoever is that?" I said, "I've got a feeling that could be Code A I think I saw her a few years ago at Forton Road Surgery.
H

A Q You say it was mid-morning. Are you sure about that?
A And I never saw anybody the whole afternoon, apart from ---

Q You say it was mid-morning. Are you sure about that?
A It was probably... Code A had come down so it could have been about 11; 10.30, 11 o'clock time.

B Q It would have been early in the morning? Half seven, eight o'clock?
A No.

Q No?
A No.

Q Did you ever write a letter saying that it was early on the morning of 21 August and
C talked about a conversation with Code A ?
A I never had a conversation with Code A

Q Did you write a letter at one stage saying "early on the morning of 21 August a lady came to Code A s bedside"? Someone you recognised as Code A ?
A I never said "early morning". I do not remember saying "early morning". It was in the morning.

D Q I wonder if I can just hand you a page, Code A

Code A I think it is fairer to give the witness the first page as well, just so she knows what the document she is looking at is. (Two sheets handed to the witness)

Code A I think that is a letter that you wrote a long time ago? (The witness started to
E read) I am not inviting you to read it all, Code A just to identify whether that is the letter.
A This bit is ---

Q I put a highlighter pen over one small section of the letter.
A Oh yes.

F Q In 2002 ---
A "... early on the morning..." Yes.

Q --- was your memory that it was early in the morning?
A I know it was not after ---

Q --- which you still talk about.
G A It was not after 11 o'clock. I know that. I know it was in the morning because Code A Code A had come down, I think after taking one of Code A So it may be ---

Q That is nearly at the end of the morning, is it not?
A --- early.

H

A Q What I am suggesting is that you would have seen Code A when she attended the ward before she went off to work as general practitioner? She would have been at the ward before eight o'clock, or about then? So, early in the morning?
A It was not that early in the morning, no.

Q Can you agree with me that what you wrote in your letter in 2002 was that it was early on the morning of 21 August? If you look at the letter, Code A that should help you?
B A Yes. Yes, I am looking at it. It says here also "early on the morning".

Q Yes. Of 21 August?
A Yes.

Q Can I take that back, please?
A Yes, you may. (Sheets returned to counsel)
C

Q I think that night, the night of 20th -21st, you had been trying to sleep in a chair next to Code A 's bed?
A I stayed all night, yes.

Q And that must have been distressing for you, as well as very uncomfortable?
A It was very stressing, yes. Luckily enough, the lady in the next bed, Code A was
D in the same position as me, and we got talking. We had a cup of tea and we had a biscuit and we got some sleep. I stayed in the morning. They asked me to... They were very, very nice, the two night staff that were on. They asked if I could just sit back out of the ward a little bit while they made Code A comfortable. That was the only time I left her and then I went back in and I stayed. Code A came down. They went and got me a bit of breakfast from the cafeteria, and I stayed right up until four o'clock that afternoon.

E Q Code A came into the room. Were there other people in the room ---?
A Yes.

Q --- apart from you and Code A ?
A Code A No – just Code A

Q And how long had they been there when Code A was there?
F A I suppose they had been down about 20 minutes, half an hour or so. We were just sitting round Code A 's bedside. They were holding Code A 's hand.

Q What you have told us is that Code A said, "Won't be long now"?
A Yes. And I shall never forget that as long as I live. There was no caring attitude, no "Who am I"? "I am Code A "

G Q I think the nursing staff all wore uniforms?
A Sorry?

Q The nursing staff all wore uniforms?
A Yes, yes. They were.

Q Did it not seem obvious this was a doctor?
H

A A I do not think she had a white coat on. Yes, probably. We did probably think, "Well, that could be a doctor." Somebody else is not just going to walk in and walk round the bed like that, and look across and say, "Won't be long now" and turn round and walk out. Why did she not introduce herself? Why did she not say, "I am sorry. Is there anything you want to discuss with me?" There was not anything, and I think that is the thing that hurts as well as the drugs that will stick in my mind till the day I die.

B Q Code A does not recall what you have talked about, but might it be that she was being discrete whilst you and Code A were distressed?
A Do you not introduce yourself? Do you not say, "I am sorry to disturb you. My name is Code A. Could I just have a look at Code A?" I do not think I have ever met anybody who would ever walk into somebody like that and just ignore you completely.

C Q Can I suggest if she was there, she was making it plain that she was there and if you had wanted to talk to her, it would have been clear that the opportunity was there for you?
A We could have spoken to her, yes, but she did not even give us any chance to. It is just in and out within a few seconds. As I say, Code A looked and said, "Who was that?"

Q But Code A had been in pain the day before?
A Yes, she had. Yes.

D Q And is it right that she was not very communicative with the nursing staff? People had difficulty in communicating with Code A?
A Yes, she was towards the end. She had difficulty in communicating. That is why, when I asked her if she was in any pain and she did manage to say "Yes," that I knew there was, and there was something wrong.?
A I understand.

E Code A Thank you very much, Code A That is all I ask you.

THE WITNESS: Thank you.

Re-examined by Code A

F Q I will be very short. All right?
A Thank you.

Q Your understanding, you told Code A was that Code A was being transferred to the Gosport War Memorial Hospital for rehabilitation?
A Yes.

G Q And you were asked about whether you were present at an assessment by Code A?
A Yes.

Q On 4 August?
A Yes.

Q Just before transfer?
H A Yes.

Q Can you remember speaking to Code A?
A I think I spoke to Code A once when we were up in QA.

Q Code A's note of 4 August, so just before Code A was transferred – and for members of the Panel this is 99A again – is this:

"Transfer to Daedalus NHS
Continuing care on 6/9/98."

So two days later.
A Yes.

Q
"AM → for"

and then there is a doctor's note which means four to six week's observation –

"... and then decide on placement".

A That is right. That is what we understood.

Q Right. That was your understanding of what was going to happen to Code A?
A That was my understanding, yes.

Q My last question is, you were asked whether Code A was deteriorating, and the last two days you told us that on the evening of 20 August, when you went back, you found – this is after Code A had been there – Code A was unconscious.
A She was unconscious, yes.

Q And she never woke up ---?
A No.

Q --- between that time ---?
A No.

Q --- and when she died the following day?
A The following evening.

Q Were you able to tell whether she was deteriorating during that period?
A She just looked so poorly, so tired and so sleepy. (The witness broke down)

Code A: I am sorry. I did not mean to distress you. I will stop. That is all that I ask. If you want a break, I am sure you will be given one.

Code A Absolutely. We have come to the end of the questions from barristers. There may be questions from members of the Panel. If you would like to take a little break now before that, we can certainly arrange that.

THE WITNESS: Thank you.

A

Code A Would you like to do that?

THE WITNESS: Yes.

Code A Let us say then, ladies and gentlemen, 20 minutes. Everybody can go and refresh themselves at this time. We shall be back here in 20 minutes and there will be
B some questions from the Panel, and that will be it.

THE WITNESS: Okay. Thank you.

Code A I should of course say to you, please do not discuss anything about the case.

C THE WITNESS: Thank you.

(The Panel adjourned for a short time)

Code A: Welcome back, everyone. You are happy to continue now, are you, Code A Code A

D THE WITNESS: Yes, thank you. Sorry about that.

Code A: Not at all. It is just a few questions from some of the members of the Panel. I am going to turn first of all to Code A, who is a lay member of the Panel.

Questioned by THE PANEL

E Code A I just have two points for clarification, really. When Code A was moved to the War Memorial Hospital, you said that you did not actually speak to any doctors in particular?
A No.

Q Who did you understand to be in charge of Code A s care?
A I thought it was Code A. I do not know whether he was a Code A or just a
F Code A but he seemed to be the only one, and a Code A – I think Code A Never really saw many other people really to speak to, or around Code A

Q I think we touched on it earlier on, so if you had any problems would you have addressed them to Code A or the other Code A person that you mentioned?
A To Code A

G Q It would have been Code A? Okay. In relation to time when you said that Code A Code A was experiencing pain, could you just elaborate as to how you established that she was in pain? Given that she suffered from dementia, I am just wondering how clear that was?
A She was lying in bed and she was not moving. She was just still. Every now and again I could just see, like her cheek or her lips sort of... Little clinchings. And I sat for quite a while watching, on and off; it was not all the time and I just thought, "I don't know. I think Code A has got pain of some sort," and that is when I said to her, "Have you got a
H

pain," and I said, she did answer me and she did say very quietly, "Yes". And I said, "I will go and see if I can find someone."

Q Then at that point, did you actually speak to one of the nurses or staff?
A I asked one of the nurses. They were at the nurses's station. I think it was on their afternoon hand-over, and she said, "Someone will come along and see you in a minute." But I had to go back again after about 10 minutes, 15 minutes, and then I waited quite a while again and Code A came in.

Q And when you spoke to the nurses, what did you actually say? Did you say, "Code A Code A s in pain"?
A I said, "Could somebody please come and have a look at Code A I think she has some sort of pain. She looks as though she is uncomfortable."

Q All right.
A "And she looks as though she could have a pain."

Q And what was the response then? That someone would come along?
A They would come along and see her in a minute.

Q And how long did this period go on for?
A I think I waited a good 15 minutes or so.

Q And how was it left in the end?
A Code A then came in. He looked at Code A and he just said, "We'll give her something." He said, "When you come back later on, she might be a bit sleepy, but she'll know you are there."

Q Am I right that he then spoke to Code A and Code A were ---
A I went across to work and I phoned her up, and I said, Code A, can you please get down to the hospital, see what they are doing with Code A She seems uncomfortable. I think she has a pain. Nobody else seems to think she has," and I was just told that they will give her something and she would be quite sleepy, but she would know I was there when I went back in the evening. And when Code A went in, I think about three o'clock-ish, she said that they were with Code A then, and she said, "I got told that Code A seems to think Code A is in some sort of pain."

Q And Code A actually told you that? Is that really ---?
A Yes.

Q They communicated that to you?
A Yes.

Code A Okay, I think that is all. Thank you.

Code A Thank you. Code A is a medical member of the Panel.

Code A Hello, Code A Can you hear me all right?
A Yes, thank you.

A Q I just want to clarify one or two things as well. I think you said that at the time that your mother had this illness you had been a care assistant, a manager care assistant ---
A No, I was not a manager. I had Code A come to stay with me for a couple of weeks when Code A went into hospital. Code A died in hospital and Code A stayed with me and I looked after her and nursed her for five years. As I said earlier, it got to the stage that I could not make my house safe for her with some of the things that she was doing.

B Q But you described yourself as a senior care assistant?
A I was a senior care assistant.

Q For about a year before this happened?
A For a year. As Code A went into Code A I started work as a senior care assistant.

C Q So that would make you aware of some of the technicalities of the care of old people?
A At the time I would say I had only been there a year when all this happened. We had not really in the nursing home had a lot to do with syringe drivers then.

Q That is fine.
A I might have probably then been able to pick up a little bit more and know more then. It is as the years have gone on and I have been doing the job, yes.

D Q So first can you clarify this for me about Code A ? I think it has been described as a rest home but I am not sure what that means. Was it a residential home or a nursing home?
A No, it was more of a residential home and it was just for dementia and Alzheimer's patients, yes.

E Q Then I think you described that Code A did deteriorate before she got this devastating illness, the urinary tract infection, that she deteriorated?
A When she was at home I think I went through a phase where she was quite naughty actually and whatever I tried to explain to her, then I was a silly so-and-so, and she would not do it. So I had to try and make things safe in the house for her. Then, after a little while, when she was in Code A she seemed to go through another phase where she was quiet and quite peaceful and she was happy just to sit in their lovely lounge that they had and she
F chatted and mumble-jumbled with other ladies in there.

Q So what I am trying to feel comfortable with is a picture of Code A just before she became very, very ill and had to go into the QA. Physically, how was she before she got that infection?
A She was quite well. She was really quite well in herself. I had taken her out, the weather was nice. We had had a wander around the gardens, not for very long because she
G was quite happy in the lounge and she knew her surroundings but, yes, I took her out for a little walk and she would sit there and she was happy and she was well looking.

Q Pretty much up until that infection?
A Yes, and then I got a phone call to say that Code A had had a UTI and she was not responding to treatment that we think she is better to go up to QA, yes.

H Q But where I was slightly confused was I think at one point you were asked and you

A answered a question that she was dependent and I gathered that she needed help washing herself.

A She needed all help, needed all care. She needed help with dressing and washing, yes.

Q And going to the toilet?

A Yes.

B Q But she was walking around?

A She would walk around, yes, and sit at the table in the dining room with all the others and she would eat her tea and have a cup of tea.

Q But she was happy in her own little world, kind of thing?

A She was happy in her own little world, yes, and if anybody did not know that she had got dementia you would not think there was anything wrong with her really because she did, C she looked so well, and she was kept nice and smart.

Q So right up until her urinary infection she was smashing?

A She was smashing, yes.

Q Then she went into the QA very ill but she perked up again after the treatment?

A She perked up, yes.

D

Q She perked up and was eating and drinking?

A She was eating and drinking. That is why they released her from the QA to go to the War Memorial.

Q And walking with some help with a Zimmer frame?

A I am not sure on that point because she was in bed or sitting in the armchair when we E went to visit, but I would not honestly like to say on that.

Q But eating and drinking and talking?

A Yes.

Q And happy?

A I think she was a little bit more confused because she could not understand probably F why she was up there, yes.

Q OK.

A But I still thought, with a bit of care and rehabilitation, she would be fine again.

Q That is why she went to the War Memorial Hospital?

A Yes.

G

Q In your mind, for a little bit more help?

A For a little bit more help, a little bit of rehabilitation, yes, and probably replacement.

Q And she would probably go to a place where she needed more physical help?

A More care, yes.

H Q But you described that pretty much as soon as she got to the Memorial Hospital, and

please tell me if this is wrong, that she deteriorated again?
A She did quite rapidly actually, yes. I mean, from going in when they brought her down in the afternoon, and she was sitting in the lounge having a cup of tea and she had a biscuit and I chatted to her, and she said, yes, she was OK.

Q That is at the Memorial?
A That was at the Memorial, yes. Then gradually as the days went on I noticed that she was being hoisted, she could not walk anymore, she was sleepy, very drowsy.

Q Code A has written in his notes, apart from anything else, that she would need subcutaneous fluids. Do you know what that means, subcutaneous fluids?
A No. For a UTI you would usually try and encourage people to drink as much as they can.

Q So do you remember in the first day or two after she had gone to the Memorial Hospital whether she had a drip up of any kind?
A No, she did not.

Q OK. You have suggested that Code A 's deterioration was due to neglect.
A Not a very nice word, yes. Yes. I mean, when you put Code A into hospital or anybody, you put them in there and you think they are going to get good care and they are going to get looked after. When you say neglect, you do not want to think that other nurses and that have neglected her. Some of them ---

Code A I just want to be careful about this. That is not a word this witness has used so far.

Code A It is not. I am sorry. If it is my word, is it too strong a word?
A No, no, no. I mean, I thought that she was in there, she would get really well looked after, and she would have a little bit more quality to her life.

Q So, put it this way, did you think that her care was not as good as it should be?
A It was not as good as what it should have been, no.

Q Would that be a professional opinion as well, given your experience?
A No, because, as I say, I had only been in a nursing home for a year then but, no, I think anybody could see that if somebody is poorly like that and they have had a UTI, you would encourage them to try and drink and to give them something that they would be able to swallow or a build-up drink, anything like that. When I went in one night, as I said before, there was this cheese sandwich that I do not think I could have even eaten with this huge great big thick wedge of dry cheese in it and all I could see were some little teeth marks around it. That was not building Code A up. Yoghurts or – when we could find her care plans, because half the time they were not at her bed, they were found around the passageway and outside somebody else's door, I think in one instance it said something was written up in error for another patient, but we could not see for days had she been given a drink, had she been given something?

Q In those first few days were you there a lot?
A I tried to, to work in with my shifts so, yes, I popped in, in the morning, I popped in, in the afternoon, or when I finished at eight o'clock in the evening, and Code A were really

A good as well.

Q Were you there for as long as hours in a day?
A What, sorry?

Q If you put it all together, were you there for some hours every day or ---
A No, because ---

B

Q --- or an hour maybe?
A Yes, about an hour. I think on the actual day that I did complain that I thought she was in some pain, I think I got there about probably midday and had a couple of hours there and I hung on as long as I could waiting for someone to come and see me with my concerns.

Q Have you any evidence in what you saw as to whether Code A was not being fed
C and was not being watered?
A Not while I was there, no.

Q You never saw it happen?
A No.

Q And you did not see a drip in the first few days?
D A No.

Q Thank you very much. That is very helpful.
A Can I just say, sorry, her urine bag was just full of blood. It was thick and it was full of blood.

Code A Thank you very much.

E

Code A Thank you, doctor. You are nearly there. It is just me left now from the Panel. Both of the barristers read to you a note concerning a meeting that you had had with Code A
A Yes.

Q I am just going to read it to you again and then ask you a question about it.
F A Yes.

Q '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."

Now, when you were asked questions about this, I understood you to agree that there was a discussion concerning the fact that Code A 's general condition had deteriorated and you
G also specifically told us that in fact there was no discussion concerning the use of a syringe driver.
A That is right.

Q What I did not hear you say anything about, and I am just checking to see what your recollection is, is the middle bit. Was there any agreement or discussion about active treatment being not appropriate?
H A None whatsoever, none at all. A syringe driver, any form of drugs, medication, there

was not anything mentioned whatsoever.

Q So did you at any time, in consultation with any of the various medical persons involved, give your view that so far as the family were concerned the position now was that it would not be appropriate for there to be any active treatment?

A If I had known that Code A was in a lot of pain and, yes, she probably was on her last few hours and if somebody had sat and explained to me and the family maybe that we feel that your mum might benefit from having a syringe driver fitted up, and everything explained, maybe things might be different. When nobody had even said shall we try a Paracetamol or Oramorph or anything to try and find or find out where the pain was coming from – I mean, Code A might have just had a headache for all we know or maybe a little tummy ache. Nobody knew. Nobody had any idea that Code A was in any discomfort, distress, or anything and then the first time the syringe driver was mentioned was when I was in that night and she was absolutely unconscious.

Code A Thank you very much indeed, Code A There is just a tiny hurdle or two still to go. I need to ask, first of all, Code A whether he has any questions arising out of the questions that were asked by members of the Panel.

Code A I do not, thank you.

Code A He does not. I ask the same question of Code A and he also has no further questions. So that is the end of it. Thank you very much indeed for coming to assist us today. It has really helped us a great deal.

THE WITNESS: Thank you for listening.

Code A We are very pleased to be able to hear you and I am pleased to be able to tell you that you are now free to go.

(The witness withdrew)

Code A That is the evidence that we call in relation to Code A in this part, as it were, of the proceedings hearing from patient relatives. We are about to move on to the case of Code A and we will be calling Code A, one of Code A I take it you might want a little time to look through the transcript of the opening. Could I also give you or ask to be given to you patient bundle E? (Bundle handed) I do not know if you think it would be beneficial for you to have a little extra time so that you can look through the chronology in relation to this patient and to have a look through the notes as well. It is a slightly more substantial case in terms of the amount of evidence than the previous witness.

Code A You are on top of the material. Do you think 20 minutes is going to be sufficient or would we need more?

Code A I would give yourselves 30 minutes, if I may say so.

Code A Thank you. Then, in answer to your previous question about the bundles, the Panel is taking into evidence bundle E and it will be marked as exhibit C6.

Code A Thank you.

Code A We will now break for 30 minutes to enable the Panel to have time to read and prepare for the first witness in respect of patient E so 12.30 pm, please, ladies and gentlemen.

(Luncheon adjournment)

Code A Welcome back, everyone. Code A first of all, we have received, I assume from your good self or those assisting you, three replacement pages for bundle E, that is to say, replacements for pages 63, 65 and 67, all of which make the reading very much easier. So we have incorporated those into the bundle and we are very grateful to you.

Code A Sir, can I give you some more?

Code A Yes, by all means.

Code A I expect you will have noticed that there are still some pages that are difficult to read and we cannot cure all but we can help with some. Pages 30 and 31, can I pass up replacements? (Documents handed) Perhaps it has already been done. It has not been done in mine.

Code A For page 30, one has to look at page 193.

Code A Yes, I am grateful. Page 31 is, I think, fresh. Then also I think you will find your current page 47 is not particularly easy to read and, if that is right, I can give you a replacement.

Code A Not particularly easy to read would be an understatement.

Code A The reason is that those, I suspect, originally were taken off microfiche. We have now got the originals and so we are able to provide you with the proper copies.

Code A That is very helpful, thank you.

Code A Apologies again.

Code A We have been given replacements for pages 65 and 67, both of which are now very clear.

Code A We are now there. What we are going to do, just before the witness comes in, I am going to ask my instructing solicitor to switch over the E bundle that is there and also, if we may, remove all of the other bundles just to make life simpler for the witness.

Code A for the record, the Panel have used the time before the luncheon break which we extended so that, in addition to re-reading your opening in relation to patient E, we were also able to work our way through the chronology which you had provided and the references.

Code A I am grateful, sir. I think we are now ready for the next witness. This is the only witness this afternoon but I think she will take a little while. Code A please?

Code A Sworn

(Following introductions by the Code A

Examined by Code A

Q Is it Code A ?
A It is indeed.

Q Code A name is Code A and you went through a period when you were known as Code A ?
A Yes, I was Code A yes.

Q You are here to tell us about the treatment Code A received at Gosport War Memorial Hospital?
A That is right.

Q I would like to ask a little about your background. You are retired, but you were a Registered General Nurse. Is that right?
A Indeed, yes. I retired after 42 years and I worked, after I retired from full-time work, in a consultancy basis for two years giving advice on elderly care and I am a volunteer at our local hospice as well.

Q You said you were 42 years as a nurse?
A That is right.

Q At what seniority? I know there are a number of levels in nursing.
A Indeed, yes. I qualified in 1959 and worked my way up the ladder from staff nurse, to sister, to being matron in charge and then an operations director for a big PLC company that had nursing homes.

Q Whereabouts in the country did you do most of your nursing?
A Most of my nursing, probably, I did seven years in Richmond upon Thames, I did four years down in Cornwall – I did not know you wanted a history – but anyway mostly over the country, about four/five main jobs after I qualified and also, of course, originally with the National Health Service for some years.

Q Did you work at any stage in the Portsmouth area?
A No.

Q You have never worked at the Gosport War Memorial Hospital?
A No.

Q Let me turn to ask you about Code A I think she was born on Code A and she was sadly Code A at the relatively young age of 67?
A That is correct.

Q From 1984 she lived with you. How many Code A did she have?
A She had Code A I am the Code A

Q I think Code A.
A Yes, Code A

Q ... is in the room at the moment?
A I believe she is.

Q Were you close to Code A?
A Absolutely.

Q She lived with you from 1984 until when?
A Probably something like five or six years, I should think.

Q Then what happened?
A I was working full-time, Code A was living with me in my home and she began to get forgetful. I would have phone calls from neighbours saying that she had gone up the road and left the front door open, or left her key behind, or she had been in to see them and said, "Code A had gone away on holiday and she had not seen her for some time".

Q Which was not right?
A Not at all, no. It became evident that she needed full time care, that if I was working full-time I could not give her as much supervision. It was not so much nursing care, it was really supervision.

Q Did you come, at the time, to a pretty convenient arrangement?
A A very convenient arrangement, yes.

Q Tell us about that?
A I approached my employers in a 50-bedded nursing home in Basingstoke and asked them if I could have Code A admitted there.

Q They were happy with that?
A Absolutely. She did not require nursing care, she just required 24-hour supervision to make sure that she was safe and I was there, obviously, working five days out of seven.

Q From what was she suffering, would you class it as dementia simply?
A She was becoming forgetful about things that happened recently. She could recall things from the war time beautifully, but she was not suffering from anything. She did not have any heart problems or blood pressure problems, she was not taking any medication at that time.

Q Would she forget where she was?
A Not at that stage, that was later on.

Q In other things, how sharp was her mind?
A Very well. She played scrabble avidly, she had a daily newspaper, she took an interest in her family, she read books, she crocheted every day and made the most beautiful things from patterns.

A Q I think in 1997, you were yourself thinking about retiring from the nursing profession?
A Yes, that is right.

Q You, yourself, I think have a number of Code A ?
A I do indeed, I have Code A

B Q Did you decide that you were going to move? Having given up the job that you were then in, did you decide to move down to the seaside?
A I did because Code A were living there at the time.

Q Tell us where you moved to?
A I moved to Code A .

C Q Was that the first time you had lived in the Gosport area?
A Absolutely.

Q Otherwise you would not have moved there?
A No. Code A lived there, I was retiring, Code A was in a nursing home, it made sense to move Code A

D Q Tell us what happened about Code A and where she moved to?
A She moved to a nursing home in Lee-on-the-Solent that was known to my Code A Code A who is also in the nursing profession. She had checked it out and knew the staff working there. They had a vacancy come up in a few weeks time and, therefore, she moved and I moved down a bit later on.

E Q Was that in 1997; if you are not absolutely sure, I think it was probably around that time?
A I retired in 1997, so it was at the beginning, 1997, she moved down there, yes.

Q I know there came a point when you were less than happy about the treatment she was receiving at the Glen Heathers?
A Really to do with her accident, yes.

F Q I am not going to go into the whole background of it, you understand. This hearing is not about that, but I do want to hear about the accident and how you heard about it?
A Code A had a fall at lunch time on 29 July 1998. I visited during the afternoon and was aware that Code A was extremely anxious and uncomfortable and distressed. I asked the members of staff on duty had anything happened to Code A and I was told "No". Unfortunately, later on in the afternoon I had to leave because I had an appointment, and while I was away messages were left on my answerphone to say Code A was very
G poorly. The night nurse rang me at about 9 o'clock at night to say, "I have just come on duty, Code A did have a fall during the day at lunch time and I have come on duty and I can see that I think she has fractured her femur and we are sending her to Haslar", and I immediately said, "I will follow in my car", which I did.

Q I think you went to the hospital. I am going to turn up a few documents. There is a file that you will see on your left which is marked file E. I would invite you to follow what I
H am saying to the Panel. You will find some documents which you probably recognise in that.

A The first document for the Panel is page 168. This is just to give us some timing and an accurate date for this event.
A 168?

Q There are lots of numbers at the bottom of the page, but if you look for the number each side of it in manuscript. The easiest way to find it is the typed "169". It is an Accident & Emergency Department form. This is, as we can see, an Accident & Emergency
B Department form. It shows that the date of arrival is 29 July, the time of arrival is ten past nine in the evening, brought in by ambulance, and we can see that there is a triage note to show that Code A had had a fall in the nursing home. On examination:

> "Difficult to assess due to known dementia, appears to be in discomfort from right hip."

C There is then a little mark "shortening or rotation". The little mark, I was about to say, normally means "no sign of", I think?
A No, there is shortening and rotation.

Q You, I think, reviewed these notes at some stage?
A Yes.

D Q You came to the view that, in fact, what had happened – I think I can lead you on this – is that something had happened at the nursing home. She had actually been walked on her fractured femur?
A She had, yes. I had been told at the nursing home that she had been walked.

Q Nothing to do with the Gosport War Memorial Hospital?
A Nothing whatever.
E

Q That was something that happened at the nursing home. She was taken into the Haslar and I think that night she was very poorly?
A Very poorly.

Q And no doubt in some pain?
A She was in pain, yes.
F

Q I think she was given morphine while she was at the Haslar. Do you recall that, did you know that?
A I believe she was given it on the night of admission to make her comfortable for the night for a decision to be made the next day.

Q We also know that she was given something called haloperidol?
G A Yes.

Q We have a note at page 172. There is a note that I want to ask you about in case it arises later in the hearing. Do you see page 172?
A I have.

Q Do you see about two-thirds of the way down that:
H

A "Lives in nursing home
Has started falling over last six months – not investigated
Supportive Code A lives nearby."

That would be you?
A Yes.

B Q "Quality of life..."

Then it is two arrows pointing downwards which means deteriorated or gone down?
A Not as good.

Q Not as good markedly. What was your impression of Code A s life at that stage?
C A It had certainly changed since her admission. She had been put on various medications which I was not happy about.

Q When you say her admission, to where?
A To the nursing home.

Q To the nursing home, not this admission?
D A No. This is giving a history of her at the nursing home. In fact I had an appointment with her GP to discuss her medication because frequently I would find her asleep and not as active as she had been. The GP explained to me that the nursing home had made a request, because she sometimes got lost or wandered or sometimes called out, and it was the nursing home staff that had asked for her to be given something to make her more manageable.

Q That is not something you approved of?
E A No.

Q She was in fact operated upon the next day?
A The next morning, yes.

Q On the 30th?
A Yes.
F

Q Tell us about her recovery after the operation?
A Her recovery was quite remarkable. I had a conversation with the surgeon that I was worried that she may not actually come through the operation and his answer to me was ---

Code A I do not want to any hearsay.

G Code A I do not think this is hearsay. In fact this is a conversation about what was thought might or might not happen, it is not factual. Is there a real objection to this?

Code A Yes.

Code A (To the witness) This is nothing to do with you at all, it is a matter of legal procedure.
H

A Code A This is a lawyer's things. You did not think Code A was going to come through. Tell us how she recovered afterwards?
A She recovered extremely well. Within two or three days, I think the notes will show, she was able to be stood up with a zimmer frame and walk a few steps. She was lucid, she was off all her medication, she was able to hold good conversations with us, she was having three meals a day, she was completely hydrated and getting better every day. Her wound site was absolutely perfect.

B Q We will have a look at her food intake in a while. We have a drug chart, and I am just going to ask you to help us. If you turn to pages 238 and 239, we can see the entry for haloperidol. You probably know how to read these rather better than I do. Are you used to looking at this sort of document?
A Yes.

C Q On the page before, we can see "Once only and Pre-medication drugs"?
A Yes.

Q Were you given to understand that Code A was given some Oramorph during the course of her stay at the Haslar?
A No.

D Q If you turn up page 245, I want to know if this is a document you have ever seen before and, if it is not, I will move on. It is an evaluation form. Have you seen that before?
A I am sure I have because I was shown most of these some time after Code A 's death.

Q In light of your last answer, if you look at this, on 30 July, the day of the operation, we can see intravenous morphine was given in Accident & Emergency.
E A That is right.

Q After that do you see a further 2.5 mgs given, I think that is Oramorph, but it is difficult to read, "Unable to tolerate". Do you have any recollection of knowing about that at the time?
A At the time I was told that she needed some analgesia directly following the operation and after that she did not need anything for pain because she was pain free.

F Q You told us something about her recovery and her food intake. I want to turn to the week after the operation just to have a brief look at that. Would you turn to page 260 of these records. We are now looking at a food record chart. It is a week after Code A 's operation.
A Yes.

G Q Let us look at the food that she was at least being given and we can see how much of it she could actually eat. She started off with breakfast, with some tea and is that Weetabix?
A Weetabix.

Q Two spoonsful. It does not actually indicate to the right whether she had that or not. Then fruit juice. Then for lunch she had a stew, of which she had the gravy only, some potato, cauliflower, peach mousse and some juice. Then in the evening we can see that she had a fairly full dinner.
H A That is my handwriting.

A

Q This is your handwriting?
A I visited in the afternoon, in time to give her a drink and to give her supper on most days, and the afternoon and evening meal, that is my handwriting.

Q So you were making notes of ---?
A The nurses asked me to write down whatever I gave her to eat while I was there.

B

Q Right. Over the page ---
A Is that all right, to say that?

Q Yes. Of course it is. I did not realise that your handwriting appeared on these records. Can we go over the page to page 261. Does any of your handwriting appear there?
A My handwriting is at the evening meal, and some fruit juice at supper time

C

Q I will not go through all of Code A 's meals.
A No, no.

Q I just wanted to get an impression of these, of what she was able to eat. At page 264, we can see really that she was eating ---
A Page 264: my handwriting is at the evening meal and supper.

D

Q By this time she was having three meals a day?
A Yes.

Q I think she was eating more than I do.
A And drinking. Very well. She was very well.

E

Q Then can we just go to the 11 August, which is page 265?
A Yes.

Q This is, in fact, as we are going to hear, I think, the day that she transferred?
A That is right.

Q We can see that for her breakfast she had a bowl of porridge and some orange juice?
F A Yes.

Q So we come to the 11 August. Would you tell us, please, how this came about, that she was transferring to a different hospital?
A The Code A at the Haslar Hospital told me that Code A had now been in for eleven days.

G

Code A Is this being objected to?

Code A knows the rules, and they should be adhered to.

Code A I am going to make an observation here which is that, traditionally, within these walls, we are fairly relaxed about matters of hearsay unless there is an objection taken, in which case I am sure counsel will be much more careful.

H

Code A I am sorry if it sounds pompous as a response, but I have been coming here for 20 years and I have not known that there is a relaxed attitude taken to the rule about hearsay.

Code A A difference of experience, then. The fact remains that when it is a matter that the defence objects to or, indeed, either party objects to, then it is customary for counsel to be more careful. It is not a matter of just counsel knowing the rules in my view.

Code A Sir, I am grateful. Code A knows that I do not want hearsay. If he wants to call the doctors that are being referred to, he can do so.

Code A, please just proceed with caution.

Code A I will proceed with caution. (To the witness) Tell us about the transfer. First of all, did you appreciate that Code A could not remain at the Haslar for ---?

A Of course.

Q --- for ever, as it were?

A Of course.

Q Were you able to have any discussion with Code A about where she was going to?

A Only in as much as I said that she would be going to a different hospital.

Q She did in fact go to the Gosport War Memorial Hospital?

A She did.

Q Did you know of that hospital before she got there? Had you ever ---?

A Oh yes, it is the local hospital to where I was living, yes.

Q Did you in fact go and have a look at the Gosport War Memorial Hospital before she was transferred?

A I did. I went the day before and introduced myself on the ward and asked to see where she would be likely to be staying.

Q Tell us – did you see the ward or did you see the room that she was going to be in?

A I was told she was going to go into a four bedded room when I was shown a four bedded room, and I had an opportunity to discuss Code A with whoever was on charge on that day.

Q Do you remember who it was now? I know ---?

A It would be in my notes, but....

Q All right. It may not matter.

A No.

Q Code A was, in fact, transferred on 11 August?

A Yes.

Q How soon after her transfer did you go and see her?

A I went to see here on that day. I actually was there when she arrived in a sitting ambulance.

Q Just before we go to that, I want you to have a look at another note, please. Page 24. We cannot hear what your conversation was with the surgeons at the Haslar but we can read what they thought.
A Yes.

B

Q This is effectively a referral letter, as I understand it. Can we go to the second page. This is dated 5 August 1998.
A Yes.

Q And it refers to seeing Code A on 3 August, so that is when she is still at the Haslar?
C A Yes.

Q It says at the top of page 26:

"When I saw Code A she was clearly confused and unable to give any coherent history. However she was pleasant and cooperative. She was able to move her left leg quite freely and although not ale to actively lift her extended right leg from the
D bed, she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despit4e her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport War Memorial Hospital. I understand that Code A intend to give up the place in Glenheathers Nursing Home as they have been unhappy with the care, but would be happy to arrange care in another nursing home."

E A Yes.

Q Did that accord with your understanding of what was happening with Code A ?
A Yes.

Q Could we then turn to page 30 of these records, you will see Code A s first note. Again, I just want to ask you about your impression of Code A nd whether this
F coincides with that. All right? First of all, did you see Code A on the 11th?
A I did indeed.

Q The day of her transfer. What time did you go and see her?
A I was there when she arrived in the ambulance which I think was about mid-day.

Q And the sort of ambulance that she was transferred in, I think did you say was a sitting
G ambulance?
A A sitting ambulance, yes, and they transferred her into wheelchair and wheeled her to the ward.

Q How mobile was she by that stage? Was she mobilising as far as you can remember?
A She was mobilising and transferring with the help of two people, and using her zimmer.

H

A Q Right. How long had she been able to.... She needed help, obviously, getting out of bed?
A Yes.

Q But once she is out of bed and she sat up?
A Yes.

B Q How long had she been able to use a zimmer?
A Since about just over, probably, 48 hours after her operation. They got her out of bed and she was able to weight-bear. That is in the notes somewhere.

Q I am not going to the exact timing ---
A No.

C Q --- which perhaps does not matter too much.
A No.

Q But your recollection is she was mobilising relatively soon after the operation?
A That is right.

Q Do you remember whether you had met Code A on this day?
D A No, I did not.

Q So you were there when she got there. Did you see her into her room, or can you remember how it all worked?
A I did not see her into her room. The Code A said she had arrived and she was okay, and it was better that I left her for a little while to settle and to come the next day. And I went the next day.

E Q But you saw her arriving?
A Yes, yes.

Q And you saw her being transferred in a wheelchair?
A Yes.

F Q Did you have an opportunity of saying hello to her?
A Oh yes.

Q Or goodbye to her?
A Oh, yes, yes. I chatted with her and I unpacked her things and put them in the wardrobe and did the different things that you do. The next you saw her was the next day?
A Yes.

G Q This note records that she is transferred to Daedalus ward?
A Yes.

Q Is that continuing care?
A That is how I read it.

H Q Then there is the sign for a fracture of the right femur, I think it is?

A A Yes.

Q 30 July?
A Yes.

Q Past medical history: I am not going to go through all that because I cannot read it.
A That is a hysterectomy in 1955. It could be... It is 1955 or thereabouts.
B

Q Or 1953 or 1955, yes. Can we look at "On examination"?
A Yes.

Q "Impression: frail...". Is it "demented lady not obviously in pain. Please make comfortable." "Transfer," I think it is, "with hoist"?
A It says, "with hoist", but they were not hoisting her at the Haslar Hospital. They were
C allowing her to walk with a zimmer, with somebody each side of her.

Q "Usually continent"?
A Yes.

Q Did she have episodes of incontinence?
A Very, very occasionally, and only when she had the accident, she had an accident, but
D she would go to the toilet to pass water, etc. etc.

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

Q I think that is a Barthel score of 2. Do you know about the Barthel scoring system? I am not going to test you on it?
E A Oh, good! Yes. It is really they do it in a scale to see what they can do, really.

Q It is not something you had applied yourself to other patients?
A No in my recalled memory.

Q Okay. I am going to move on. Then this note:

F "I am happy for nursing staff to confirm death."

Can I just ask you: when Code A was transferred to Daedalus ward at the Gosport War Memorial Hospital did you think that her life was in danger at that stage?
A Absolutely in no way whatsoever. She was admitted to Gosport War Memorial, as I understood it, from the Haslar Hospital for two to four weeks rehabilitation, to get her more mobile, to enable her to be transferred to a nursing home. She was not a frail lady. She was a
G size 14-16 dress size.

Q All right. If you find it upsetting ----?
A No.

Q --- have a glass of water. It is sometimes better to continue.
A I am fine.
H

Q If you find you cannot continue, we will stop. All right?
A Yes.

Q Now tell us what happened the next day when you went to see Code A ?
A This would be on the 12th, when I went to see Code A She was unrousable. Totally out of it. I could not wake her, shake her, push her face. Absolutely out of it. And I asked a care assistant what had happened, and she told me that Code A had been ---

Q I am sorry. No. There is going to ---
A Sorry?

Q You are quite right. I am sorry Code A you are right. Do not tell us what the care assistant said to you.
A Okay.

Q I just want to know what state Code A was in. You could not rouse her.
A Unconscious.

Q You are a nurse?
A Yes.

Q Did you make attempts to rouse her?
A Of course. I thought perhaps she was sleeping when I first got there, but then, from her respiration et cetera, that showed me that she was unconscious.

Q Up to this point – up to her transfer – apart from the period when she was being operated on, had she to your knowledge been on morphine?
A No.

Q Tell us how things went on from there. Did you speak to somebody about what you found?
A I did. I was told that she ---

Code A : I will have to stop you, because we may have to have a legal argument about whether this is admissible. In normal circumstances, unless this is going to reveal something (a) that is contentious or (b) which is factually otherwise unprovable, I would be surprised if there is any objection to this sort of evidence. Most of this, if not all of it, will be included in the notes. I am sorry, I would like to pursue this with the witness. It goes very much to what was happening, and this witness's state of mind. If there is formal objection to it, then I will have to take time to dig out every note which reveals what I suspect we are going to hear in any event. Can I just ask my learned friends if this really is objected to still. I just do not want to waste time going through notes which are otherwise perhaps admissible.

Code A : If it is the patient had been calling out and showing signs of being anxious, I do not object to that going in.

Code A Right. On the 12th, you told us that your mum was unrousable. Did that position change?
A No. I asked why she was in that condition and I was told she had been given a little something because she had been making a noise and was over-anxious.

Q Right.
A They did not know at that stage that I was a nurse, but I asked what she had been given, and I was told, "You won't know what it is, but it is Oramorph."

Q Again, up till this stage had Code A appeared, at least to you, to be in any significant pain?
A No.

Q Presumably after the fracture occurred and after her operation there were periods of discomfort?
A Yes, and I think she only required something like paracetamol or co-dydramol while she was in Haslar on one or maybe two occasions in eleven days.

Q I think you stayed with Code A on the 12th?
A Yes.

Q What was happening so far as you were concerned about food and drink?
A She was not having any.

Q Up until the 11th, as we have seen from the notes, she had a fairly hearty appetite?
A That is right.

Q Do you know why she was not receiving any further food at this stage?
A You cannot feed or give drink to an unconscious patient.

Q Was she on a drip of any sort ---
A No.

Q --- that you saw? Was she being provided with fluids in any way?
A I waited until she was rousable, which was late in the evening, and I gave her a bottle similar to this (indicating small water of water), of a still fruit-flavoured drink and she drank the lot.

Q So in the evening she became conscious?
A She came round. Yes.

Q She came round?
A Yes.

Q And you were able to give her a bottle of juice?
A Yes.

Q And did you have to leave her then?
A It was ten-ish, I think, when I left. Yes.

Q The next day I think you did not going back to the Gosport War Memorial Hospital but your daughter did?
A I did go later in the day, but Code A went first.

A Q I am not going to ask you about what Code A told you.
A No.

Q But did there come a time when you found or realised that she had had some sort of further accident?
A That is right.

B Q And as a result of that, are you aware that she had to return to the Haslar?
A It took 24 hours for them to transfer her after her fall, where she had dislocated her new hip.

Q And how this occurred appears to be, from the notes, that she had fallen out of a chair?
A That is what I was told.

C Q The effect of that fall was that she dislocated the same hip that had been repaired?
A Yes.

Q And she was re-admitted to the Haslar as a result?
A Yes.

D Q Again, when she went back to the Haslar, and this I think was on 14 August ---
A That is right.

Q --- did you thereafter have any complaints about her care?
A None whatsoever. She was admitted into Haslar and was operated on within an hour which they were able to do because she had had no nourishment. She had had Oramorph on 11, 12, 13 and 14 August.

E Q Were they successful in --
A Absolutely, absolutely. I spoke to the Code A He showed me Code A 's limb, he showed me the X-rays, and the conversation was that she can go back to the War Memorial now and I said words to the effect of "Please, not yet".

Q You did not want her to go back to the War Memorial Hospital at that time?
F A No, and he said "We can keep her just for a couple of days" and I thanked him very much.

Q Did she then remain at the Haslar --
A She did.

Q -- until the 17th?
G A She did. She recovered consciousness the next day, they started her on a diet, she was able to take fluids. She only had, well, minor discomfort really. Within 24 hours they had her up standing and weight bearing on her leg again with another Zimmer and she was eating a good diet and drinking and she was having no medication so she was compos mentis and chatting to family and absolutely back to how she was when she was in there before.

Q If we go to page 197, please, we will see the Registrar's note of the ward round on
H 17 August.

A A Yes.

Q The Registrar writes, or rather I suspect this is the house officer who writes, following the Registrar's ward round:

"Fit for discharge today (Gosport War Mem). To remain in straight knee splint for 4/52."

B

Is it "fat pillow"?
A "For pillow between legs".

Q "For pillow between legs (abduction) at night."

What does that mean?
C A It is just that they are going to make sure that her leg is in the right position.

Q "No follow up unless complication".
A Yes.

Q Again, without telling us what you said to anybody else or what anybody else said to you, did you think that Code A was at that stage again on the road to recovery?
D A Absolutely.

Q On 17 August was she transferred back to the Gosport War Memorial Hospital?
A Yes, she was.

Q If we go back to page 31, which is Code A 's note again, do we see in the middle of the page, I think that is 17 August?
E A Yes, it is the 17th.

Q "Readmission to Daedalus from that RHH"?
A Royal Haslar Hospital.

Q Is that "Reduction under intravenous sedation"?
A That is right.
F

Q And there is an indication that she had remained unresponsive for a while after the operation, yes?
A That was explained to me at the hospital at the time that because she was elderly and she had had this intravenous, that it took her a little time to wake up.

Q Then I think it says "Now appears peaceful". Then there is a word I cannot read but
G I think it is "Continue haloperidol. Only give Oramorph if in" – and I am interpreting this, and I hope correctly – "severe pain. See Code A again". Tell us, please, your experience when you next went to visit Code A ?
A I inquired as to what time she would be expected back to Daedalus Ward and I was told it would be about midday. I arrived at the ward at 15 minutes past 12 and, as I pushed open the swing doors, I could hear a tremendous screaming and I recognised straightaway and said to Code A "That is Code A ". I entered the room where she was. She was
H laying in a terrible position for somebody who was supposed to be having a leg splint on for

A two weeks because there was no leg splint on, and she screamed in the most terrible way with pain. You can tell when somebody is in pain. I asked for a qualified nurse to come and I believe her name was Code A but it is written down, but do not ask me now.

Q I think you are right.
A She screamed and screamed and the last words that Code A ever uttered to me was "Don't just stand there. Do something. Pain, pain." I said to Code A "Stay here, I am
B going straight back to Haslar to find out what position she was in when she left the ward this morning".

Q Let me stop you now for a moment.
A Fine.

Q All right?
C A Yes.

Q Did you get help to rearrange Code A on the bed, first of all, before you left?
A I did. A qualified nurse came into the room and I said "Look at Code A s position. Will you help me change her?" We pulled the sheet back and her hip was in an awful position and we used nursing procedures with hands under her bottom and under her thighs and gently got her so that she was sitting square as she should have been, but she did not have
D the full leg splint that she should have had continuously.

Q I was going to ask you about that. The full leg splint ---
A Yes.

Q --- who should have put that in place?
A Well, she was supposed to be discharged with it from Haslar. I have no knowledge of
E whether it was on when she left and not on when they moved her because, unfortunately, they did not have the normal canvas to transfer her.

Q I am just going to ---
A I am sorry.

Q That is all right. I was just going to invite your attention to page 46 of this bundle
F because I think that is going to reveal to us what appears to have gone wrong. Do you see the entry towards the bottom of that page?
A Yes.

Q 17 August ---
A Yes.

G Q "Returned from R N Haslar. Patient very distressed. Appears to be in pain."

Then, to the left, we can see:

"No canvas under patient – patient transferred on sheet by crew."
A A sheet, yes.

H Q Now, you probably have an understanding of what that means.

A A Yes.

Q I am not going to ask you if it is upsetting ---
A No, I am all right.

Q Canvas would have supported her body, presumably?
A Absolutely, yes.

B Q If you transfer somebody in a sheet, just using my common sense, the hips are going to squish up, as it were?
A Yes.

Q Because the body is not being kept straight?
A That is right.

C Q So the hips will flex and something seems to have happened to Code A as a result of that?
A Something happened on the transfer into the bed.

Q That appears to have caused Code A certainly pain?
A She literally screamed the place down. People were in and out saying "What is this
D noise? What is going on?" et cetera.

Q You have told us you went back to the Haslar and you had a conversation there.
A I did.

Q When you went back to the Gosport War Memorial Hospital what was your intention? What did you want to happen to Code A ?
E A I wanted Code A transferred back to Haslar.

Q Right. Did you have a conversation with anybody about that?
A Yes.

Q With whom?
A Code A
F

Q Can you remember, was this on the following day ---
A No, no, this was on the 17th.

Q On the 17th?
A Yes.

G Q Tell us about that conversation with Code A
A I explained that I had returned to the Haslar because I was distressed about Code A Code A s condition and I was convinced that she had had a further injury so I went to Haslar. I went up onto the ward and I spoke to the Code A I said "What was Code A s condition like when she left here?"

Q Again, I am going to stop you. I think it is probably accepted the injury did not occur
H at the Haslar, it appears to have occurred on transfer?

A A No, but I wanted to know that it did not occur there.

Q Right. As far as you understood it, were the Haslar happy to have Code A back if necessary?
A As I came through the doors from speaking to the Code A I came through the swing doors, I came face to face with the Code A who had done the second replacement, the dislocation. He said "Hello, how are you? How is Code A ?"

B

Q All right. You would undoubtedly have revealed what was going on?
A I told him exactly what had happened or what I felt had happened and the fact that she was in such severe pain and anxiety that she was screaming continually.

Q All right. As far as you understood it, having spoken to people there, they were happy to have her back if necessary?

C A He said to me "What has happened?" and I told him and he said "I have had no referral. I have had no telephone call. Tell them to ring me. I will have her back straightaway."

Q Okay. You then go back to the Gosport War Memorial?
A Yes.

D Q Tell us what happens there?
A I told Code A exactly that conversation.

Q And his reaction?
A That he would speak to Code A and Code A came and spoke to me.

Q Tell us about that conversation?

E A Code A said to me that in her opinion it was not appropriate for a 92-year old lady to be transferred back for a further procedure and I said that they were willing to have her back and I wanted her to go.

Q How did that resolve itself?
A It did not. She was given Oramorph because she was screaming and I was happy for her to have something to stop the screaming because I heard and saw her, you know, and in

F fact she had – although it was boarded, as they say, four-hourly, and this is on the 17th, this is following admission back into the War Memorial, she had four doses in a period of seven hours, including two injections intramuscularly into her thigh which are not recorded anywhere. She was creating absolute mayhem with her screaming.

Q Just stop about that because that may be important. You say she received two injections directly into her thigh?

G A Yes.

Q Of what?
A I do not know what was in the syringe. I never saw any medical notes until after Code A Code A died, but it was being given to her for pain.

Q Who delivered that?

H A Code A and she had had four doses of Oramorph as well. She never regained

consciousness. I never saw my mother speak again.

Q If we go to page 63 of these notes, and I am sorry to jump about so much ---
A That is fine.

Q Medical records are not always easy to follow. It is page 63. It is one of the new pages that we have got.
A 62 or 63?

Q 63, I was going to start with.
A I have it, thank you.

Q We can see that under the as required prescription heading Oramorph 10 mg, and this prescription is dated 11 August and it is signed by Code A If we look to the right-hand side, we can see when these doses were given and we can see, I think, that going back to 11 August when she was first admitted ---
A Admitted well, yes.

Q -- she appears to have received Oramorph at 5 ml which would be, I think, 10 mg, at 11.15 in the morning and then another 10 mg half an hour later at 11.45, if we are reading these times correctly, which we may not be. Then, on 12 August, we can see Oramorph and 13 August, and then we have to go to the right-hand side of the page. You get to 17 August and you have just said that she received four doses of Oramorph. We can see the first one appears to have been at one o'clock.
A One o'clock.

Q 1.00 pm. Then I cannot, I am afraid, tell what the next timing is but the one after that is 16.45 and then one at 8.30 in the evening and then the following morning on 18 August. Then we can also see below that the drugs have been written up, diamorphine at 22.00 on 11August that does not seem to have been administered, hyoscine and midazolam also written up on 11 August, and the midazolam – it is very difficult to read but I believe that is 20 to 80 mg variable dose and we can see that that started to be delivered on 18 August.
A Yes. These drugs were given after she was unconscious.

Q Now, again, can I ask, do you have a – why do you say that?
A Because on the 17th, when she was screaming and shouting and she had the Oramorph and then she had two injections in her thigh, she went unconscious into a coma and she never recovered. She was never awake again.

Q If we go to page 65, we can see the diamorphine was written up on 18 August, so the day after Code A s re-admission?
A Yes.

Q And so this would have been given in the syringe driver at the same time, it would seem, as the midazolam?
A Yes, and the haloperidol as well.

Q And the haloperidol which we -- I will just pause for a moment to just check whether that is right. Yes, you are quite right, the last entry on page 65 is the haloperidol, 5 to 10 mg. That has also been written up, it would seem, on 18 August, and that has all been delivered

A together in a syringe driver.
A Yes.

Q Were you aware of the syringe driver being set up?
A Following the session on the 17th we returned to the ward on the 18th and I was seen by Code A who said that Code A had not had a very good night and that she now had a massive haematoma and it had been decided that she would not be returning to Haslar but
B she would be nursed with sedation to make nursing easy if they had to move her, change her, or if she became incontinent, and it would be administered through a syringe driver.

Q What was your reaction to the syringe driver?
A Yes, of course, I wanted Code A to be pain free but my experience and understanding of a syringe driver, if correctly administered with the right dose for the right patient, and I know this from my work at the hospice as well, is that a syringe driver can be
C done so that the patient remains conscious, able to be hydrated, can very often walk and go home for an afternoon, can read a paper, but the dose is such that it is keeping them pain free. It does not mean they have to be unconscious for the rest of their lives until they die.

Q Now, did Code A remain unconscious?
A Absolutely.

D Q And I think she died Code A days later on Code A ?
A She died on the Code A so she was unconscious from the 17th with no hydration whatsoever.

Q Now, I am afraid we have not been able to get hold of a death certificate. You have probably got one.
A Yes.
E
Q Perhaps we should have asked you to bring it with you. We are still waiting for one at the moment.
A I believe it is in the possession of Code A but I cannot be sure of that.

Q We might be able to organise afterwards bringing one from you. It is a strange position that we are in.
F A Yes.

Q Do you remember what was on the death certificate?
A Exactly, yes.

Q What was it?
A It was marked 1(a) which usually indicates there is going to be a (b) or a
G number 2 afterwards, because I have experience of death certificates, "1(a) bronchial pneumonia".

Q During the period that you had been with Code A did you see any sign of bronchial pneumonia?
A No.

H

A Q Again, I do not want to go into this because this does not relate to Code A directly, but I believe you had some discussion with the coroner's assistant about this. Did you have a discussion about what was going on the death certificate?
A When I went to register the death?

Q Yes.
A Yes, I did.

B Q There came a point when you effectively agreed what was going to go on the death certificate because you wanted Code A to be...
A No, the death certificate was given to me at the hospital in a sealed envelope. I had to take it to the registrar who opens it, turns it round and asks you to read it and say it is correct. I said it was not.

C Code A: I think that is probably all I want to ask, but I think now, in any event, might be a good time for a break. I would rather not close my examination in chief just so that I have a moment or two to check my notes.

Code A: The witness has been on the stand for one hour ten minutes. We will take a break for 15 minutes. You will be taken to a room where you can get some tea or coffee or other refreshment. When we return, it may be Code A will have more for you, but
D in any event we will go on to questions from the doctor's counsel.
A Thank you.

Code A We will break now, 15 minutes please.

(The Panel adjourned for a short time)

E Code A Welcome back. I remind you that you remain on oath. Code A?

Code A There are two very short matters I wanted to ask you about. One is in relation to a note I had been trying to find earlier and I had a wrong reference. It is a nursing record on 13 August. Could you turn to page 46. I had been trying to find the place where the notes revealed what had happened to Code A and at the time I did it – I see Code A nodding, I am grateful – I could not find it. I appreciate this is not your note, but the notes
F reveal that on 13 August 1998:

> "Found on floor at 13.30 hours.
> Checked for injury, none apparent at time, hoisted into safer chair."

Then there is:

G > "Pain rt hip internally rotated."

I think it says, is it, 17.30? Perhaps you cannot read it any better than I can?
A I have not actually seen that sheet before.

Q Was that your understanding, ultimately, of what you understood the nursing staff had---
H

A A When I asked questions during the afternoon, they said that Code A was shouting because she was demented.

Q This, I think, reveals that that was what the problem was?
A Yes, there was an injury.

Q This is something that has been puzzling me. As an experienced nurse can you help
B with the way this note is made. It is timed at 13.00 hours, "Found on floor at 13.30". How would this note come to be made in normal circumstances. That is just an anomaly, is it?
A It is not correct, because at 1.30 they were not admitting that she had had any accident whatsoever.

Q I want to ask you briefly about 18 August. Again, I hope not to cause you any distress, but do you remember on 18 August you told us Code A was effectively
C unconscious. Do you remember you were in the room when Code A came in on that day?
A Yes.

Q Can you tell us what happened then, what did Code A say, if anything?
A Code A just came into the entrance of the doorway, folded her arms and lent on the wall and said, "The next thing will be a chest infection".

D Q Did you respond to that?
A I did not say anything, but I did say to Code A "Well, she certainly has not got a chest infection now".

Q You did not say that to Code A ?
A I did not. I did not acknowledge the statement really.

E Q Did she say anything else to you?
A No.

Code A Thank you. Would you wait there.

Cross-examined by Code A

F Code A I think at that stage you and Code A were on the verge of complaining about things that were happening. Is that right?
A I was making notes at the time, yes. I stayed with Code A continually.

Q At that stage were you thinking of complaining?
A Well, I was not happy with her general care, no.

G Q Were you complaining about things that had happened at the nursing home as well?
A Not then, no.

Q Can I take you back to the start of the history. I think what we know is that Code A Code A 's health was deteriorating, from you told us, from about the time she went into the Glen Heathers Nursing Home?
A Her physical health was not deteriorating whatsoever. She was a strong lady. She was
H coming home to me at weekends and for tea. She was crocheting, walking and doing

A scrabble, but her memory was getting forgetful but, physically, she was a strong able-bodied lady.

Q I understand, but was there a period for many months when she was not talking, talking to you?
A I do not think I can answer that. There was not months when she did not speak to me, no. There was not months when she did not speak to me, there would be days when she
B would say to me, "Code A where is Code A?", or "Code A where is Code A?", and get us in a muddle, but, physically, she was a strong able-bodied lady.

Q I understand that, but would you turn to page 24. It is a document we have looked at before. It was Code A s reply to a referral of Code A ...
A Yes.

C Q ... by the Haslar. He says that:

> "Fortunately two of Code A were present when I visited so I was able to obtain information from them about Code A premorbid health. It would appear that Code A has been confused for some years but was mobile in her nursing home until around Christmas 1997 when she sustained a fall."

D The implication is that there was a downturn in her physical health?
A There---

Q Is that wrong?
A In 1997 Code A was still able to walk about, go to the toilet, wash her face and hands and eat three meals a day.

E Q My question was whether there was a deterioration in it. He talks about her being mobile until around Christmas, "when she sustained a fall" and it appears that there was a deterioration from about then?
A She slowed up after she had a bad fall.

Q There is reference to being seen by Code A and then further down that paragraph:

F

> "According to Code A she has been 'knocked off' by this medication for months and has not spoken to them for six to seven months."

Is that right or was it wrong?
A I would say that the statement that she did not speak to us for six or seven months is incorrect.

G Q So when Code A is saying he has got the history from you and Code A has he misunderstood it?
A He may have misunderstood it, but I do not think we ever quoted that she did not speak to us for six or seven months because that is not correct.

Q When he says her mobility has also deteriorated during that time, is he right or has he misunderstood?

H

A A Her mobility deteriorated and she began to have falls because she was on the haloperidol and the trazodone which was given to her to quieten her down to make her manageable within the home. I did complain to the GP about the level of medication.

Q Is it right that she was having falls in the six months or so before the period that we are talking about?
A Yes, of course she was.

B

Q I think we have seen other references to that. Would you look at page 108. This is February 1998 so, obviously, six months or so before the time that we are really concerned with?
A Yes.

Q This is Code A a Code A in old age psychiatry, who talks about Code A as a
C lady who had severe dementia, "who since about Christmas seems to have deteriorated further"?
A Yes.

Q She talks about her speech, and says that occasionally she comes out with a few understandable words?
A Yes.

D

Q Is that right?
A Would that be right.

Q In February. I do not need to go through all the detail of that letter, but I think if we turn over the page to page 110, and look at the paragraph headed "Impression", Code A writes:

E

"This is a lady with severe dementia with, I think..."

It may be what she dictated was "END" stage illness, and it may be that has been misunderstood. "END" stage is a phrase that is used in the caring professions, is it not? It is one you recognise, I think?
A You mean E-N-D?

F

Q I do?
A I do not think we can presume that is what it means, because she certainly was not in 1997 at any end stage.

Q This is February 1998 when the letter was written. If it does mean "END" stage, and it has been mis-typed by the secretary, you would say that was wrong, would you?
G A I would say that was wrong.

Q If we look at page 172, this is a note we have already looked at, this is the Accident & Emergency clerking-in record after Code A had her fall. I think Code A has already drawn our attention to the passage three quarters of the way down the page:

"Lives in nursing home.
H Has started falling over the last [six months]

A Quality of life has deteriorated."

A I agree with that because the family felt that the medication she was on was causing her falls and that is why we saw the GP to discuss it.

Q I think if you look slightly further down, what is found on examination, the doctor has noted:

B "Marked bruising around the face [secondary] to a fall [ten days] before".

A Yes, she had a severe fall where she hit her face on some furniture.

Q Would you turn to page 188 as well. This is a letter which is clearly part of the history with which we are concerned, but it does give some past medical history, just so we C can see it again. This is written by a staff nurse at the Haslar Hospital, talking about Code A Code A 's past history. I think you agree with what is written on that page under "Past Medical History"?

A In particular the first three lines:

"She is fully weight bearing, walking with the aid of two nurses on discharge."

D Alzheimer's was never diagnosed, she was always referred to as having dementia.

Q But "worse over last six months", is right?

A Yes, I would agree.

Q There is reference to the level of care that she needs, and a compliment to the devotion of Code A in the middle of the page?

E A Thank you.

Q A reference to speech, again, and from what you have said to me, you do not disagree with what is said there?

A No.

Q I think you did speak to the GP, and we have reference to it in some of the records F that we have.

A We made an appointment and went to his surgery, "we" being Code A and myself.

Q At page 775, which is three from the end, may be the quickest way to get there.

A Yes.

Q It is not the easiest note to read and I do not think we can blame the photocopying for G this. It is 9 June 1998 and underneath that there is a reference to "Code A", which I take to be you?

A If I can find it, yes.

Q Do you have that?

A I have the page.

H Q "Code A concerned re haloperidol"?

A A Yes.

Q "Inj [injection] BD", I think?
A Yes. I cannot see anything about "Code A.

Q It is 1mg BD – I am sorry. Do you have that?

B Code A It is under the date.

THE WITNESS: Yes. One milligram BD, yes. I have not seen this before. I have never had this. This is a doctor's note, the brown ---

Code A It is a Lloyd George card kept by the GP practice?
A Yes, yes. Okay.

C

Q Absolutely. I think it has your name in the left margin and it may relate to you?
A Yes. He had spoken to me in his surgery, yes.

Q I understand.
A Yes.

D Q There is a reference, "Staff report agitated ++ if she doesn't have it."
A Ummm.

Q "Omitted if she isn't well." Then "Code A feel she should not have it." That is you discussing with the GP?
A That is right.

E Q What is going on?
A That is right, yes. I had not seen her before.

Q If we just turn over the page in that record at the bottom of the page, it looks like there is an entry put in in error, in the middle of the page, but at the bottom of the page for 9 July 1998:

F "More agitated
Screams out"

It may be "Fine at night". It could be "fire at night" but I do not think ---
A "Fine." I think that is "Fine at night".

Q Is it "tearful" or "fearful"?
G A I could not decipher that.

Q And a reference to the haloperidol – is that increased?
A "1 ml BD". I do not know what she was having before. "1 ml BD"? 1 mg BD was what she was having before, yes. At the top of the page it says he has seen both Code A and myself. "Code A seen", and it says, "Code A with..." something.

H

Q If we go over the page, just to the last one, again I do not know if you have seen this. This is a reference ---
A I have not seen this. I have not seen any of these doctor's notes.

Q But there is a reference on 19 August 1998?
A Yes.

Q A telephone call, apparently, from Code A at the nursing home inspectorate?
A All right. Okay.

Q Responding to a complaint that you had made, I think, to social services, about the nursing home.
A Right. Okay, yes.

Q And you have told us you had concerns about the way the fall that Code A had was dealt with?
A That is right.

Q Let us stay with the history, if we may and what we know is that Code A was admitted to ---
A Can I just ---?

Q Of course you can.
A The Code A of the 8th is just two days before she died.

Q That is right.
A So this referral here may have been prior to that, if you are with me. I did complain to social services about Code A but I did not know it was referred to her GP.

Q We do not know whether this is a phone call out, or possibly a phone call in.
A No.

Q It is in the records. The Panel have it.
A That is fine.

Q And they will look at it.
A That is fine.

Q I just wanted your evidence ---?
A That is fine.

Q --- on the relevance of this.
A That is fine.

Q And you are telling me that you did make a complaint?
A I did make a complaint because I felt the level of sedation was causing her to fall.

Q I understand. Coming back to the admission that Code A had, we have looked at the clerking note made by the doctor when she was admitted, and you have told us that she had some morphine whilst she was in hospital?
A Yes. When she was admitted and taken up to the ward, they told me they were going to give her an injection and review her in the morning.

Q And what you told us is that she was given morphine at the Haslar on the night of the admission?
A Yes.

Q And I think what you have told us was that she did not have it after that?
A As far as I knew, she did not have it after that.

Q Do you think you might be wrong, and that she did have it for several days?
A No. I do not think that. I think the nurses would have told me because I particularly asked what she was having for pain, and they said that she had something like co-dydramol or paracetamol, only requiring a very small amount of pain relief, considering the size of the operation.

Q I hear that. Do you think you might have mis-recalled what you were told about the morphine that Code A had had?
A I mis-recalled? I do not believe I have.

Q No? Have a look at page 243 if you would, please, Code A
A Yes.

Q You were asked about other pages by Code A during the period of Code A 's first admission to the Haslar.
A Uh-uh.

Q You were not asked about this, and this shows at the top of the page morphine being given intravenously.
A I am not surprised. It is the day of the operation.

Q No, I understand that.
A Yes.

Q But I think if we look down the chart, we can see that it was given on subsequent days as well?
A A small dose for three days following the surgery.

Q I understand that.
A Yes. I was not told, but ---

Q What you have told us ---
A --- I think that would be a quite normal ---

Q What you have told us is that you were told that Code A was not given any morphine. That is what you have told us.
A I said as far as I knew she was not given any morphine.

A

Q Right.
A I was told that she had only mild analgesia following her operation, and I would think that a small dose like that on three days following major surgery would be perfectly normal, once a day.

Q That may well be right. I was just concerned about your recollection. Do you
B understand?
A Well, I am not surprised after ten and a half years.

Q Code A ---
A I am sorry. I am sorry.

Q --- there is no criticism of you about the times of the past. Do not think it is a memory
C test. If things have gone because of the passage of time from your memory, there is no criticism whatsoever. Please do not think there is. All right? But I think what we know is that whilst she was still at the Haslar, Code A assessed Code A We have seen the letter on page 24, and the history that he took from you and Code A Just following through, we know that Code A was transferred after that assessment by Code A transferred to the War Memorial Hospital on 11 August 1998. We have seen documents that confirm it and we have seen Code A 's note on page 30. I am just going to ask you to turn to that again. You
D have told us, again, you were not present when Code A assessed Code A ---
A No.

Q --- on first admission to the War Memorial Hospital. She had been walking with a zimmer at the Haslar but you cannot say that she was not transferred by hoist when she was seen by Code A or just before?
A They were not using a hoist at Haslar Hospital. They were transferring her on her two
E feet.

Q I understand that. We have seen Code A has written a Barthel score of 2. It is not an area about which you are comfortable, I think, Barthel scores?
A No.

Q So I will not ask you, but the Panel may want to look on a couple of pages to page 41.
F A Oh right, yes.

Q This is done, I think, by a nurse. It is the same date?
A Yes.

Q The 11 August, 1998. Your recollection was that it was a sort of chart where points are given for various tasks?
G A People are assessed as to their capabilities.

Q Again, I do not need to ask you about it, but we will see that the nursing staff undertaking this Barthel assessment give a score of 3 on that date. What we know happened during that admission is that something happened to Code A We have looked at page 46. Perhaps we can turn to it again.
A Are we talking about her re-admission? Are we?
H

Q During the first time she was at the War Memorial.
A Okay.

Q During that time we know that the records suggest she was found on the floor at some stage on 13 August?
A Yes.

Q 1998. We see that from the record a Code A was contacted and an X-ray was ordered. I do not know if you had any contact with any doctor around that time?
A No.

Q And I do not know if you know who Code A is?
A No.

Q But I think you know that the X-ray showed that there was a dislocation?
A The X-rays were not done until the following morning.

Q What we see from the note, since you have raised it, that the note says:

"Code A contacted, advised X-ray AM and analgesia during the night."
A Yes.

Q Yes?
A Yes.

Q
"Inappropriate to transfer for X-ray this PM. Code A informed."

A Yes.

Q Would that have been you as the Code A being informed?
A Yes. They telephoned me at home quite late, 9.30-ish, and said, "I think she has done some damage and she will be X-rayed in the morning."

Q We see on that same page, page 46, AM:

"Right hip X-rayed. Dislocated. Code A seen by Code A and informed of situation."

A Yes.

Q
"For transfer to Haslar A&E for reduction under sedation."

A Yes.

Q Yes?
A Yes.

Q You had a conversation with Code A about that X-ray?

A A I did indeed. She said, "Your worst fears of last night are right and we are transferring her to Haslar." I was convinced she had a bad injury the day before.

Q We know that it was a different doctor who was involved the day before, and we have another entry for the afternoon of that day.

"Notified that dislocation has been reduced today in Haslar for 48 hours."

B

Then:

"[Something] returned to us.
Family aware."

A Yes.

C

Q And it follows you would have learned of what was happening?
A Yes.

Q Yes?
A Yes.

D Q After several days at the Haslar, your mother was then transferred back to the War Memorial Hospital?
A Yes.

Q I think what you told us was that you were not present when Code A arrived, but you were there shortly after?
A Very shortly afterwards.

E

Q And I do not know if you were told what had happened, but the note suggests that the ambulance crew transferring Code A had not got a canvas under patient to transfer her over, but did it by a sheet.
A This information was not made available to me till after she died. All I was told was, "Something has happened and Code A is very distressed." "Something". We know something has happened, but what the something was – whether they dropped her or what they did, I was not told. I only learned about the canvas after her death.

F

Q All right, but you saw Code A in a very considerable degree of discomfort?
A Terrible.

Q It was clear that it was pain she was in?
A Oh, absolutely. Absolutely. She stated she was in pain.

G

Q Yes.
A Yes, and you could see. You can tell when somebody is screaming through temper or in terrible pain.

Q She was given pain relief on a number of occasions, you told us?
A Within a few hours, yes.

H

A Q I understand. You told us that she was given two injections?
A Yes, during that time that she was ---

Q Do you know who gave those?
A Yes, Code A gave them.

Q Do you know what it was?
B A No, but he told me it was for pain, because I had said. I knew that she had had Oramorph, and I said, "She is still in pain. She is in terrible pain." And he said, "I'll give her something," which he did.

Q I do not know if you ---
A That was witnessed.

C Q I am not disputing it, Code A
A No, no.

Q Just because I am a barrister asking you questions, do not think I am suggesting everything you say is wrong.
A No. I am sorry. I am sorry.

D Q I do not know if you have ever seen any medical record that relates to that injection, or those injections?
A I have looked at the medical records and I cannot find an entry for the 17th, of her being given an injection.

Q Right. It may be something has gone missing, or was not recorded?
A Or was not recorded.
E

Q But Code A needed more pain relief later on that day?
A Yes.

Q Because we have seen entries with respect to Oramorph that day?
A Yes.

F Q And continuing in to the evening?
A Yes, and it is strictly down there as four hourly, and she had four doses in seven hours, plus two injections.

Q I wonder if I could just find the page again where those entries are recorded. I am told it is 63 and 65 – thank you very much. This was an "as required" prescription, and it was Oramorph. Do you agree that she was ---
G A Where does it say "Prn"? It says "four hourly" – Oramorph. It does not say "Prn", which is "as and when".

Q It says "As required prescription", just above Oramorph.
A Oh yes, yes.

Q All right?
H A Okay. Four hourly as required.

Q That may be right, but it was clear that Code A was in discomfort ---
A But as a nurse ---

Q --- at a time during the evening.
A As a nurse, if it said "Four hourly as required", four hourly is as required. It is not four doses in seven hours. That is my opinion – sorry.

Q That may be right, Code A but Code A despite the pain relief, was at least in stages during the rest of the 17th, at periods of time she was in pain still?
A She was in pain until it took effect.

Q I understand.
A But she was known to be sensitive to it because Code A has written it on the notes, that she is sensitive to Oramorph.

Q I agree with that. I agree with that. If I may, can I take you to the note on the 17th. It is page 31.
A Yes.

Q And what we have as Code A 's note on that day is:

"Readmission to Daedalus from Royal Hospital Haslar.

Closed reduction under I.V. [intravenous] sedation. Remained unresponsive for some hours."

That I think is a comment on Code A coming round after the sedation that she had. Yes? You are nodding?
A Well, I do not know whether she is referring to her discharge note when she had the second procedure. She did not wake up quite as quickly as they expected her to.

Q I understand.
A Or whether she is referring to the fact that she is ---

Q She is referring to what ---
A --- to the stuff that they have given her on the 17th at Daedalus.

Q No. I think she is referring to the discharge.
A The discharge note, where she did not wake up. Right. Okay.

Q Yes. "Now appears peaceful" is what Code A has ---
A Not in a million years did she appear peaceful. She arrived at the hospital and for the next so many hours she screamed. It was mayhem. She screamed the place down.

Q What I ---
A That is why they gave her the pain relief.

Q What I am suggesting is that Code A had arrived back at the hospital at 11.48?
A Yes.

A

Q That is the time we have.
A And the ambulance drivers state that she screamed all the way, and she screamed continually in the ward, so "Now appears peaceful"....

Q What you have told us ---
A Yes.

B

Q --- Code A , is that Code A gave her two injections?
A Yes.

Q Yes?
A And she had had the Oramorph as well.

C

Q And she then got Oramorph throughout the day?
A Uh-uh.

Q Yes? I am suggesting that at some stage, at lunch time or later, Code A assessed Code A and at a time when Code A was peaceful because the medication she had had at that time was having effect?
A Well, it must have been later on then because Code A and I did not leave Code A

D

Code A 's side that day.

Q And what Code A has written is, "Now appears peaceful". She has written:

"Plan. Continue haloperidol
Only give Oramorph if in severe pain."

E

A Yes.

Q But Code A was periodically during that day in severe pain, yes?
A The amount they gave her caused her never to wake up again. From the 17th she never regained consciousness at all.

Q Well, is that really right?

F

A That is absolutely right.

Q She was still in pain over certainly the following day.
A She was not conscious.

Q On the 18th --
A She was not conscious.

G

Q -- I suggest Code A was still demonstrating that she was in pain.
A Well, she was not screaming or moving or doing anything, she was totally unconscious --

Q Well, have a --
A -- from the 17th.

H

Q Have a look at Code A s entry just below on the 18th.

"Still in great pain. Nursing a problem. I suggest subcutaneous diamorphine, haloperidol, midazolam. I will see Code A today."

That is what happened.
A We stayed with Code A continually.

Q You had another conversation with Code A about Code A We have seen the reference to you being told about the syringe driver.
A Code A told us about the syringe driver. It was already in situ when we arrived. It was already in place.

Q Page 48, if you would. It is page 47, I should say, first. On the 18th:

"Reviewed by Code A for pain control via syringe driver. Treatment discussed with Code A They agreed to use of syringe driver to control pain."

A We were told that was to be the plan of action and, as I have said before, I understand with a syringe driver if the dose is correct the patient can remain to be lucid and able to eat and drink and carry out normal procedures.

Q I understand, Code A , but --
A Code A was already unconscious.

Q You know that for people who are in the terminal stage of a dementing process --
A Code A was not terminally ill. She was not suffering from anything from which she was going to die.

Q I am going to suggest that she was at the end stage and had been for some time of her dementia and that is what the doctors were saying.
A Dementia does not kill people. She was not at the end stage of her life. She was a fit, strong woman. That shows from the 17th when she was unconscious she did not die until the night of the 21st. Therefore, her reserves from being a strong, healthy person and having a good diet allowed her to remain alive during that period of being unconscious. She had no nourishment whatsoever. If she had not been a strong, fit lady she would not have lasted another five days on a syringe driver --

Q Well --
A -- or three days or whatever it was.

Q You know, as someone who has got the experience that you do, that patients with severe dementia sometimes never walk again after a fracture of the neck of a femur?
A I also know that Code A was up on her feet within 24 hours walking with a Zimmer and they thought it was remarkable and the surgeon commented to me "We have just done it for the Queen Mother, we will do it for Code A because she was walking about beforehand. That is why we will give her a chance of having her femur done."

Q You know that the mortality rate in the weeks after a fracture of the neck of femur, sadly, is very high, very high?

A A If something else happens to them that causes them to die. It is not always just from a fractured femur.

Q And that is particularly the case in the very elderly and those with mental impairment or some kind of dementia? The statistics are that the survival rates for patients, and it is very unfortunate, are very low, the survival rates.
A She was not admitted to have palliative care drugs for a terminal illness. She was not
B suffering from a terminal illness for which those sort of drugs are given.

Q And is it your experience as well that the process of transferring elderly patients who may be confused, who may have medical problems as well, transferring can itself lead to a decline?
A Sometimes patients are upset about going to a new place, yes, I would agree with that.

C Q And Code A --
A It does not cause death.

Q But it is very frequently associated with a terminal decline, the final decline to death?
A I cannot agree that Code A was in the terminal stages of her life.

Q No. I accept that you cannot agree it but I am just inviting you to reflect upon it.
D A OK.

Q That this is something which is true, that patients who are unwell, who are at the end stages or near the end with dementia and who have a fracture very frequently do not leave hospital?

Code A I think this has gone on long enough. The witness can only answer what
E happened to Code A not statistics, and she has told us what has happened to Code A

Code A was keen that you should know of this lady's experience and I am inviting her to reflect upon that when she answers the questions that I ask.

Code A I think she has done that.

F Code A I agree. I think the question had been raised on the 17th about whether it might be appropriate to transfer Code A yet again back to the Haslar?
A Absolutely, yes.

Q And the first question was would it be appropriate to do that with a patient of Code A Code A s history and in her condition?
A As far as I was concerned, yes. Had she been in her own home, she would have been
G transferred. If she had been in a nursing home, she would have been transferred. The hospital offered to have her back because she was not in pain when she left and there had been an accident caused. The causation of her pain was not investigated, the relief of her pain was investigated, and she was given analgesia.

Q There was an X-ray done.
A No.
H

Q On the 17th?
A No.

Q There was an X-ray that showed there was no dislocation?
A I am sorry, I did not know or I do not remember that.

Q And the X-ray showed that there was no problem that could be treated back at the Haslar. Did you not know that?
A Well, I do not recall it at the moment because --

Q Have a look at page 47, if you would?
A Yes.

Q It should still be open in front of you.
A Yes.

Q This, again, is the 17th.
A Yes, I have got it here.

Q The day when she arrived back from the Haslar and something happened on the transfer.
A Yes.

Q It has got a reference which may be to you.

"Code A records surgeon to say Code A must not be left in pain if dislocation occurs again."

A That is right, and she was supposed to be in a straight leg splint or two weeks and she was not.

Q I understand that.

"Code A contacted and has ordered an X-ray."

A Right.

Q Yes?
A Yes.

Q I do not know if you can confirm that Code A was not there when she was contacted. She was contacted by telephone?
A Yes.

Q She was not on the ward?
A We did not see her, no.

Q And I do not know if you recall Code A tried to give a verbal order for an X-ray to be undertaken but a verbal order was not sufficient for the X-ray department, they had to get another doctor in, and that is why Code A --

A A I do recall that.

Q -- became involved. Do you recall?
A I do recall that, yes, I do recall that.

Q That is why, if we look down page 47, we see the hip was X-rayed at 14.45. The films, meaning the X-rays, were seen by Code A and the radiologist. Code A was one of
B Code A No dislocation was seen. Had you forgotten that? Again, there is no criticism if you had but had you forgotten that there was an X-ray?
A Because there is two occasions when she has had a fall and she has been X-rayed.

Q So you have told us there was no investigation but there was, was there not?
A I find it difficult because we did not leave Code A and I do not remember on that day that she went for another X-ray so I cannot say any more, I am afraid.
C

Q But the X-ray showed that there was no dislocation. If the Haslar might have been able to take her, they would not have been able to do anything for her.
A Well, she would at least have been in a splint to support the leg, would she not?

Q The Haslar had treated her in operations twice?
A Yes.
D

Q There was nothing to do a third time because there was no dislocation shown on the X-ray, yes?
A Some damage was done.

Q But she was in pain and, as I have suggested, reviewed the next day by Code A Her treatment was discussed, and we have looked at this already at the bottom of that page.
E A Yes.

Q ".. with Code A They agree to the use of a syringe driver to control pain and allow nursing care to be given."

That is right, is it not?
A Yes.
F

Q You have told us that Code A was unconscious from that time.
A Yes.

Q I just want to take you over the page, if we might, please. It is the evening, I think, of the 18th. Again, this is not the best photocopy but it looks like the 18th at 20.00, so 8.00 pm, after the syringe driver has been started.
G

"Patient remains peaceful and sleeping. Reacted to pain when being moved."

A And you have told me there was no dislocation so she would not be in pain, would she, if there was no dislocation?

Q I am not an orthopaedic surgeon, I am afraid, so I may not be the man to ask but Code A
H Code A was in pain when she was being moved as has been recorded, I suggest, and there is

reference to:

> "Code A quite upset and angry about Code A's condition but appears to be happy she is pain free at present."

Was that right?
A Yes. It is very difficult when you see somebody in so much pain and you cannot do anything about it.

Q Yes. But it is clear, is it not, that the doctors or certainly Code A had tried to investigate Code A by ordering an X-ray, it had not been possible to get a verbal order, and that Code A 's pain was being alleviated? That is right, is it not?
A Continually, yes.

Code A Thank you very much, Code A

Re-examined by Code A

Code A I have only got one very short matter to ask you about. You were asked by Code A about the time that you made a complaint on, I think, 19 August. If you need to turn it up again, it is page 777, right at the back of the bundle. It is the last page before the tab. I do not want to go into the detail of that but on 19 August, from what you have told us, you would have been at the Gosport War Memorial Hospital for at least most of the day, if not all of the day?
A We stayed day and night.

Q This sequence of events of the fracture, the repair, the subsequent dislocation, back to the Haslar, back to the Gosport War Memorial Hospital again, had all of that in your view been started off at the nursing home as a result of the fracture, the original injury?
A Had all of what started off?

Q This sequence of events that we have been discussing?
A Originally, the fall was at the nursing home, yes.

Q Yes. Where we see here an allegation of over-sedation, at that time that was an allegation in relation to the nursing home over-sedation, nothing to do with --
A Yes, because it caused her fall.

Q Because you thought that is what had caused her to fall?
A That is the start of the sequence of events which led to her death, yes.

Code A Exactly. That is what was clearly troubling you at the time. I understand. Thank you.

Code A , that brings us to the end of the formal questions from counsel. There is now the opportunity for members of the Panel to ask questions of you and I will just check to see what the position is. I was checking because if there had been a lot of questions I would have suggested that we let you take another break now but it appears that only one member of the Panel wishes to ask a question or questions of you so, if you are comfortable with that, we will go straight on.

THE WITNESS: Yes.

Code A That member of the Panel is Code A and he is a lay member of the Panel.

Questioned by THE PANEL

Code A Good afternoon.
A Good afternoon.

Q I have a little confusion in my mind and I want to put this right. You have given evidence to say that you went into the ward and Code A was shouting out in pain and you could hear it from entering the door.
A From the swing doors on the entrance to the ward.

Q You could her that shouting out in pain. I think you said you were accompanied by your sister?
A I was.

Q When you got to Code A she then said something to you. Can you just repeat what it was again?
A Yes. She was screaming and she saw me come in and stand at the edge of the bed and she said "Don't just stand there, do something. The pain, the pain."

Q Right. That was aimed at yourself?
A That was aimed at me.

Q Then what did you do?
A I said to Code A "Stay with Code A and I will go to Haslar and see the condition of Code A from Code A as to how she was when she had left that hospital to come to this hospital."

Q Right. Let me just stop you there. So Code A was shouting in pain, she was asking you to do something, and you thought that your best course of action was then to go back to the hospital, the Haslar?
A Yes, within minutes. First of all, I called a staff nurse and moved her position.

Q Would you say that again?
A I said within minutes because the first thing I did was to ask a staff nurse to come in and change Code A 's position to make her more comfortable.

Q That is what I thought you said.
A I did.

Q That is where I have got confused.
A I am sorry.

Q No, it is not your fault, it is mine. They are long days. That is where I have got confused. You actually had to go and get someone to help you --

A We asked a healthcare assistant to go and get a trained nurse, which she did.

Q Right. But you had to go and get a trained nurse even though she was shouting out and the whole ward could hear her in pain?
A Yes.

Q And then am I right in saying that you said that you and this trained nurse made her comfortable?
A We made her as comfortable as we could at the time and then I left and went to Haslar and I spoke to the doctor who did the operation.

Q So when you got there, there was no one actually attending Code A ?
A There was a healthcare assistant in the ward attempting to give her something from a plate. I do not remember what it was at the time but she was trying to feed her and she was actually quite nasty when we arrived because, as we came in the door, she said "You try and feed her something. She hasn't stopped screaming since she got here." So I said "Will you go and get a trained nurse, please, because look at Code A 's position."

Q Right.
A That is what happened. That is exactly what happened.

Q Thank you very much. I do not think I need to pursue it any further.

Code A Thank you, Code A do you have any questions arising?

Code A No.

Code A ?

Further re-examined by Code A

Code A Just arising from that, when you did look at your mother's position, were you able to correct it fairly quickly?
A Well, as best as we could because she had not got her splint but her leg was in an awful position, considering she had just had another replacement, and she was in a sort of a heap on the bed so we straightened her.

Q And you could see that?
A Yes, we could see that.

Q So you straightened her out?
A So the nurse and I did as you did in those days, with your hands under her hips and under her legs, and got her straight onto her bottom.

Q Did that seem to relieve her?
A Yes, it did seem to relieve her, yes. Apparently after I left she continued screaming and that is when they gave her something for the pain.

Code A That is all I ask.

A Code A Thank you, Code A and thank you, Code A That is the end of your testimony.

Further cross-examined by Code A

Code A Can I raise one question out of the answer just Code A received?

B Code A Do you say you saw the injections given by Code A ?
A I did, indeed. We were present.

Code A In that case, I will not pursue it, thank you.

Code A That truly is the end of your testimony. Thank you very much for coming to assist us today. It is enormously helpful for panels to have live evidence and we C are most grateful to you for taking the time and subjecting yourself to what we do well understand are the stresses and strains of appearing in these circumstances. Thank you very much indeed and you are free to go.

(The witness withdrew)

Code A If I can take you back to you witness schedule. You will see that that is all the D evidence that we have for you today, which may be, in any event, convenient given the travel difficulties we all face, or some of us face. Tomorrow we will be moving on to deal with Patient F who is Ruby Lake. We are, at the moment, spot on schedule. Whether that will continue remains to be seen.

Code A Are you in a position at this stage to hand to the Panel bundle F?

E Code A I am sorry, that is one that is being sorted out next door. If you give us a few minutes – we can either do it now or we can get it to you in the morning.

Code A I am going to suggest that the Panel will start tomorrow, assuming we are all able to be here on time – I am told the video conference link also needs to be tested tomorrow morning at 9 o'clock, but that will not prevent the Panel being here for 9.30 to read all that you may have for us. That would be, therefore, re-reading your opening in respect of F this patient, also reviewing the schedule that we anticipate will be at the beginning of the new bundle and then cross referencing with the references that you so helpfully have put in. I would have thought that that is going to take us something in the region of an hour, if the last patient was anything to go by, but it may be the next one is shorter, I do not know.

Code A I think the next one is almost certainly shorter. Tomorrow's evidence is not such a heavy evidence day. There are two witnesses, but only one, I suspect, will be G particularly substantial.

It also occurs to me that I have not formally made an application to you to receive the evidence of Code A by video link. I do not think it is resisted. I see Code A agreeing. I can give you the explanation tomorrow, but at the moment I am going to take it that it is likely it is going to be received with an ajar door, as it were, which I will not have to push too hard to get you to receive the evidence in that way. The witness is in Kuala Lumpur H and it would be very difficult, not impossible, I do not say, but ---

Code A We are used to receiving evidence that way and, if it is not objected to, then there will not be any difficulties.

Code A I am grateful.

Code A My suggestion was that the Panel would take an hour. You seem to think it may not need so long to prepare.

Code A: The notes are not quite as bad, but it does take a while to go through them. What I am saying is that the evidence itself will not take quite so long as today. I would have thought giving yourselves an hour would be sensible.

Code A The Panel will be here at 9.30 for that purpose, but for all other parties there will be no need to be here before 10.30am.

(The Panel adjourned until 9.30am on Thursday 11 June 2009
and the Parties were released until 10.30 am)

**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Thursday 11 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 FOUR)

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)

# INDEX

A Code A Good morning everybody. Code A before we move on, the Panel have spent the last hour going through the materials in respect of Patient F and we do have one query that you might be able to answer for us at this stage. In your opening on Day 1/51A, you referred, and I quote.

> "One of the last notes made by Code A Royal Haslar Hospital before she transferred on 8 August was 'well comfortable and happy. To GWMH today'."

B

We have looked through the schedule and through the bundle itself, and the only document that we can find that seems to come close to that description is to be found on page 519 of the bundle. That is a clinical continuation sheet under the date, just halfway down the page, 18 August. It appears to read:

C

> "Ward round Senior House Officer. Well comfortable and happy."

Some other references and:

> "To GWMH today."

There is then a signature which, arguably, might be Code A Might that be the gentleman or doctor to whom you were referring?

D

Code A Yes, and we are calling him this morning.

Code A He is a Code A ?

Code A I think he is, yes.

E

Code A He was conducting the Senior House Officer's ward round?

Code A We will have to let him explain that.

Code A We do have the right reference?

F

Code A Yes, and I did not imagine it. It is in his statement and he will be giving evidence about it and explaining why he did the ---

Code A I think he will tell us he is a Code A and was at the time.

Code A I might have promoted him. It comes from not having a military background, but apart from that we are ready to start.

G

Code A We are checking on the list because within the transcript the name, Code A has been rendered with a "P", which is why we did not pick it up on your schedule, but the gentleman is Code A ?

Code A : That is right, yes. We are going to begin by reading a statement to you in relation to Code A Patient F. It is the statement of Code A who says that she is the Code A She made a statement for the GMC dated 3 June 2008, and it simply

H

A corrects various items and typos and the like in her main police statement. I will read the main police statement incorporating, I hope, those amendments. The police statement is dated 12 April 2005 and she gives her occupation as Community Nursery Nurse. She says:

"I make this statement with regard to Code A Code A who was born on Code A and died on Code A

B Code A was born on the Isle of Wight and was one of ten children. I am not aware of any family illness nor any illness which affected Code A in the early stages of her life. I do not how old Code A were when they died, but I think my Code A was in her 60s.

Code A was the youngest of the ten children and all her siblings are now deceased. I do recall some of my Code A Some of them lived into their 90s, others not so C long.

As a Code A worked in a shop on the Isle of Wight and in 1935 she Code A At the time Code A was in the Army Medical Corps. Code A who was born in 1939, then Code A and then my Code A who was born in 1950.

D After the war Code A went to Theological College and became a Methodist Minister. As a result we did move about the country, living in Cornwall and Basingstoke. We then moved down to Gosport and then Eastleigh prior to Code A retiring in Gosport.

Code A died in 1983 and Code A continued to live in Alverstoke. Code A had her own home, her own friends and enjoyed a good quality of life.

E As she got older she did suffer from gout and leg ulcers. This caused her quite a bit of pain. These were something that she would have regular treatment for. The other thing she suffered from was arthritis. She had various aids in the house to help maintain her quality of life. Her mobility was limited and she did not go out on her own.

F However there were things that affected her in the later stages of her life. Code A did not drink or smoke and I would say that she was a fit and healthy woman for her age. Her GP was local and was Code A who was with the surgery in Stoke Road.

In late July 1998, Code A had a fall whilst at home. She was alone at the time but was able to contact a friend who was in turn able to call the police who broke down the door and called for an ambulance. As a result of the fall, Code A broke her hip and was taken to the Royal Haslar Hospital. She underwent surgery later that day and was G given a new hip.

I was able to see Code A later that day. She was post op so I did not spend a great deal of time with her, I just made sure she had what she needed. Code A stayed in Haslar for about two to three weeks. I would visit her most days.

Whilst Code A was at Haslar I never saw her out of the bed. It was clear that the H operation had had quite an affect on her. Her mood could go up and down and there

would be periods when she did not talk, although she could be quite lucid and was able to hold a conversation.

I think at this time Code A had developed a cough and there was question mark over fluid on the chest. As result, I think she found nil supplements easier to digest than normal food and was quite happy with these.

On being told Code A was going to be moved to the Gosport War Memorial Hospital, I raised concerns that I felt Code A was not well enough. I think I spoke with a nurse but I do not recall who. I was assured she was fit enough to be moved and on 17 August 1998 she was moved to the [GWMH]. This was on Monday.

I saw Mum on the Tuesday, 18 August. She was in a private room and appeared to be clean and well cared for. She was able to talk and I cannot recall any concerns. Code A had numerous visitors, family and friends. My initial view was that I did not expect a fall and a hip operation to cause her demise. However I was realistic enough to realise that the trauma of the fall and subsequent surgery could take its toll on an elderly woman, which became more apparent as the weeks went by. Up until late Wednesday 19 August, when Code A appeared to be quite agitated and distressed, I felt there was a good chance Code A would be coming home.

I was able to talk to Code A on the Wednesday but by the Thursday, [that would be 20th] there was a noticeable deterioration. She gave no visible signs and was unable to respond either through hand gestures or oral communication. I cannot be sure at what stage it started but I think Code A was on a syringe driver at that stage.

When I saw Code A on the Thursday Code A were with me as well as my Code A and Code A Other friends from church would also visit. I spent most of the day with her on the Thursday and went to see her again on the Friday.

I found the hospital staff to be helpful with regard to allowing us to stay. They seemed quite caring but I do not recall talking to anyone in any great detail about Code A's condition. By the Thursday [20th] we were all aware that Code A was very ill and we did not expect her to last that much longer.

On Code A I spent the day at the hospital with Code A Code A were also there, as was Code A as well as Code A and Code A

Code A seemed quite peaceful during the day and was to all intents and purposes asleep. She died in the early evening with the family close by.

Code A's death was certified by Code A and cause of death was shown as bronchopneumonia. There was nothing that struck us as out of the ordinary with regards her care. Code A was cremated."

This witness also gave evidence at the coroner's inquiry. The evidence did not take every long. It runs to about four pages of transcript, but I was conscious yesterday when I was reading out pages of the transcript, that it was probably quite difficult to follow as you listen

to it. We do have copies just of these four pages, if everybody is happy for you to have them. I suggest that you use them as a tool while you are listening rather than exhibit them because in due course you will have the transcript in any event. I have not mentioned this to my learned friend, but I do not suppose there is any problem about it. (Agreement given) I am grateful. If the Panel are happy to receive them, I will hand them out.

Code A They are very clear on the transcript, but for the purposes for now, as you are reading them to us, it would assist, yes. (Document distributed)

Code A We are looking at the bottom of the page where we can see Code A was sworn, examined by the Code A Ignore the rest of it. The Code A says:

"Code A I do not know if you want to stand or sit. You are Code A [sic]?
A Yes.

Q You are Code A?
A Yes.

Q Tell me about Code A
A Do you want a broad --

Q If you want to read your statement, if that is easier.
A I do not mind. She was a very quiet, gentle lady I think, always quite a peace keeper in general. Her star sign was Libra and that is what she tried to do within the family: keep the peace. She did balance us all out really. She was born on of Isle of Wight, one of ten.

Q Something to do with the sea air.
A I do not think she knew some of her brothers because some went to war before she was born. I do not know how old Code A were when they died but I think her mother was about 60 - but then having ten children. All her siblings are decreased now. I do remember some of Code A some of whom lived into their 90s, and others were killed as young boys in the war.

She worked as a shop assistant on the Isle of Wight until she Code A Code A at the time was in the Army Medical Corp. They had Code A Code A After the war Code A went to theological college and became a Methodist minister.

Q On the island?
A He became a minister and then as a result of that the first place we moved to was Cornwall then subsequently to Basingstoke and Eastleigh. We did have those moves. They moved to Eastleigh last. Code A returned back to Gosport. Code A died in 1983 and Code A continued to live in Alverstoke. She had her own home and her own friends. She was still very involved in church life and generally had a good quality of life.

She had suffered over the years with arthritis and then latterly with gout and quite significant ulcers in her legs which gave her a lot - she never complained particularly

she grumbled about them. "My blessed legs will not go" but she did not really complain.

Q She was not a complaining sort?
A No, not really. She just grumbled they did not go as fast as she would like them to. They did cause her quite a lot of pain and they were quite nasty ulcers and she had regular treatment for that which went on for some years. Also her arthritis gave her quite a bit of pain. She had various aids around the house to enable her to maintain her quality of life.

Q Like?
A She had rails to go up the stairs.

Q Was that an OT assessment..."

I think that must be Occupational Therapy assessment:

"A Yes. A raised toilet seat and various bars to help. Her mobility was limited and she never went out on her own but she was always game to go anywhere anyone would take her. These were things that really affected her in later life. I do not remember, as a young woman, her having any problems. She did not drink or smoke. For her age really I would have said she was a fairly - not fit but a fairly healthy women for her age all things considered.

Her GP was local, Stoke Road in Gosport. In late July she had a fall at home. She was alone at the time but managed to contact a friend who was able to call the police who broke her door down and called for an ambulance.

Q That is when she was taken to Haslar?
A Yes, as a result she had broken her hip and was taken to Haslar. She underwent surgery later that day. I was able to see her later that day but because she was post-op I did not spend a great deal of time with her. I made sure she had what she needed.

She was in Haslar for about two to three weeks where I visited most days. While she was in Haslar I personally never saw her out of bed. Having since read the medical notes it seems that she did get out or they did have her out with a Zimmer frame a few times. I never saw her out of bed. It was clear that the operation had had quite an affect on her. She was really not very well.

Q Code A was quite clear about that, the setbacks that people suffer. That is a standard problem of the injury but it knocks the stuffing out.
A She was very slow, much slower than other people who had had broken hips. Her mood would go up and down. Some days she was quite lucid and hold a conversation and the next day she would not speak at all. In fact a few days she turned away from me and ignored me and would not talk at all, was quite grumpy with it.

I think she developed a cough at this time and there was a question of her having a chest infection. I think ECGs were done and also there was a question of fluid on her chest or lungs. She was not eating or drinking very

well and they gave her meal supplements, which I can remember she told me she enjoyed particularly the banana flavoured one. She seemed happy to be having those than being bothered with food.

On being told she was to be moved to the Gosport War Memorial, I did raise concerns with the hospital staff. I did not think she was well enough to be moved. I did speak to a nurse but I do not know who. She assured me that she was fit to be moved and in fact obviously that day I think she had one of her brighter days again so subsequently she was moved. I thought it was the Monday but all the information we had it was obviously the 18th, which I think was the Tuesday.

She obviously went over in the morning and I went to see her in the afternoon. She was in a private room and appeared to be clean and well cared for. She was able to talk and I cannot recall any real concerns. She had numerous visitors, family and friends. My initial view was that I did not expect a fall to cause her demise but I was realistic enough to know the trauma of the fall and the surgery often took their toll on elderly ladies. It looked as if this was how I think we were thinking that unfortunately she was becoming one of these statistics so to speak.

It became more apparent as the weeks went by she clearly was taking a long time to recover. Up until the late Wednesday when she became really agitated and distressed I still felt there was a chance that, I said in my police statement, she would be coming home but probably that was unrealistic I think. She would have needed further care. I have been able to talk to her by the Wednesday but Thursday there was a noticeable deterioration and she gave no visible signs and was not able to respond either through hand gestures or communication.

I am not sure at which stage it was started but I think she was on a syringe driver by then. When I saw her on the Thursday Code A were with me as well as Code A She had visitors from church and we were there Thursday and Friday with her. The hospital staff we did not see much of them, because they came in to see she was OK and occasionally move her but there did not seem to be any need while we were there. They seemed quite caring while we were allowed to be there. It did not cause any concerns there. By the Thursday we were all aware she was very ill and had doubts as to how much longer she was going to live. We were there all day on the Code A and Code A and a few other people during the day. She seemed quite peaceful during the day, to all and intents and purposes asleep. She passed away in the evening with the family close by. It was quite quick. We were a bit surprised at the speed from the move but again, having read more now about her medical history, we realised how poorly she was.

Q It is significant that the move itself can actually tip the balance.
Code A was commenting on this. I think Code A mentioned it as well. It does have an effect on people. On the Friday she was not communicating at all.

A No.
Q Thursday, hand movements?

A Thursday I think she was not, no. I called Code A to come and we were not actually sure whether she did notice we had arrived or not. No, she did not on the Thursday.

B Q Sad, is it not?
A Yes."

Then she was cross-examined by Code A who asked:

"Code A: You say at the end of your police statement that there was nothing that struck you as out of the ordinary in regard to her care.
C A No, not really, not at that time. She was certainly clean and tidy and being cared for. What I did not know was I knew she was on the syringe driver but nobody actually spoke to us about that. Nobody asked or suggested. We did not have any conversation about they thought she needed to go on that or any of her medication. Obviously I was not aware what dosage was going in there until we have read things now. We were aware she was poorly and actually again did not know why syringe drivers were used, and felt that she
D was being cared for in the way she had peace at the end."

That is all Code A asked.

On your schedule the next witness is shown as Code A but I am actually going to switch the witnesses round a little bit. I am first of all going to read the statement of Code A Code A who is a nurse.
E

Code A is a flight sergeant and so we know where she was working, I expect. She made a statement dated 26 January 2005. She says:

STATEMENT OF Code A Read

"I qualified as a nurse in 1990 at the Arrowe Park School of Nursing, The Wirral after
F three years of training that was a mixture of study base and practical experience. I worked as a RGN, Registered General Nurse at RAF Ely, Cambridge, having left the National Health Service to join the Royal Air Force. I worked there for approximately eighteen months moving to RAF Wroughton, Wiltshire as a RGN, I stayed there for approximately 3½ years. I joined the Royal Haslar Hospital working initially in out patients in January 1996 for approximately two years. I then worked on E3 and E6 wards within the Haslar Hospital as a Staff Nurse. A Staff
G Nurse is exactly the same as RGN [Registered General Nurse]. In 1994 I was promoted within the Air Force to the rank of Sergeant.

In October 2000 I was posted to RAF Innsworth, Gloucester as a training developer. Developing medical training within the RAF. This was a desk job."

Then she deals with 2004, which perhaps I do not need to deal with.
H

A

"As a staff nurse as Haslar Hospital I would work day and nights shifts, 7.30am (0730) to 3.30pm (1530), 1230 pm and 9pm (2100) and 8pm (2000) to 8am (0800). E3 ward was a mixed orthopaedic ward with approximately 26 beds caring for a wide range of ages and orthopaedic conditions. The ward was usually full.

As a staff nurse [I] would be responsible for the nursing care of approximately six patients as the named nurse, dealing with those patients care plans, wound care,
B dispensing prescribed medication, monitoring of the patients condition and liaise closely with other health care professionals, ie the medical officer, physio, pharmacist. Whilst on duty I would also assist, oversee the care and treatment of the other patients on the ward.

The team on the ward would consist of at least two RGN/Staff Nurses, on a day shift normally four and approximately four healthcare assistants. These were unqualified
C nurses, at Haslar these were Army medics who had undergone some medical training within the Army both full time within the Army and full time within the hospital. There were also student nurses and or student medics that required training and supervision. It was also my responsibility to ensure that the medical records for each patient were accurate and up to date. As a staff nurse I would either fill in the medical record myself or countersign a healthcare assistants entry. I would also be responsible for the management of my staff, ie, welfare, leave and any other problem they may
D have.

My supervisor at that time would have been a military commissioned nursing officer who was in charge of the ward.

I have been asked to detail my involvement in the care and treatment of Code A I have no personal recollection of this patient but from referral to entries in her medical
E notes … I can state the following."

Can I now direct you to the various pages that she refers to in her statement. She uses different numbering but can I ask you to go to page 607.

While we have the files open, we have once again identified in one case a sheet that has not copied particularly well. It is not the one you are just about to look at, but when we dug out
F the original, the first part is in red ink and so it did not copy. We have done something to highlight that. May I therefore pass that to you – a copy of page 395. While you are doing that, there is a page that the next witness refers to that is not in your bundle at all. We have numbered that page 573a.

I go back to page 607:

G "I have been asked to detail my involvement in the care and treatment of Code A Code A … I can state the following…".

On the page that she calls 164, and you will see 164 in the large type, we see:

"…. on page 164 I have recorded in Code A s medical record on the 8th August 1998."

H

A In fact, if we go to the page before we shall see that the substantial entry on page 607 is indeed all part of August 1998.

Then the entry that she refers to is against the notation "PM". She says:

> "PM Attempts were made to nurse Code A on her side."

B That is in the top third of the page on page 607.

> "PM Attempts were made to nurse Code A on her side. Unable to tolerate this at all, much more comfortable sitting up in bed due to breathlessness. Eggenton bed now in situ. Pressure areas unchanged. Very poor fluid intake.

Just to remind the Panel, if I may, this is dealing with three days after her admission to
C accident and emergency for a broken hip. She says:

> "I believe by looking at Code A 's medical records that I was not the named nurse for Code A but I would have been assisting with the care and treatment of her. Code A Code A had had surgery on her hip three days previously, her left hip.
>
> I had attempted to move Code A onto her right or left side to alleviate pressure from
D her sacral area, the bony area just above the buttocks. This was to prevent further deterioration of the sacral area. The skin on her sacral was broken. Code A was unable to be nursed on either side as Code A wanted to sit up to aid her breathing, this could not be achieved as easily whilst she was on her side. Code A was able to breath easier whilst sitting up. An Eggenton bed is a special type of bed that makes a person easier to manage, due to the fact that the bed can be moved so you don't have to physically move the patient all the time. These are particularly useful for patients
E that spend a long time in bed and are susceptible to pressure sores. Pressure areas unchange, this would have been from the previous entry, I would have seen Code A Code A 's pressure areas, ie, heels, ankles and sacral to note that these were unchanged. Very poor fluid intake. Code A throughout the late shift had not drunk much fluid.
>
> I have then signed the entry."

F On page 164 she says – this is the same page:

> "9/8/98 … am"

so that is the next entry.

> "… full bed bath this morning. Seen by Code A IV fluids
G recommenced. Venflon patient initially, extravasated at 12145 hrs – to be resited. Fluid and diet intake remains minimal."

This entry carries on over the page, the 9 August continuing:

> "… vomited x 2 this morning, mobility improved. Walked around bed with zimmer frame and assistance. Sat out for one hour. Unable to tolerate nursed on side, always
H

rolls onto back. Hip dressing changes, less oozing from drain site, wound is satisfactory. For CSU this afternoon.

Code A had been given a full bed bath that morning. She had also been seen by Code A he was a Senior House Officer, this would have been during a daily ward round. Code A 's fluid intake and out put would have been reviewed by Code A and intravenous fluids, ie, a drip was set up. It would have been normal for a drip to be commenced after surgery this had been stopped previously hence 'recommenced'. That would have been because Code A 's output of fluid was greater than her input which could lead to dehydration. Venflon patient initially was a tube that should sit in the patients vein to allow the drip to enter the patients body. At 1215 the tube had come out of the vein allowing the fluids to enter the surrounding tissue, extravasated. As I was not qualified to resite the venflon I would have had to request the house officer to resite [it]. Patent means working. Fluid and diet intake remains minimal means what it says. Code A had vomited twice that morning but her mobility had improved. She had walked around her bed from one side to the other using a zimmer frame and the help of one or more staff, probably two. Unable to tolerate nursed on side, is as previously explained. She always rolled back onto her back. Her hip dressing was changed. A drain is put in place during surgery, it is a tube that allow blood fluid to drain from the wound. This prevents formation of a large bruise or swelling in the wound area. Code A s drain had been removed previously although it leaves a small hole, ie, drain site. By oozing I mean seeping of bloody fluids and it was less than previous. The wound would have been examined and found to be clean, dry and free from infection, ie, satisfactory. For CSU, catheter specimen a urine test to ascertain whether she had a urine infection or not. I may have requested this or the doctor Code A may have asked for it. It could have been asked for for a number of reasons, a routine check, because she had had a slightly raised temperature or because her urine output was low. I have then signed this entry.

I have also recorded on page 165" – so on the same page –

"AM All care given this morning. Area between buttocks remains moist and broken – cream applied. No further diarrhoea, seen by SHO, ECG perform, bloods and chest x-ray. Antibiotics changed to I/V as unable to swallow large tablets. Eat small amount of ice cream at lunch time. Urine output good. Ulcers need re-dressing today, both legs. IVI in progress 6 hourly.

All care [given] mean, oral care, washing, full bed bath and ensuring that Code A was comfortable and dealing with any requests. Area between buttocks is probably the same as the sacral area as before had been examined and found to be moist and broken. Moist is recorded as that is an indication of potential for infection, in the broken area. This would have been a hard area to manage as Code A was virtually bed ridden with diarrhoea. The cream applied would have been a barrier cream to protect the area as much as possible from breaking down any further. Code A was seen by the Senior House Officer who had requested investigations for her heart (ECG), bloods (blood test) and lungs x-ray. Her intake of antibiotics was changed to intravenously as she was unable to swallow large tablets. Code A ate a small amount of ice cream at lunch time that would have been less than a normal portion. Her urine output had improved and appropriate to her intake. Code A had leg ulcers

A

when she came to the hospital and they were due to be re-dressed that day according to the district nurse care plan. IVI is the fluid that is given intravenously, the fluid prescribed by the medical officer was to run over a six hour period. It is normally in a one litre bag. It would have been recorded on a fluid balance chart."

Then she turns to page 167 as she calls it, our 610, and it is the first entry at 19.30:

B

"Code A remains very sleepy. Doctors unable to recanulate after initial Venflon fell out. To encourage oral fluids. One x diarrhoea, small amount. Difficult to nurse on side ? change bed tomorrow.

I have recorded the fact that Code A remains very sleepy, I am unable to say why I have put 'remains' or the reason behind her sleepiness. Code A was on a drip the Venflon (tube) which fell out and the doctor was unable to put another one in

C

probably due to the fact that she had weak veins. Therefore we were to encourage oral fluids. She had had one small bout of diarrhoea. It was difficult to nurse on her side as previously. I have questioned the fact whether Code A required a different bed or not.

Also on page [for us 610] I have recorded."

D

12 [August], so it is the bottom entry which says 12 August AM –

"fair morning, full wash given. Sat out one hour. Bottom remains extremely red. New electro bed awaited. Fluids taken in reasonable amounts. Urine output satisfactory. Awaiting antibiotics change to oral.

This continues [on the following way]

E

... wound dressing left intact. No further oozing noticed. Ulcer dressing to be changed this afternoon.

PM Ulcers re-dressed as per district nursing plan. New bed arrived.

I have signed the initial AM entry but not the second part of the entry... but can

F

confirm that this is my writing.

Fair morning, indicates that Code A probably felt a bit better within herself. Full wash given, same as a bed bath. Sat out one hour. Code A would have sat out on a chair for one hour. There are benefits to Code A sitting out, i.e. mobility, she would have walked to the chair, circulation and as she is sitting up it would have benefited her breathing. But only for short periods as it would have been detrimental to her

G

pressure area (bottom). Code A 's pressure areas remained the same as previous. As there was no improvement a new type of bed was requested to nurse her on i.e. electro bed. Due to the fact that her fluid intake had improved and that she was not receiving I/V fluids Code A required oral instead of I/V antibiotics. Wound dressing left intact. The wound dressing would have been examined and found to be clean and dry with no requirement to change it. There was no further oozing from the drain site. I have then mentioned that her ulcers dressings needed to be changed in the afternoon.

H

I have carried on the entry PM and noted that the ulcers were re-dressed as per the

district nurse's care plan. I have also recorded the fact that Code A 's new bed arrived. I cannot now recall the benefits of an electro-bed.

On 18th August 1998... I wrote a transfer note..."

You will find that back on page 23 of the notes. She gives a sort of explanation for it. I am not sure how much explanation it actually reads but I will read what she says so that you have the evidence. She first of all sets out the heading. She says:

Code A was admitted by the accident and emergency department on 5 August 1998 following a fall at home. She was found to have fractured her left neck of femur and a left cemented hemiarthroplasty was performed later that day.

Post-operatively, Code A has had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload and oral intake and fluid output were monitored for the following few days, and this has now resolved, it appears.

Presently, Code A is slowly mobile with a Zimmer frame and supervision. She is able to wash her top half independently but requires help to wash her back and bottom. Prior to admission the district nurses had been attending weekly to dress bilateral leg ulcers, the notes of which are included. These were last dressed on Sunday and are usually re-dressed every 4-5 days.

Code A has a broken area on her left buttock and in the cleft of her buttocks. This area is improving and a dressing of kaltostat and opsite has been re-applied this morning. She has been nursed on an Eggerton mattress whilst here as she is unable to tolerate being nursed on her side.

The hip wound has a dry dressing in situ and steristrips have been applied following the removal of clips. These should be left in situ for approximately 7 days.

Code A has a small appetite and oral fluids need encouraging. She has a urinary catheter in situ which was inserted post-operatively. Code A did have diarrhoea post-operatively but this appears to have resolved and she does request when requiring the toilet.

She is usually lucid and only very occasionally seems confused at night.

Code A is aware of this transfer and should visit this afternoon.

Unfortunately, Code A usually wears a hearing aid in the left side which appears to have gone missing. We will conduct a full search today. Please contact E3 if there are any concerns. No follow up appointment is required."

She says:

"I have then signed the letter, printed my name and put my title, i.e. Staff Nurse."

A She explains:

> "The neck of the femur is the top of her leg bone, fracture indicates that it had a crack in it and it as not a full break. It would have been replaced by an artificially false one that would have been stuck into place."

I am not sure how accurate her description of the surgery on that would be.

B

> "After the operation (post-operatively) Code A made slow recovery, exacerbated (made worse) by bouts of angina (intermittent heart pain). These problems appeared to have been brought on (secondary) to fluid overload. Code A had an I/V infusion that was given too quickly post-operatively....."

That appeared to have resolved.

C

Really the rest is just explanation and I do not think we need it. In the last two paragraphs she says;

> " 'No follow up appointment is required' would have come from the orthopaedic consultant and this indicates to me that her orthopaedic problem, i.e. her hip did not require any further input from a surgical specialist. Her transfer to the Gosport War
D Memorial Hospital would have been to allow elderly medical intervention and rehabilitation."

She explains that Haslar Hospital at the time was a tri-services hospital and that members of the Navy, RAF and Army all worked there and its patients were both military and civilians.

That deals with her evidence. I was going to call, if the Panel are prepared to carry on, Code A
E Code A

Code A Before you do, Code A I appreciate we have only been in open session since 10.30 but the Panel has been working since 9.30, so we will take a 15-minute break now, and then launch straight into your next witness.

Code A: Can I confirm something with my solicitor? (Pause) Could I just take you to
F the end of the witness schedule dealing with Code A our very last witness, witness number 47? There is a note to say that he is not available on 1 July and I have suggested a reading day. Can I ask you to scrub that out? In fact, for anybody who was making plans for 1 July, he is now available on that day but I am told that he is not available on the afternoon of 30th. It may be that we will not start until 31st but that is a long way in the future.

Code A Anything can happen between now and then but I am encouraged to see
G that we are still very much on schedule.

Code A Also, witnesses 11 and 12 for tomorrow: we have been told by Code A s team that those witnesses can in fact now be read; that is Code A and Code A. I am very grateful for that.

Code A Our schedule is different. Witness 11 is Code A
H

A Code A I am sorry; it is 12 and 13, Code A and Code A and both can be read. We are not proposing to bring any witnesses forward or to rejig anything unless you wish to persuade us to do so. I think we will probably have enough to do tomorrow in any event.

I also gather there were one or two problems with the video-link this morning,

B Code A Yes. I understand that is not yet sorted. According to the schedule, you are also intending tomorrow to read Code A and Code A is expected to attend. Is that correct?

Code A Yes.

(The Panel adjourned for a short time)

C

Code A Can I mention that you have the bundle for Patient F. We have not formally given it an exhibit number. It should be C7.

(File marked C7 for Patient F)

D Code A Sworn

Examined by Code A

(Following introductions by Code A )

Code A Is your name Code A ?
A It is.

E

Q Are you still a Code A in the Royal Navy?
A No, I am a Code A in the Royal Navy

Q I want to ask you about the Royal Haslar. Is that where you were working at the time of these events?
F A The Royal Hospital Haslar, yes.

Q The Royal Hospital Haslar, we have heard is staffed from personnel from the services. Is that right?
A It was a mixed staffing of both Armed Forces staff and civilian staff.

Q If you are a member of the Armed Forces, you retain your rank at that hospital and we
G will see that through the notes. That also means you are working with civilian medical staff?
A That is correct.

Q The patients who were treated at that hospital, we have also heard there was a mixed grouping of military patients and civilian patients?
A That is correct.

H

Q Does that mean it was in part a hospital funded by the NHS and in part by the MOD. How did it work?
A My understanding, and I have never been party to the funding arrangements, is that there was an arrangement with the local NHS funding body that the Royal Hospital Haslar would treat, obviously, service patients and then it would treat a number of civilian patients. Beyond that number the NHS would then pay extra money, so there was a certain number of patients that were treated on a free basis and then beyond that number, patients were treated on a ---

Q What size hospital was it, did it have an Accident & Emergency Department?
A It did at the time, yes.

Q Does that mean it does not now?
A It does not, it is part of Portsmouth NHS Hospitals Trust at the moment.

Q Could you keep your voice up, this is a big room and with air conditioning.
A Sorry. It is currently part of Portsmouth NHS Hospitals Trust and it is where we currently do elective orthopaedics and some elective general surgery.

Q At the time of the events that we are considering, it had an Accident & Emergency Department?
A That is correct.

Q Presumably, also, it had trauma wards and intensive care?
A It certainly, at that time, had high dependency. I cannot remember whether at that time we still had intensive care, but we did at one point have intensive care.

Q The Gosport War Memorial Hospital, was that near by?
A Yes, it was relatively close.

Q How far is it from the Royal Haslar?
A Within two to three miles I would think.

Q Was there a regular transfer of patients between the two hospitals or was that a rarity?
A I think it was fairly regular, yes.

Q Did you do any work at the Gosport War Memorial Hospital?
A Not at that point, but I have subsequently.

Q But not at the time of the events that we are considering?
A No.

Q I want to ask you about a particular patient called Code A I know that you probably have not had to think about this patient for a little while, but you have had your statement given to you this morning in which you set out your dealings with the patient. You have also had the hospital notes made available to you?
A That is correct.

Q We know that this patient was admitted to the Royal Hospital Haslar following a fall at home and she had fractured the left neck of the femur. Is that the top of the femur where it comes into the hip socket?
A That is correct.

Q She had been admitted to your hospital as an emergency and I think she had undergone surgery the same day. You did not perform that operation?
A I was not involved with that operation.

Q She had what is described in the notes as a left cemented hemiarthroplasty. Can you tell us what that is?
A That is a common technique to treat certain types of hip factures where the broken part of the hip is removed and a metal half a hip replacement is inserted.

Q I think you came to deal with this patient for the first time on 10 August, so that is five days after her operation and about eight days before she goes off to the Gosport War Memorial Hospital. Can you take us through her notes and tell us generally what was happening with this patient. Would you turn to the notes to page 510. You will find lots of page numbers at the bottom, but the page numbers that we concentrate on are those with two lines either side. Do you see a note in your writing on this page?
A Yes.

Q Is that the one halfway down the page? Unfortunately, the date has been lopped off by the hole, but I think it is 10 August?
A Yes.

Q Is that your name on the left?
A It is.

Q Then "ATS". Is that, "Asked to see"?
A It is.

Q Can you take us through this note. You do not need to translate every single word of it, but give us a pen picture, if you would?
A This relates to a note that I put in the notes, having been asked to see the patient. I recorded that the patient was rousable and denied being in any pain.

Q Pause for a minute because people may be making notes to interpret your writing. Is it patient rousable?
A "Patient rousable, denies pain". "SOB" for shortness of breath and palpitations.

Q Does that mean a heart palpitation?
A Yes, irregular heart, and I recorded that further history was unobtainable.

Q Why would that be?
A I suspect because the patient was disorientated and not well.

Q Then we have "On Examination drowsy".
A "Clinically anaemic". "No JCCL" for jaundice, clubbing, cyanosis or lymphadenopathy.

Q That little zero sign is an indication of what follows is not there?
A Is not there. She was dry and apyrexial.

Q Which means no fever?
A No temperature.

Q No high temperature?
A I then went on to examine her cardiovascular system, which is the CVS, and recorded that her pulse was 90, regular but with ectopics. Her JVP, jugular venous pressure, seemed to be at a level within normal limits. She had a slightly thrusting apex beat to her heart and her blood pressure was recorded at 120/60. I listened to her heart sounds and heard 1 and 2 present but no added sounds. I then examined her respiratory system and noted that she was making poor expansion, but that it was equal on both sides. Her percussion note was resonant on both sides and there was moderate air entry on both sides. I did record there was evidence of inspiratory crepitations at the base on the left side. I then looked at her ECG and noted the presence of ectopics, sinus arrhythmia and ST elevation.

Q When you say you looked at her ECG, does that mean that you had an ECG printed report?
A No, I just had a print of the ECG.

Q Which would have been taken earlier?
A Yes. With ST elevation in B4 lead. I then went on to record what I thought my impression was at the time. I thought she was dehydrated, possibly had a chest infection and may have suffered a myocardial infarction, an MI.

Q You then write up your plan?
A I requested some haematology investigations, a full blood, urea and electrolytes, a CKMB, which is a creatinine cyanate isoenzyme chest X-ray, and cultures. I recorded the last set of Us and Es available to me at that point. I instigated a plan to give her some fluid, 1 litre of normal saline over six hours, and a plan of coming back and reviewing at a later date.

Q I think, unfortunately, and we may come to it later, something went wrong with that saline drip?
A It was changed. There is an entry in the notes to say it was changed.

Q I want to pause there for a moment. You had been asked to see this patient. Would you regard this as a full examination, a partial examination or what?
A I would regard this as an examination to try and work out what was wrong with the patient at that moment in time.

Q So you checked her pulse and her heart, you checked her respiration?
A Yes.

Q You made a note of your findings and you made a note of the plan?
A Yes.

Q As you set out.

A A Yes.

Q You said you asked for bloods to be taken?
A Yes.

Q Would you just look at the end of this. You signed this. What comes underneath your signature?
B A SHO. Senior house officer, "to Code A", who was the Code A Code A and 151 was my bleep number.

Q At this stage you were a senior house officer?
A Yes.

Q And your rank at that stage?
C A I was a Code A

Q Does your rank go with your seniority in the hospital world. Once you become a registrar, or specialist registrar as they are now called, do you go up a rank?
A To a certain extent, yes. It is not absolutely linked.

Q Would you take us on to your next note, overleaf?
D A This is a note dated 10 August, the same day, at 14.30 and this is when I returned to review the patient. My impression was that she was much improved and seemed alert, bright and orientated and was passing urine well.

Q Your concerns about dehydration appeared to have resolved?
A Yes, she seemed better.

E Q Underneath that?
A I have written "Bloods as over" because there were recorded blood results on the previous page. She had had her chest X-ray that I had had a look at and I felt it showed a left sided basal chest infection with no evidence of failure. I recorded she was on Augmentin 600 mgs tds, three times a day IV.

Q Is that simply to keep her blood pressure up?
F A No, no. Augmentin is an antibiotic.

Q Was that put in to deal with the chest infection?
A Yes.

Q Can you give us your plan?
A Continue with therapy, observe fluid balance over night as prone to go into failure and
G also I requested chest physio.

Q "Prone to go into failure" signifies what?
A That I felt she would be a patient who would be likely to develop heart failure if she had too much fluid put in intravenously.

Q So one has to watch the fluid balance?
H A It can be a problem with some patients.

Q The next review, I do not think that is you at the bottom?
A It is not, no.

Q Do you know who that is?
A That is Code A

Q Over the page, again, we have a fairly full note from you.
A This is a note dated the following day on the 11th, beginning with "Ward round SHO". I felt she was much improved, apyrexial with good urine output. I re-examined her chest; I felt there was good expansion equal on both sides; percussion note resonant was clear on both sides; there was good air entry on both sides; and I could detect no focal signs, so no evidence of any of the crepitations I had heard the previous day.

Q Is this a check that you have done by listening, palpating and using a stethoscope?
A Yes.

Q And you made a note of it?
A Yes, I recorded a plan to change her to oral Augmentin, so stop the intravenous antibiotic to encourage fluids, Ensures, which are build up drinks, to ask the dieticians to see her and to repeat the urea and electrolytes.

Q The fact that you are switching to oral Augmentin and Ensures seems to be an indication that she could take things orally quite reasonably?
A I think that would be reasonable at that point, yes.

Q Over the page, that first entry I do not think is yours, that is another review. We can see the urine output is down. A record is taken of the pulse and the blood pressure and we can see – I appreciate this is not you, but I would like to ask you to help us if you can - "Plan: to stop iv fluids." Then, is it 40mg of –
A Of "iv frusemide", it looks like.

Q And "something examination tomorrow"?
A It looks like a "chest X-ray tomorrow morning may be useful to confirm failure".

Q What is all this telling you when you came to do your ward round the next time?
A The previous night she had had an episode of left ventricular failure, which is what has been recorded in the notes, and that some treatment had been given at that time. The following day, on the 12th, it was a registrar ward round, so I was recording the registrar's observations of the patient rather than my own.

Q And just help us please with what you have written.
A I have written:

"Much improved has sat out today
Not in failure"

I have also recorded "no further diarrhoea", but there was some concern that she was developing a sacral bed sore. The urine and electrolytes were improving.

Q And the development of a sacral bed sore presumably can be a problem for an elderly person?
A Yes.

Q Who remains in a hospital bed?
A Yes.

Q What would you try and do to prevent that from getting worse?
A There are a number of measures that are taken to try and prevent bedsores. You can change the bed the patient is on, try and encourage them to be up and about more often than being sat on their bottom, or sat in bed. With the nursing staff being aware, they can try and take more care to prevent this getting any worse or developing.

Q Again, at the bottom, we can see – which may be related to your last comment:

"Plan mobilise & physio"

A Mobilise and physio, and encourage oral fluids.

Q So this is to try to get this lady out of bed, presumably?
A Yes.

Q Moving?
A The aim is always to try and get people as mobile as possible after a fractured neck of femur, so we try and encourage patients to mobilise.

Q And you wanted to encourage her to drink more orally?
A Yes.

Q And then, over the page, we see, "Stop Augmentin". Is that an inpatient where concerns over the infection have been resolved?
A I think so, yes.

Q "No..."?
A "No I.V. fluids."

Q I am sorry?
A "No I.V. fluids" – not intravenous fluids.

Q And "daily..."?
A "Daily U&Es".

Q Daily ---?
A Daily urea and electrolytes.

Q Then we can see underneath this – again this is not your writing, I do not think?
A No.

A Q But it is a request to Code A to assess this patient from the point of view of her future management. It reveals that she was admitted following a fall which resulted in a fracture. She underwent an operation.

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

B

Previously she lived in a ground floor house being visited twice weekly by the district nurse for the past 4 weeks or so."

I cannot read the next bit.

"She [something] physio [something] also visited her for the past 6 weeks or so.

C [Something] yours in anticipation."

So this is effectively a referral within the hospital system?
A Yes.

Q And did you know Code A ?
A Code A was a Code A geriatrician who used to visit the hospital, I am not sure how
D often, but she did not work there all the time but she visited during the week.

Q Then, underneath that, we see Code A did see the patient – I think on the same day as the referral, 13 August.

"Thank you. Frail 85 year old with

E

1) Cemented ...

Can you pronounce that word for me please?
A Hemiarthroplasty.

Q Thank you:

F

" ...hemiarthroplasty of hip
2) LBBB"

What is that?
A Left bundle branch block.

Q Is that left ventricular failure?
G A Yes.

Q Then just reading through:

"4) Dehydrated but improving."

Sorry – what is number 3? "Rich..."?
H A Sick Sinus Syndrome/AF – atrial fibrillation.

Q Then:

"4) Dehydrated but improving.
5) Bilateral buttock ulcers
6) Bilateral leg ulcers
7) Hypo --- "

What is that?
A Hypokalaemia.

Q Which is?
A Low potassium.

Q I can read "anaemia" but what is the first word?
A "Normochromic".

Q Indicating what sort of problem?
A This is getting a little bit out of my realm of expertise.

Q All right – and mine.

"9) Vomiting and diarrhoea"

Then:

"Suggest:

1) K+ supplements ..."

and then over the page:

"2) Hydrate orally"

Is number 3 "stools"?
A I think so, yes.

Q "... (if not sent already)". So she wants a check on what is happening with the bowels, presumably.

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

In fact, we see a note from you, I think. Is that "Thank you Code A "?
A Yes, it is – thanking Code A for her input, reporting the results of a stool sample which showed no evidence of growth, and recording that we had started the slow K potassium supplements.

Q Then is it your ward round next, on the 14th?

A A The following day it is ward round Code A - they are the Code A ward round and Code A

Q Which you are noting?
A Which I am recording.

Q Tell us what happened, please?
B A It recorded that the patient was well, had stood with frame and the plan was to mobilise and the Gosport War Memorial Hospital next week.

Q The next entry is not yours, I do not think?
A No.

Q Nor is that of 15 August?
C A No.

Q But can we just have a look, please, towards the bottom of this. Do we see an entry "Muscular skeletal pain"?
A Yes.

Q And then underneath that:
D

"Plan: 1) Analgesia codeine phosphate"

Can you tell us a little bit, please, about codeine phosphate? Is that something you can help us with?
A Codeine phosphate is an analgesic. It is quite a potent oral analgesic which is quite regularly used, both in hospital and out of hospital.
E

Q Can we go to 17 August, please. This, I think, is your note again?
A Yes. I recorded entry from a ward round taking place at 8.40. It recorded the patient was well; temperature was 37.3; no chest pain; mobilising slowly and awaiting transport to the Gosport War Memorial. The plan was to continue.

Q The next entry is yours as well?
F A Entered the next day at 9 o'clock.

Q Would you have examined the patient at this time or seen her and spoken to her?
A I would normally see and speak to her as part of the ward round and would examine a patient if there was a specific problem or concern.

Q Can you tell us about this note, please – tell us what you found?
G A On the 18th I recorded that the patient was well, comfortable and happy, and that the previous night she had had a single spike of temperature, up to 38.5. The temperature was now 37.3. She was mobilising well and the plan was for her to go the Gosport War Memorial today. The intravenous line was removed and the nasal oxygen that she had had was stopped.

Q All things are relative, I suppose. This was an elderly patient, of course, but can you tell us what you meant by "well, comfortable and happy"?
H

A I recorded that the patient did not seem to be in any distress, either physically or did not seem to be in any pain and seemed fairly normal for a patient of her age who had gone through a fractured hip and a hemiarthroplasty and her post-operative recovery.

Q If she had been exhibiting any pain, or mentioned any pain, would you have made a note of that?
A Yes.

B

Q If you just keep your finger where you are, page 519, and go back to page 461, which is the same – the day before in fact.
A Which page again?

Q 461. This is not your note – it is the physiotherapy note, but I just want to see if you can clear something up for us. First of all, 17 August 1998. In the bottom we can see\'

C

"Bright – sitting out in chair"

That, presumably, means out of her bed rather than outside?
A Yes.

Q Then "mobilise with supervision – managed well" and then, underneath that: "Patient
D discharged home safe and independent". She was not being discharged home.
A I think you would have to ask whoever entered that note.

Q Finally, I wanted to ask you about the drugs that she was on when she left your care. We may need your help. Would you go to 573a first of all, we can see in the box in the bottom right, date of discharge, transfer or death. In this case it is discharge and transfer, I suppose – 17 August 1998. Who would fill this?
E A That has been filled in by Code A who was the house officer on the firm at the time.

Q You tell us what this records?
A This is a discharge summary. It is a photocopy – there are usually three or four sheets of carbon paper that are designed to go with the patient, recording what medication they are on; a brief line about the diagnosis why they have been admitted at hospital, and then any
F other information. They are not the most communicative forms.

Q No. I can see that, but it should set out the drugs?
A Yes, it should.

Q Can you just take us through these, please. Allopurinol?
A This is a medication used for gout. Bumetanide, which I am afraid I cannot tell you
G what that is. Digoxin is a drug used to control irregular heart beats and Slow K, which is a potassium supplement.

Q Are any of those analgesics?
A No. Well, I am not sure exactly what bumetanide is, but I do not recognise bumetanide at all.

H Code A I think our medical member may be able to assist.

Code A Bumetanide is a diuretic. It is a substitute for the drug frusemide that was used earlier.

Code A Thank you very much indeed. That was helpful. May I comment, that there is no reason at all why the medical member should not assist at any stage if he recognises that we are having difficulty. I am sure neither side would object.

Code A That is very kind. Thank you.

Code A Could I then take you back to the rest of the drug records. Would you go back to page 569, please, this is going right back. I am not going to go through every drug and test your knowledge but 569, I think, is the drug record from this patient's admission on the 5th. If we go over the page, to page 570, again I just want to alight on any drugs which have an analgesic effect. These are always slightly difficult, frankly, to read. They have been slightly chopped off on the left. Let us see if we can make do with what we have. Can you tell us what these drugs are?

A No, to the first one. The second one, I think, is allopurinol. The third one is aspirin. The fourth one I suspect is bumetanide. The fifth one is digoxin.

Q Apart from the aspirin, as far as you know, did the others have any analgesic effect?

A No.

Q Over the page, please?

A We have diamorphine.

Q Just pause there for a moment. This is 5 August, so this is on the day of the accident, I think, on the day that the patient has broken her hip. We can see that she is given a dose, is it, of 3.5 to 5 mg?

A I do not know.

Q Intravenous. In this case, that would simply mean by injection, presumably?

A Yes.

Q Can you read the next entry down?

A The next entry is morphine. Then it is cyclizine, naloxone, coproxamol. I cannot tell you exactly what the next one is – I cannot read it. Then finally a lot of paracetamol.

Q So we can see of the analgesic drugs, but we can see diamorphine 2.5 mg seems to have been given on the 5th at 13h00. Can you read that?

A I see, yes.

Q Is that right?

A As far as I can tell, but I did not write this.

Q If you cannot read it, you cannot read it. You are in the same position as we are. Then underneath that morphine was prescribed but does not appear to have been given?

A There is a note in the bottom, in the "Directions" which suggests that this might have been part of a PCA, or patient controlled analgesic, because there is a PCA chart, although the first word before that is not legible.

A

Q Does that appear then to have been crossed through?
A Yes.

Q Then we go down to coproxamol and coproxamol appears to have been given on the 6th and the 7th and the 8th, I think?
A It looks like it was just the 6th and the 7th, and then crossed off on the 8th.

B

Q I see. Thank you. So given for two days and then paracetamol is given really on a daily basis. It looks about three times a day until 16 August and given orally?
A Yes.

Q Over the page, 572, I see this is "Drugs Postponed or not Administered". So we can see that temazepam was not administered because the patient was asleep. Then if we go to
C the following page, 573, we can see the Augmentin being prescribed that we spoke about earlier and we can see that temazepam was prescribed, and it is to be given at night, nocte. Is that right?
A That is correct.

Q It is 20mg temazepam. Can you tell us: does that seem to have been given?
A There are three signatures, suggesting that it has been given three times and then there
D are three crosses in the box, which can either mean that it was given and someone forgot to sign for it, or it was not given.

Q At the time that she was discharged, she does not appear to have been on any analgesics at all?
A Well, she was on the drug chart that analgesics were prescribed but she was not necessarily taking any when she was discharged.

E

Q And the journey between where she was at the Haslar and the Gosport War Memorial Hospital, who would that normally have been undertaken, do you know?
A I cannot tell you. I can speculate but I cannot tell you for sure.

Q Do not speculate. How long would it normally take?
A Again, I cannot give you a straight answer to that.

F

Cross-examined by Code A

Q Doctor, I am going to ask you questions on behalf of Code A Can I just take you to page 618? This shows codeine phosphate that you told us is a powerful painkiller?
A Yes, it is quite powerful.

G

Q It is not clear from the photocopy but that was certainly given in 16th, I think, the second of the two dates?
A It would certainly seem that way, yes.

Q The first one looks as if it could say 18th but that would be unlikely if the date below that ---
A I would agree with you.

H

Q Probably 15th then, the first date? Then further down obviously paracetamol.
A Yes.

Q Which was given on 17th and again, it would seem, on the morning of 18th?
A Yes.

Q The day of the transfer. Can I just ask you about the hip and what an operation of the type that this lady underwent actually involved?
A Yes.

Q The femur is the thigh bone and there is a ball at the top of it which fits into a socket in the hip?
A Yes.

Q And a fracture of the neck of the femur is where my wrist is or thereabouts?
A Roughly, yes.

Q A fracture there will involve an operation to remove the ball?
A It depends on degree of displacement. When you have an intracapsular fracture neck of femur, which is a fracture that occurs within the hip capsule in the neck, the treatment of it depends on the displacement of the fracture. If it is considered undisplaced, we will frequently try and fix the fracture.

Q Can we just understand the term? Undisplaced means that ---
A The ball is still where it should be.

Q I understand. If there is some displacement?
A Then it depends on the age of the patient. If you have a young patient, say a teenager or a young adult, you would still make an attempt to replace the natural head and then fix the fracture.

Q The head is the ball?
A The ball, sorry. If you have an older patient, then you get into the realm of replacing it in some form or another. If you have perhaps a patient in their sixties who is fit and active, then you might proceed to do a total hip replacement. If you have a more elderly patient, then you are likely to do a hemiarthroplasty.

Q Hemi means?
A Half, and arthroplasty, replacement, so half a hip replacement.

Q So that means replacing the ball or the neck?
A No, just the ball. What happens is the hemiarthroplasty has a stem that goes down the canal of the femur. If you have a fracture that extends into the extracapsular area, so down below the neck, then it is treated differently.

Q You are saying that sometimes there can be a fracture of the bone?
A Yes.

Q The thigh bone below the neck as well?
A That is correct.

Q Can you tell us where the fracture was here?
A Sorry. I do not understand the question.

Q With this patient, from what you have seen?
A This lady had an intracapsular fracture neck of femur.

Q So that involves the replacement of the ball?
A Yes, with a stem that is attached to the ball and the stem fits into the femoral canal.

Q Right. What needs to be done in the operation is they need to re-mount part of the femur?
A Not necessarily because some patients have very soft bone; you can actually just push down the implant without reaming out the femur. If the bone quality is a little bit better, you may need to use a rasp to create a space for the stem of the hemiarthroplasty.

Q You are joining the metal to the bone?
A Yes.

Q It is clear from the answer you have just given me that that can be done in different ways?
A That is correct.

Q You have made it clear that the age of the patient and the general fitness of the patient may be quite significant for the surgeons?
A That is true. Hip fractures are more common as people get older and it becomes a bigger operation for patients to go through as they get older and so, as patients get older and more frail, we try and limit the length of surgery that we put them through.

Q That is because older, frailer patients do not tolerate it as well as younger, fitter ones?
A That is correct.

Q Can I just ask you this? We hear of people getting a hip replacement as an elective piece of surgery?
A Yes.

Q The hip joint has worn away in various ways and so people may go in for a hip replacement which is elective rather than trauma?
A Yes.

Q Is the difference between the two important?
A It is. If you have an elective operation, it is a planned operation; it is an operation really at the choosing of the patient and of the surgeon. As surgeons, we try and select patients that will do well in operations and try and make sure any medical problems are fixed before the patient has an operation, to try and maximise the chance of them coming through the operation without anything going wrong. With trauma, that option is not there because the patient has perhaps had a fall and has broken the hip and the need for an operation becomes overriding and you do not necessarily have much time to fix any medical problems before you operate.

A Q If the patient has had a fall, the patient has had to undergo the trauma of the fall itself?
A Yes, and a lot of elderly patients are quite infirm and are prone to falling and unfortunately, as a result of that, these make up the majority of our fracture necks of femur patients.

Q Is it the case that sometimes patients have lain in pain after a fall, sometimes for some period of time before they are discovered or the alarm has been sounded and they are
B brought into hospital?
A Yes, absolutely.

Q Perhaps it is obvious but that of itself may contribute to the condition of the patient when you see them?
A Oh, yes.

C Q It is a major operation?
A It is a pretty big operation for patients of this age to go through, yes.

Q Patients of this age: you mean patients in their seventies and eighties?
A Yes.

Q Would it be fair to say that technically it is not a particularly complex operation and
D one can predict a very high success rate for the surgery?
A The technical side of the surgery is relatively easy to replicate. It is the getting the patient better after the operation that is the challenge.

Q It is a challenge. Tell us why?
A Because this is a big physiological stress for anybody to go through. You might have a patient who is 70 or 80 who is fit for day-to-day activities but if they fall and break their
E hip, having to go though the operation is a big stress for them. Unfortunately, complications occur after hip replacement surgery. There is an associated mortality with fracture necks of femur.

Q That is not because of the nature of the operation?
A No.

F Q It is because of the other issues – the age of the patient, their ability to recover from surgery which is significant, and the associated trauma?
A Yes.

Q Is it commonly the case that other issues to do with the patient's health arise? There is quite a high mortality rate?
A There is; 10 per cent of patient who have fracture necks of femur will die in hospital,
G and in the order of another 30 per cent will die over the next four to six months following the operation. It is only at about six months to a year that their age-related mortality returns to their normal cohort level.

Q I understand. If we were to chart the mortality shortly after the operation with patients as against their age, would there be much higher levels of mortality the older the age group?
H A Yes, you would expect mortality to go up with age.

Q Can I come to the set-up in Portsmouth and Gosport as it was in the mid-1990s? What we know is that the Royal Hospital Haslar had a surgical unit where you worked. Patients would be treated there and discharged after their period of treatment came to an end?
A Yes.

Q Some patients would be able to go home?
A Yes.

Q Some patients would not be well enough to go home and would need some continuing care?
A Yes.

Q Was the War Memorial Hospital one facility that was used commonly for post-surgical patients?
A Yes.

Q We have heard of the Queen Alexandra Hospital as well in Portsmouth. I do not know if you are able to tell us: was that dealing with their post-surgical patients in a similar way?
A Yes. The Queen Alexandra Hospital is the principal NHS hospital, still is, in Portsmouth. It had its own trauma admissions but sometimes at Haslar we would send patients over to the Queen Alexandra if there were things that we could not deal with, and then they would also have access to rehabilitation. I suppose step-down beds is the best way of describing them.

Q Step-down beds?
A Yes, the idea being that if someone is well enough to leave hospital but not well enough to go home or to a residential home, they might go to one of the War Memorial Hospital beds.

Q My question really was: are you able to confirm for us that both the Haslar Hospital, where you worked, and the Queen Alexandra Hospital were both sending postoperative patients to the War Memorial?
A My understanding is yes.

Q Can you tell us, so far as the Haslar was concerned, whether there were occasions when you worked there when there was considerable pressure on beds?
A There are always pressures on beds within the hospital network and there is a continual drive in the health service to get patients out of hospital as soon as they are able to cope with it.

Q On a surgical ward, if a patient has a fall and a fracture, if you can take a patient, you will?
A Yes.

Q But you will need a bed for the patient after the operation?
A Yes.

Q If you do not have free beds, you cannot take any more patients?

A A That is correct.

Q You cannot operate?
A No.

Q Because you cannot treat the patient after the operation has been carried out?
A Yes, that is true.

B

Q In order to be able to continue operating, there needs to be efficient transfer of patients away from the surgical unit?
A Yes.

Q But, as against that, there must be balanced the best interests of the patients?
A That is always the primary concern, of course.

C

Q Where was the pressure coming from? Were there consultants resisting pressure from managers?
A I do not think it is like that. I think there is a normal, steady flow of work through every hospital's doors every day but you get peaks and troughs, so you have some days when you are relatively busy and some days when you are relatively quieter. The capacity for slack in the system is not that great and that can mean you have some days when it is harder to get
D patients in than other days. I was not aware of any particular pressures over that period.

Q Can I talk about your days when you were at the Haslar? We have seen the records from page 509 onwards in relation to this patient. I should have started earlier on really, should I not? Can I take you to 503? These are notes I think all made by doctors?
A Yes, these are medical notes made by doctors.

E Q Can we just go through and it may be you can identify when the Sundays are.
A I will not be able to identify where the Sundays are without a calendar.

Q Let us just look at the first entry on page 503. This is what is written up as a ward round on 6 August by '[Code A]'. Can you remind us who [Code A] is?
A No, I am afraid I cannot.

F Q It is a house officer and you have told us her name [Code A] We can see that from the section.
A Yes. Could I just stop you there? [Code A] who is a house officer, has written the notes but her initials are not [Code A]

Q I know but she is clearly doing a ward round?
A Yes.

G

Q It is her again later the same day at the bottom of the page and over on the next page?
A Yes.

Q There is another doctor, a junior house officer, making the entries on page 505?
A Yes.

H

Q Apparently, still on 6 August at 2300 hours or thereabouts and then 2 o'clock in the morning that doctor is still there and able to attend to the patient again?
A Yes.

Q On the next day, 7 August, this is the surgeon, the Code A? That is his surname.
A That is right.

Q And the note clearly written up by the house officer and the house officer has been able to review that patient, if we turn to page 506, twice more on the same day after the ward round?
A Yes. It is obvious but there is 24-hour hand-over on that ward?
A Yes.

Q With doctors there 24 hours day?
A There is availability of doctors 24 hours a day, yes.

Q Can you just tell us the grades of doctor? We have seen a house officer. We have seen a junior house officer, JHO.
A Well, house officer and junior house officer were the same grade. There was then a senior house officer, a registrar and consultants. Those were the four grades within Haslar.

Q Let us go on to the next day, if we may, page 507, a review by a house officer, in the small hours after midnight?
A Yes.

Q On the 9th a review by you?
A No, that is Code A

Q Sees the patient, do you infer, twice that day?
A It would seem so. There are two signatures referring to two separate blocks of text.

Q If you turn to 509 another review by Code A and, it would seem, she goes back to the patient again, at the top of page 510.
A It may refer to the same entry – it may not be a separate entry, it may be an extension of the first entry.

Q After she has seen the patient after her review, you see the patient the same day?
A Yes.

Q After you have seen that patient, there is another entry for 10 August. Is that Code A?
A It is, yes.

Q He has a characteristic signature?
A He does.

Q After his involvement with the patient, that same day, the 10th, we have another entry by you in the afternoon?
A Yes.

Q On to the next day, the 11th, page 512 at the bottom, a review by the house officer and then a review on page 513 by you the same day, a ward round?
A Yes.

Q Another house officer's review the same day on page 514?
A Yes.

Q Then the registrar does a ward round the following day, 12 August. You cannot tell us when the Sunday is because there is cover there each day full time?
A Yes.

Q And there are doctors there all the time.
A There was.

Q At the time when you were doing a ward round, how many patients would you be seeing, roughly?
A I am sorry, I cannot remember how many we would see.

Q Ten, twenty?
A It would probably be in the order of 10 or 15, I would think.

Q If you did a ward round with the consultant, how long would that take?
A They would normally take about an hour.

Q If the registrar was doing one, a similar sort of length of time?
A It would obviously depend on the number of patients. The more patients to see, the longer it would take, but yes.

Q Obviously, if there is a ward round with the registrar, or ward round with the consultant, would there be two doctors there?
A Yes.

Q One of them can make the notes while the other one is undertaking the assessment of the patient?
A Yes.

Q That would be standard form.
A That is normal practice.

Q In those circumstances?
A Yes.

Q Dealing with this patient: she had a fracture, admitted to hospital on 5 August, she was discharged on the 18th, so 13 days later. She was carefully managed, I am sure you would say, from the notes we have looked at?
A We tried, yes.

Q Your suspicion was that this lady might have had a myocardial infarction?
A Yes.

Q Your note says that there were ectopic beats when you listened to her heart?
A Yes.

Q That is an irregular beat?
A Yes.

Q There is a cardiologist on the Panel and he will know.
A He will know better than I will.

Q He will. Staying with the same theme, despite the careful management of this patient and fluid levels, she still went into heart failure?
A Yes.

Q Again, I am sorry if this sounds like a viva, but "AF" is atrial fibrillation.
A Yes.

Q It is the heart not beating appropriately?
A Again, it has been a long time since I have had to deal with this regularly, but it is where there is a discontinuity between the control structure within the heart, such that you get irregular heart beats.

Q The sequence?
A Yes, the heart is not beating as efficiently because it is not beating regularly.

Q We have seen at page 512 an entry that you have made just above your signature, "Chest physio"?
A Yes.

Q Tell us why chest physio, or physiotherapy, with regard to the chest might be important in a patient of this type?
A Elderly patients who have had hip factures are prone to getting chest infections. Atelectasis after operations is quite common. It is not unusual for people to have problems making respiratory efforts, so chest physio is often quite helpful in improving patients' respiratory function.

Q You had physiotherapists in the hospital?
A Yes.

Q They were able to assist with the mobilisation of patients after an operation such as this one, and they were full-time staff who were able to give a lot of care to patients such as Mrs Lake?
A Normally physiotherapists will visit an acute ward on a daily basis.

Q They would help with the mobilisation as well as any issue about chest and concerns about conditions that might be contained because they are bed bound?
A Yes.

Q I am looking for the notes with regard to physiotherapy. It starts on page 459. I do not need to ask you the detail, but it is clear that the nurses were able to assist with this patient pretty much on a daily basis – sorry, the nurses, the physiotherapists?
A Yes.

Q There are entries for the 6th, 7th, 10th, 11th, 12th, 13th and 14th and then just before she is discharged?
A Yes.

Q What was your understanding in 1998, if you can help us, with the physiotherapy resources available at the War Memorial Hospital?
A I cannot answer that question.

Code A Thank you very much.

Re-examined by Code A

Q I have very little to ask. Would you go back to the page that Code A brought to your attention, page 618, which was the "as required" prescription which he quite properly spotted and asked you to deal with. Would you refer also to some of the nursing records to see what was going on with this patient. It looks like she was given, on 15 August, 30 mgs at 10.35 at night?
A The date is not clear, but she has been given that dose.

Q I agree with you. Then 16 August I think is pretty clear?
A Yes.

Q She is given another 30 mgs at 10 o'clock at night. The following day, 17 August, again at 8 o'clock in the evening, she is given a paracetamol and the following day in the morning she seems to have been given a paracetamol.
A Yes.

Q To see if we can glean more about those prescriptions, if we go back to page 611, I think these are forms that are presumably filled in by nurses. At the bottom, I am not going to go through it by any means, but we can see that she is seen at 07.00 hours on 14 August:

> Code A spent a comfortable night. She was turned frequently to rest her sacrum."

Over the page, there is a reference in the middle of the next entry on 14 August:

> "No chest pain. Waiting for transfer to GWMH."

15 August reveals this at 7 o'clock in the morning:

> "Code A had some pain due to arthritis in her left shoulder overnight. She had paracetamol as charted..."

"As charted" would mean?
A As prescribed.

A Q As required?
A As required.

Q

"...to good effect. She was frequently assisted to turn and move up the bed to make her more comfortable. She has been fully alert."

B And then, "Sat out in chair". At the bottom of the page, two up from the bottom:

"Complained of pain in left shoulder/chest on inspiration. $O_2$ remains in situ."

So she is complaining about her breathing?
A It says chest pain on inspiration, taking a breath.

C Q Over the page to the morning of the following day, 16 August, we can see that she had a restless night's sleep:

"Her left shoulder/chest pain increased at one point and an ECG was performed which shows no changes to her previous ECGs."

About five lines down, do we see she has also been prescribed codeine phosphate and that is,
D presumably, the prescription we were looking at that Code A brought to your attention, "for analgesia of her shoulder pain to good effect".
A Yes.

Q "To good effect", is that a description of?
A I would imagine that that means that, having given her the codeine phosphate, her shoulder pain improved.
E

Q It worked. I am not going all the way through it and if I miss anything, I am sure Code A Code A will signal or shout to me.

"17/8/98 07.00 – Ruby had a good night's sleep after settling late and frequently calling out. Taking good amounts of oral fluid."

F Over the patient, 20.15:

"Seemed confused this afternoon."

I cannot read the next words:

"Phone call from Gosport Memorial Hospital to move mané..."
G

meaning the following morning:

"...to Dryad Ward."

Then we can see, is it pyrexial?

H A It looks like "pyrexial at 38.8".

Q That is slightly above normal, is it?
A It is about a degree above normal.

Q We can see paracetamol was given. That again seems to reflect the note that we were looking at earlier on the drug chart.
A Yes.

Code A Thank you.

Code A: I indicated at an earlier stage that there would come a time when members of the Panel would have an opportunity to ask questions of you. I am going to canvas them now to see which, if any, do have questions. Our medical member, Code A Code A has questions for you.

Questioned by THE PANEL

Code A I wonder if you could help us with two simple things. First, a previous witness's read-out statement, a nurse, alluded to the fact that a fracture is not as bad as a break. Would you like to make a comment as an orthopaedic surgeon?
A A fracture is a technical word for a broken bone, so they are the same.

Q Thank you, I just thought an expert should say that. Secondly, if we wanted to, if we need to, on what kind of a piece of paper, on what kind of a document, would we find the PCA record or prescription?
A It seems to change quite regularly, but as I recall they used to be recorded on a dedicated PCA chart, so there would be a form that the anaesthetist would have. It varies from hospital to hospital and from time to time they change as well.

Q You saw this lady on the day of transfer to Gosport Memorial?
A Yes.

Q You made a note that she was bright and alert. The nursing notes indicate that she was mobilising with a Zimmer frame. The physiotherapist, the previous day, notes that, "She is able to go from sitting to standing without help", that she is independent, and the next day, perhaps mistakenly, indicating that she is going home and says that she is safe?
A Yes.

Q Notwithstanding that, we have a picture of a very elderly lady with medical problems, we have the picture, nevertheless, of a lady who has made a good recovery?
A I think she has made a reasonable recovery rather than a good recovery, because she has had a number of post operative problems but she seems to have got over them.

Q Who needs what next?
A It would be continuing physiotherapy input to try and increase her mobility, because being able to mobilise with a Zimmer frame is one thing, but if you are going to get home you need to get off a Zimmer frame and get on to crutches and that is quite a challenge for elderly patients. It is really a question at this point of continuing rehabilitation.

Q What would have been your expectation that would happen next as you wave bye-bye to her from Haslar?
A I would expect that she would gradually and slowly continue to improve, but there could be set backs and she certainly would not be out of the woods at that point because of this associated mortality with hip factures.

Q You would expect that active physiotherapy would be employed?
A I would expect that, yes.

Q As well as, possibly, some occupational therapy?
A If it was felt that she needed some, yes.

Q Preparing, hopefully, to go home or, if not home?
A Either to a residential home or to a nursing home depending on her level of function, but at her level of function when she was discharged, I would expect probably a residential rather than a nursing home.

Q I am asking you the next question. I am not asking you to make any judgment about what is next said, but I am exploring what your reaction is in terms of what might have happened in between. The next note is the admission note at Gosport Memorial, the same day. You told us it is two or three miles down the road, the same day that you saw her bright and cheerful. It says, "I would be happy if the nurses confirmed death", or words to that effect. If you had written that in the notes later on, on the 18th had she stayed at Haslar, why might you have written that, if that is not too much speculation?
A Well perhaps if she deteriorated medically and become unwell – I think it is a little bit speculative – I am not sure, but I would be a bit surprised if I wrote that the same day.

Q If she is in the same state in which you discharged her, effectively, do you find that a surprising entry into the notes?
A That quickly, yes.

Code A Thank you.

Code A If I may, I am just going to follow on that line of thinking just a little bit further. At the end of the bundle, you will see that there is a death certificate dated 21 August, so some three days after the transfer. You will see the cause of death is recorded as bronchopneumonia. Does that cause of death and that date in conjunction cause you any surprise, or is that something that might very possibly happen?
A I think it is possible because at one point in her care on the ward, I recorded that she had evidence of a chest infection. We had instigated treatment that she seemed to respond to, but at the time I was a relatively inexperienced senior house officer. This was my first senior house officer job and it may be that I felt the patient was improving and they were not, and I missed something. It is a little surprising to see it so quickly but in the overall context of this patient, it is not a complete surprise.

Code A That is very fair of you, doctor. Thank you very much indeed. Are there any questions arising out of those Panel questions?

Code A Yes, one or two.

Further cross-examined by Code A

Q The Panel has not heard why Code A may have written "I am happy for staff to confirm death", but would you go back to page 78 for me, please.
A Page 78?

Q Yes. That is where the line that has been read to us comes from. We see the two lines above it, where Code A has written:

"Get to know
Gentle rehabilitation"

A Yes, yes.

Q And underneath that she has written:

"I am happy for nursing staff to confirm death."

Can I ask you this. If a patient dies, is it necessary for a doctor to confirm death in ordinary circumstances?
A My understanding is no.

Q I will deal with that with another witness, but can I ask: what was your expectation so far as physiotherapy was concerned? You told us that this lady would need fairly intensive physiotherapy?
A No. I have said, I think, that she would need "more".

Q Did you know that the allocation of physiotherapists to the ward where this lady was going was about an hour a week for the whole ward?
A No.

Q I think what we have seen in the note from Code A who has accepted this patient, in the notes we were looking at, just to remind you, it starts at page 516. You have gone through quite a lot of it with Code A and we remind ourselves that it is a fairly long list of conditions that Code A is referring to there. She gets to nine, I think. Over the page, I think she gives suggestions and says:

"It is difficult to know how much she'll improve but I'll take her...".

A Yes.

Q Did you know that they did not have the facility to use intravenous lines or drips at the War Memorial Hospital?
A No.

Q This lady was on a drip before she was taken off it just before she was transferred away?
A She had an I.V. access that was removed before discharge, yes.

Q And if we go to page 519, she had been on oxygen. Is that right?

A A Yes.

Code A Thank you.

Code A, any questions arising out of those of the Panel?

Code A Yes, but not very many.

B

Further re-examined by Code A

Q She had an I.V. access. Was anything going through it?
A To the best of my knowledge, no.

Q Just going back to page 78, which you were shown, which is Code A s note, we do
C not know if there was an examination of the patient from that, or not. What would have happened to your notes, your hospital notes?
A I cannot answer that, I am afraid.

Q So when the patient transfers between your hospital and the Gosport War Memorial Hospital do you know what goes, or should go, with them?
A What should go is the flimsy that we saw earlier. Then, usually, a typed discharge
D summary should follow. At the time that was common practice but I have to say that typed discharge summaries from hospital are, at best, patchy to primary care.

Q The flimsy? I am sorry – that may be obvious to you.
A Sorry.

Q Code A knew what that is, but can you tell us please what the flimsy was?
E A That was the printed sheet that you asked me to look at. It is the one I said was a number of carbon copies.

Q It is the one we have put in.
A Yes.

Q It is page 573a, I think.
F A Yes, because one copy would go with the patient, one copy would be retained in the hospital notes and one copy would be posted to the patient's general practitioner.

Code A Thank you very much.

Code A, thank you very much indeed. That concludes your testimony. We are most grateful to you for coming to assist us today, and you are now free to
G go.

(The witness withdrew)

We will break now, ladies and gentlemen, and return at 2.15 please.

(Luncheon adjournment)

H

Code A Do you wish Code A to be called?

Code A Just before we do that, there is a bit of housekeeping. Code A asked a question just before the break about patient controlled anaesthesia and we have been through the original notes. We have managed to find a document that seems to be relevant to that issue, so can I pass another document, please. Can I say, we have most if not all of the original patient notes in many files in one of the rooms next door. If any member of the Panel at any stage feels that they would be assisted by looking at those original notes, they can be made available. We are not formally exhibiting them, as one perhaps would in a Crown Court, to make them available later on, but I hope there is agreement on both sides that if any member of the Panel wants to see anything, they can just call for the notes.

Code A That is very kind. The document just passed in has the number 155.

Code A We have not re-numbered it because I want to have a discussion with you, sir, about how we should do so. It may simply be easiest to put it right at the back before the death certificate, which would make it page 623. I did not want to be presumptive about that.

Code A That is very kind of you. That seems a very sensible solution. We will mark it as such. It will go in just before the death certificate and it will be marked as page 623. (Document marked and distributed)

Code A Just to identify it for the transcript, it is a document headed "Patient controlled analgesia prescription and nursing observations" for Code A and there is an entry for 5 August 1998.

Code A Thank you very much. Can I just say, we think there is a typographical error on it. Under the "Emergency protocols", number 3, we think it should be "crash call", not "cash call"! (Laughter)

Code A: May we call the next witness, please, Code A

Code A Affirmed

(Following introductions by the Code A

Examined by Code A

Q Is it Code A?
A Yes, it is.

Q Code A first of all, thank you very much for coming and also I am sorry for the delay, the wait that you had this morning, to come into the room to give evidence. Thank you for your patience. We want to ask you just a little bit about Code A and about what happened to her when she went into the Haslar Hospital after her accident, and also what happened to her at the Gosport War Memorial Hospital. To start with, I think it is fair to say that certainly there was nothing at the time, after Code A's death, that caused you any concern about her care at the Gosport War Memorial Hospital. Is that right?
A No, none whatsoever.

A Q I understand. Could you make sure you come forward a little bit to the microphone so everyone can here you. Thank you very much indeed. We have heard a statement read for Code A – is it Code A ?
A Yes.

Q I am not going to go into Code A 's background, as it were and her marriage and her children, but you were one of Code A and I think you kept in touch with Code A and
B would see her fairly regularly. Is that right?
A Yes, about twice a month; sometimes more, just depending.

Q We know that in August, actually on 5 August 1998, she had an accident at home.
A Yes. She fell.

Q She fell over and she fractured her left hip, did she not?
C A Yes.

Q Up until that point, up until that day in her life, just tell us a little bit about 1998 when you had been to see her, what sort of state of health had she been in?
A Beforehand you mean? Oh, quite fit really. She had had a heart attack back in 1980. She suffered from arthritis but she managed to look after herself, do most of the housework. She could not walk very far but she had some very good friends who used to take her here,
D there and wherever she wanted to go and she was quite active really.

Q When she did walk, did she need to use her sticks?
A Yes, she used a stick.

Q A stick?
A One stick.
E

Q But she could look after herself. Was she living on her own?
A Yes, but she lived downstairs

Q So far as her mind was concerned, was she alert?
A Yes. She always wanted to know what was going on and what Code A and everybody else was doing, yes.
F

Q Then we know that she had her fall and she was taken in as an emergency to the Royal Haslar Hospital and I think you went to see Code A fairly shortly after she was admitted.
A Not until the weekend.

Q So was that a few days afterwards?
G A Yes. I think it actually happened on the Wednesday and we went down on the Sunday, I think, if I remember rightly.

Q When you saw Code A at the hospital, what sort of state was she in?
A She really did not want to know us that day. We also took her very best friend with us and really she did not want to know any of us.

H Q You mean not talking to you?

A A Not really, no, not a bit interested in anything really.

Q Did you see her again before she moved?
A We saw her again a week later when she suddenly said, "Oh, you can take me out". I said, "Don't be silly. What do you mean?" She said, "Oh, no, you can push me round the grounds". Well, it was a beautiful summer's day and we took her out on to the seafront at Gosport and she seemed quite bright.

B

Q How did you get her out of the hospital? Was that in a wheelchair?
A She was in a wheelchair, yes.

Q So when you had seen her on the weekend after the accident, she was not in a happy state – the weekend after?
A She was happier and more alert but then the next day again when Code A saw her, I C do to think she even spoke to her that day.

Q Before she had moved to the Gosport War Memorial Hospital, which we know happened on 18 August, she was reviewed on 17th and transferred on 18th, when had you last seen Code A before her transfer?
A On the Sunday.

D Q That you have just spoken about?
A Yes.

Q Did you live in the Gosport are?
A No, no. We lived in Northampton.

Q So you had quite a journey?
E A Yes.

Q Did you get down to see Code A at the Gosport War Memorial Hospital once she had transferred there?
A Not until the Thursday, the Code A

Q Did you go there on your own or with anybody?
F A No, with Code A and Code A and I think also Code A Code A was there as well that day.

Q We know that she died on Code A
A Yes, she did.

Q What sort of state was she in when you saw her on 20th?
G A She was unconscious and really I do not think she knew we were there.

Q Can you remember if she was on a ward or in a single room?
A No, she was in a single room.

Q So you all went in together and you went in to her room?
A Yes.

H

A Q Did you try and speak to her?
A Yes, but there was nothing. She did not speak back to us at all.

Q Did you have any understanding then why she was not conscious?
A No, I do not think we did actually. Code A had rung me the night before and said Mum was not well, she had had a phone call, "Are you coming down?" so down we went.

B Q Did you know at that time that Code A was on a syringe driver?
A I think we were conscious of it, yes, but I never saw any nursing staff, so I was never actually told but I think we just assumed that she was on a syringe driver.

Q How long were you in the room with her for?
A On Thursday?

C Q Yes?
A Probably from about lunch time until tea time and then again on Code A most of the day.

Q That was the day of her death?
A Yes.

D Q On the day that you first went down, did you see nursing staff at all?
A Not to speak to, no; they just came in perhaps and just made sure she was comfortable.

Q Did anybody speak to you about Code A being on a syringe driver?
A Not to me, no.

E Q Were you with Code A for a while the following day as well?
A Yes, we were.

Q Did you meet Code A at any stage?
A No, I did not.

Q Code A 's death was recorded at 6.25 in the evening. Were you present when she
F died?
A Yes. Well, yes, more or less. Four of us had gone out of the room and got called back quickly and she just passed away very peacefully at that point.

Cross-examined by Code A

Q Hello, Code A
G A Hello, Code A

Q You were at the inquest, I think, pretty much throughout?
A I was.

Q You were present I think when Code A , gave evidence?
A Yes.
H

Q But you did not?
A I did not, no.

Q I think we heard from Code A I do not want to ask you what he said but the Panel have seen a transcript of what was said when Code A was giving evidence and his name was mentioned by the Coroner. I just want to clarify that with you. He was an expert who was called to assist the jury. He had not dealt with any of the patients.
A No.

Q But had just written reports about them and was giving evidence within the inquest?
A Yes.

Q So you saw Code A give evidence and heard what she said. Can I just ask you a few things about what she said? In her statement she said that Code A, before her fall in August 1998, was fit and healthy for her age?
A Yes.

Q And you have pretty much confirmed that?
A Yes, she was.

Q And that after her fall when she broke her hip, there was quite a deterioration?
A A very great deterioration.

Q We know that when she was at the Royal Hospital Haslar there are records to show that she was mobilised using a Zimmer frame?
A Yes.

Q But Code A never saw that?
A No, she did not.

Q Did you see that?
A No, I did not.

Q From Code A s perspective, what she saw, Code A never got out of bed again?
A That is correct.

Q Was that the same for you – you did not see her mobilised at all?
A Only the day that --- In fact, I cannot even remember whether she was already sitting on a chair the day we took her out or not. I think she probably was and then I think they put her straight back to bed when we got back again.

Q We know that she was transferred from the Haslar Hospital 13 days or so after she had been admitted. She had a fall on 5th; she was transferred to the War Memorial Hospital on 18 August; and we heard Code A s statement said that she did not think that Code A Code A was well enough to be transferred?
A Yes, that is right.

Q Do you have a view on that?
A Not really because I had not seen her. She saw her every day virtually but I knew she questioned it at Haslar, yes.

Q You have told us that Code A was taken out in a wheelchair?
A Yes.

Q Was that when she was still at the Haslar?
A Yes, it was.

Q How was she after that?
A Awful; she did not speak to Code A again and the next day she had gone right back again.

Q So she had brightened for a day?
A Yes.

Q Are you able to tell us roughly when in the sequence that was? Was that towards the end of her period at the Haslar?
A Yes, two days before she was transferred.

Q I understand. After the transfer to the War Memorial Hospital, Code A was well cared for?
A Yes, yes.

Q You had no concerns at all about the nursing staff?
A No, not at all.

Q You thought that the nursing staff were attentive?
A We felt they did everything that they had to do, yes.

Q You said in your statement that the nursing staff were attentive and trying to make her comfortable, meaning Code A ?
A Yes.

Q You did not think anything was being done that should not have been done or likewise nothing was not being done that should have been?
A That is correct.

Q What did the atmosphere on the ward seem so far as you were able to judge it?
A We basically only went into the one room. We were not there long enough really.

Q I know but you have told us that you thought she was on a syringe driver?
A Yes.

Q And that diamorphine was given to Code A ?
A Well, I would assume that because I knew that was what they put in a syringe driver.

Q I do not want to take any advantage over you. I just want to read a line from your statement, which I do not have a copy of to give you. Let me highlight it in yellow and give you this document. (Shown to witness) That is a stement that you made in July 2005?
A That is right.

Q You say, and I have highlighted one sentence: "Do you think Code A was on a syringe driver and was being given diamorphine?"
A Yes.

Q That was your understanding?
A Yes.

Q You were a medical secretary when you wrote that statement.
A I still am.

Q So you have some experience of medical settings and treatment for patients?
A Yes, I do.

Q I think you were clearly saddened by the speed of Code A s decline and her death?
A Yes.

Q But you understand that elderly patients, if they have a fracture, can go downhill pretty quickly?
A Yes, and that is through having worked with orthopaedic surgeons and anaesthetists.

Q You did not make any complaint about the hospital or any of the staff there?
A No, I did not.

Q It was not you that had asked for a case to be heard at the General Medical Council in relation to this case?
A No, it was not.

Questioned by THE PANEL

Code A We have reached the point already when it is open to members of the Panel to ask questions of you and I will look now to see whether any of them do have questions. Code A is a lay member of the Panel.

Code A from your statement, Code A was actually on the syringe driver and was having diamorphine. Did you understand why or did you inquire why?
A No, because I knew that they were used for people who were not very well, for pain relief. No, I did not ask. I did not ever see a member of staff.

Q You did not see a member of staff and so you were happy to accept that they knew what they were doing?
A Yes, we were.

Code A That concludes the questions from the Panel. Code A is there anything out of the question just asked?

Code A No.

Code A No.

Code A That completes your testimony. Thank you very much indeed for coming to assist us today. You are free to go.

(The witness withdrew)

Code A Sir, that is all the evidence that we have for you today. It is our first early day, except that we can provide you, I hope, with bundles for Patient K in five minutes. We are moving on tomorrow morning to Code A, all being well with the video-link.

Code A There is one other matter to raise. I understand there is going to be a short application in respect of the use of the video-link tomorrow. I do not think it is disputed but I understood there was going to be an application.

Code A I prefaced it yesterday and got the indication that because it was not being objected to, I did not have to make the formal application. I do make the application formally. The Panel has power to receive evidence by way of video-link where it is necessary to do so. It is very often done, as you know. I am afraid I have not prepared a skeleton in light of the fact that I thought it was agreed that we could do it.

Code A May I confirm that there is no difficulty so far as we are concerned.

Code A I am grateful for the indication from both of you. I think that our Code A Code A does wish to give us certain advice. I am not sure that it is necessary for us to receive anything more than the indications we have already had from you.

Code A I am sure that is right. The Panel has to be satisfied it is in the interests of the efficient or effective administration of justice that there is some concern to give evidence in the proceedings through a live link. Given that all parties are agreeable that this may happen, the Panel may well be satisfied that the test is satisfied. I advise the Panel that it should formally determine the matter now, but it may not take very long.

Code A, it is correct, is it not, that the reason that the video link application has been made is because the witness concerned is out of the country and would not otherwise be available to give evidence?

Code A It would be possible, I think, to fly her back at the very end of these proceedings if that was thought necessary. Obviously we would much prefer, in order to keep these proceedings in order so that you follow these events more easily, as far as possible to call the relatives of patients at the time that we are dealing with that patient's case. That is why we have brought the case of Patient K, Code A further forward, as you will see, so that we can call this witness at this time. As I say, it is not impossible that she could be called. It would be extremely expensive and her evidence I do not think will suffer from being video-linked. Although we are video-linking from Kuala Lumpur, she is actually making a special journey from a remote part of Malaysia in order to give evidence from Kuala Lumpur, and so the witness has made efforts to assist the Panel as much as possible.

Code A I am grateful. Members of the Panel, do any of you wish to retire to consider so far as the application is concerned? For the record, I have taken swift, non-verbal soundings from members of the Panel. They do not wish to retire and they are content for the

application to be approved and agreed. It is on the basis that it would be administratively convenient to have the video-link rather than have the disruption and expense of having this witness called in at a much later stage in the proceedings. We are satisfied that there would be no prejudice to the defence in the light of the acceptance by the defence that this should happen. We are satisfied also that it would be a fair and appropriate way to proceed and we will therefore proceed in that manner. Thank you.

Code A: I am very grateful for that indication. May I just mention in relation to the video-link, and I just wanted to check with my instructing solicitor, that I believe that it has been booked between 10 and 12.30 tomorrow. I see that the Panel Secretary does not know either. Can we pass a message to the Panel Secretary when it has been confirmed what time it is booked for? We would hope to use the room, I suspect, from 9 o'clock onwards to see if we can get it working better than what it was this morning.

Code A: I understand that, in any event, the test itself is booked for 8 to 8.30 tomorrow. Assuming that that goes well, then everything is put on stand-by until the time the appointment is booked. If you say that is 10 o'clock, then that would clearly be the time we would wish to crank up the machine as it were.

Code A: Can I bring you up to date on the witness list. I have indicated we are not going to call live Code A or Code A They are going to be read. We are also now going to be able to read the statement of Code A, the defence having kindly indicated they do not want her and, having reviewed the position, we do not need her either so she will be read to you.

Code A: That is helpful.

Code A: The only live witness we will have tomorrow is Code A

Code A: May I suggest we start at the normal time and commence with reading until we get to 10 o'clock and wherever we have got, we stop there, do the live and then continue.

Code A: Yes.

Code A: On that basis, if the Patient K bundle is going to be available, the Panel will take the opportunity today to take that on board so we are ready for a clean start at 9.30 tomorrow.

Code A: I think we are just inserting the new replacement pages now and we will have five or so copies ready very shortly.

Code A: We will formally adjourn now. I am sorry, Code A?

Code A: It is unusual for me to actually turn the microphone on, but I was going to rise to say this, purely by way of a comment. The Panel will have noticed that so far, for good or for bad, my learned friend, Code A has done most of the cross-examination. There is a reason behind this with regard to all these witnesses.

Code A: I thought it was leader's prerogative!

A

Code A It is not me being lazy, is what I am trying to get across, but it may have caused some notice. The main reason for a number of these witnesses, not all of them, is that Code A appeared at the inquest and has already cross-examined them. It seemed to me to be appropriate, subject---

Code A We gathered that was the likely explanation.

B

Code A I will be on my feet at later stages in the case.

Code A We look forward to that. We will formally adjourn until 9.30 tomorrow, but the Panel will remain to do some preparatory reading.

(The Parties were released and the Panel later adjourned until 9.30am on Friday 12 June 2009)

C

D

E

F

G

H

**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Friday 12 June 2009

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

Chairman:

Panel Members: Code A

Legal Assessor:

CASE OF:

Code A

(DAY FIVE)

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)

# INDEX

Code A

A Code A Good morning everybody. While we are waiting perhaps I could deal with exhibit numbers. Code A we received from you yesterday the Patient K bundle but we did not assign it an exhibit number.

Code A I would ask that you call it C12. (Bundle marked C12)

B Code A We have also received today, Code A, a number of replacement pages for the Patient K bundle, and those have been placed in the Patient K bundle, C12.

Code A Affirmed
Examined by Code A

(Following introductions by Code A)

C Code A Good morning. Good afternoon to you. I think it is probably about quarter to five there, is it?
A That is right.

Q Thank you very much for joining us. It is Code A, is that right?
A That is correct.

D Q If at any stage you cannot hear me or you need me to repeat a question, would you just say so?
A I will.

Q I want to ask you, please, about Code A I want to ask you a little about her life and what happened to her once she got ill. She was born, I think, on Code A Code A. Is that right?
E A That is correct.

Q She was one of five children.
A That is right.

Q Code A Is that right?
A That is correct.
F

Q Did Code A live for a while in the Gosport area?
A They did.

Q Tell us a bit about Code A's work. What did she do during her life?
A She left school at 14 and she went into service. She cleaned the house and helped in the kitchen and it soon became apparent that she had a talent for cooking and most of her life
G then she pursued that. She worked for Captains in the Navy, caring for them, looking after their entertaining, and she also worked for an Admiral. Much later on in her life, she then took up working for the experimental works at Haslar. She cleaned, I think, ten offices there, just in the morning, looking after the various scientists individually and their team.

Q There is something I should have asked you right at the beginning. Is there anybody else in the room with you, first of all?
H A Yes, Code A

Q Is there anybody else in the room?
A No.

Q Okay. It is very important while you are giving evidence that you do not speak to Code A
A No. You can see me.

Q It is just that we cannot see Code A
A I know. I understand that. He is here with me. Is that okay, or would you prefer it if he went outside?

Q I am content with that. I do not know if there is any objection. Make sure, obviously, that you do not speak to him while you are giving evidence. Also, do you have any notes in front of you at the moment?
A No, nothing.

Q It is just that you are looking down at the table, and because we cannot see the whole table ---
A Maybe I should put this piece of paper aside.

Q All right. I think Code A retired from work when she was 60. Is that right?
A That is correct.

Q Code A died, I think, in 1979.
A Yes.

Q Was that of cancer?
A That is right.

Q Where did Code A continue to live after Code A s death?
A She continued to live in the house that they were renting. About six months later – I was living in Asia – I came home for Code A s ill health for six weeks, and then I returned back to Asia. We came home again December time and we persuaded Code A to come and live with us. She was living in the Gosport area and we were living in Alverstoke, and we persuaded her to sell up, cut down and come and live with us.

Q That was in the UK.
A In the UK.

Q So you moved back to the UK, did you, from Asia?
A No, I did not. We came home for a long leave for five months, five months' leave. My husband used to get five months' leave every three years. It just coincided at that time.

Q Were you working at this time?
A I was working in Asia.

Q Your occupation?
A I was working for myself. I was freelancing.

Q I want to ask you a little bit about Code A s health and, if we can, deal with the 1990s. First of all, did she suffer from hypothyroidism?
A I think much later on she did, yes.

Q I think she dealt with that by taking thyroxin, is that right?
A That is right, yes.

Q What was her sight like?
A She wore glasses for a number of years, but we saw her sight was deteriorating and much later she kept tripping – tripping up over silly little things. I happened to be over on leave again and Code A had mentioned this to me also and we decided to get her eyes rechecked out. She did not seem to bother too much with it herself, in the fact that, you know, "Oh, I've got my glasses," and I said, "I don't think you can see very well, Code A" so she went and she had cataracts. One of them we wanted done pretty quickly – because there was a great length of time under the NHS – so we paid for her to have them done privately, and then the other one she had done about six months later under the NHS.

Q After that, what was her sight like?
A Her sight was perfect. In fact, I remember that when they took the patch off of her after the first operation she was, you know, quite shocked – it was like, "Ooh!" – it was so bright.

Q I am sorry, I am going to cut you short, because we have a limited time and I want to concentrate on what is important. What about her hearing. How was her hearing?
A Her hearing was very bad. She had bad hearing for a number of years.

Q I want to turn, please, to the late 1990s, particularly February 1999, when I think you received a call. Where were you living at that time?
A I was living in Brunei.

Q Where was Code A living?
A We had moved house from Alverstoke and we were living in Fareham. She was living with us there in the family home.

Q You have referred to "we" on a number of occasions. Is Code A called Code A
A Yes.

Q Did you also have Code A ?
A That is right.

Q Is that Code A ?
A Yes.

Q To give us a pen picture in February 1999, when you were living in Brunei and you received this call, how old would Code A have been approximately?
A Code A was born in 1971 and Code A was born in 1976. Code A was not living at home then, he was working. He was also working in Asia, he is hotelier.

Q So they were in their twenties?
A Yes.

A Q Can you tell us about February 1999; did you receive a call from Code A Code A

A Yes, that is right. She was living at home working in Southampton and we always spoke regularly. Every Sunday it was a ritual that Code A sat down at 9 o'clock in the morning and waited for our call. It was the only free day for Code A if she was home and the only free day for Code A too because the rest of the week was busy.

B Q Can you tell us about the call you received?

A Code A telephoned to say that she was taking Code A to the hospital because of her fluid retention and she was having various blood tests. She phoned to say that Code A Code A had been diagnosed with multiple myeloma. At that time I did not know what it was, but she said that she did not know either because the doctor had not been particularly helpful. She checked it out on the Internet and it was a form of bone cancer.

C Q As a result of that telephone call, did you make arrangements to come back to the United Kingdom?

A I did, because we had been thinking about it for quite a long time. We actually planned to sell up and go and live in Spain and my mother was coming with us. I said to her, "I am definitely coming home if Code A is that sick".

Q It took you a little while to make the arrangements, but did you return?

D A Yes, I was working for somebody then, and of course I had to give my notice in.

Q Did you make arrangements and did you return to the United Kingdom in April of that year, 1999?

A Yes, I did and all our furnishings came with us, everything.

Q I am trying to get you to stop adding on. I will ask you everything I hope that is

E relevant, but I am going to try and cut you down a little bit. If there is something you are burning to say, I will not stop you saying it. Code A came under the care of a lady called Code A Is that right?

A That is right, yes.

Q Did you go with Code A to see Code A ?

A I did.

F

Q After a number of tests, you had what you took to be fairly good news, and that was that after blood tests and also a skeletal survey, and for the purpose of the Panel it is page 75, which is a letter from Code A where she said in relation to Code A that she had something called nephrotic syndrome which is a loss of protein in the urine, but she said,

> "There has been no other evidence to suggest multiple myeloma and the skeletal

G survey showed generalised osteoporosis which, although present in some cases of myeloma, is most likely due to her age".

At that stage, was your understanding that Code A did not have or there was insufficient evidence to show that she had myeloma?

A That is correct.

H

Q That was a very long question. Was that how you ended up after those various tests and visits to Code A ?
A That is right.

Code A For the Panel's reference, at page 65 there is a further letter dated 2 June. (To the witness): She again said:

"There is insufficient evidence for a diagnosis of myeloma or lymphoma".

Code A had problems with her kidneys. Is that right?
A That is right.

Q She was referred to a renal clinic at St Mary's. Is that right?
A Yes.

Q Code A went along to that clinic from May through to July. I want to turn to your own personal circumstances, very briefly, because it affected what happened later in relation to Code A Again, I am going to try to avoid upsetting you, and I understand that discussion of these topics can sometimes be upsetting. In June 1999, was Code A diagnosed as suffering from something called [redacted] ?
A That is right.

Q That is a [redacted] Is that right?
A That is right.

Q That must have been an extremely turbulent time in your life.
A That is correct.

Q Can you tell us how Code A was at this; time how was she with you?
A She was fantastic. She was my rock I suppose really because we used to sit and talk all day every day and I was just a complete mess. Code A would say, "You have to pull yourself together" and I said, "I am trying". I would keep my dressing gown on; I could not be bothered to get dressed, and my whole world fell apart. Code A was there for me because Code A just got on with the rest of his life. He did not want to know all the bad things about Code A He was just going to deal with it as time went on. He did not want to dwell on it.

Q Code A was fairly mentally strong about it; is that fair?
A He was, and I think it shows in his medical file.

Q Code A at this time was mentally strong.
A Very mentally strong. She would say, "Come on, what are we having for lunch, let me do the potatoes" or "Let me do the carrots."

Q One of the reasons I ask you that is in June 1999, did Code A have all her marbles, if you will forgive the expression?
A Most definitely.

A Q I want to turn to slightly later in the year to Friday 8 October. The next day, which was a Saturday, you were meant to be going down to London for a bit of a family trip.
A That is right.

Q Do you remember that?
A Yes I do, very much so.

B Q Can you tell us about what happened with Code A around this time?
A I had spoken to Code A because of the trauma within the family with Code A I did not want Code A left alone. Although Code A loved Code A and we were exceptionally close, we did not get on with Code A through no fault of ours. I said to Code A perhaps he could have Code A for the Saturday because we would be back early on Sunday morning and he said, "I think it would be a problem". It transpired it was a problem. Code A Code A used to come on a Friday evening, but this particular Friday evening he was not
C coming because he was collecting Code A on the Saturday, but Code A was not herself so I called him up was because I was concerned. He came up on his own without Code A for the first time and went in and had a chat with Code A He said, "I do not see anything wrong with her". I said, "She is not herself, Code A there is something wrong". He said, "No, no".

About 10 o'clock that night I called him again. I said, "I do not think I will be going tomorrow, Code A you will have to come up again because I really want your help". He came
D up again and this time Code A came and there was a family argument. She said that they were not having Code A because it was planned to have Code A while we went to Hammersmith.

Q I am sorry to cut you off, but the long and short of it was that there was a family argument and you decided to stay where you were and not go down to London the next day. Is that right?
E A Yes, that is right.

Q The next morning when you came down to breakfast, what did you find?
A Code A was not up and normally I would hear her moving around. When I opened the kitchen door, there were biscuits all over the floor and there were three or four cups of tea poured. I was shocked. I rushed upstairs and Code A was in bed asleep and I left her there. I went in and told Code A and they said, "Oh God". I went
F down and cleared it up I said, "I do not know what has gone on, it must have been Code A in the night." A little bit later I went upstairs to Code A s bedroom again, took her a cup of tea and woke her up. It was at that point when I said to her, "Have you had a bit of a tea party in the night, the kitchen is in a bad mess?" and she said, "Yes, I have" and she made a comment about Code A

Q Did you realise things were not quite right?
G A They were not quite right. Obviously it was something that had been brewing the day before.

Q As a result of that, you called the doctor.
A Yes, I did.

Q The doctor came out to see Code A ; that was Code A
H A That is right.

Q Was Code A admitted to the Queen Alexandra Hospital the same day?
A Yes, she was.

Q You went to see her on the 11th, so that would be the Monday. Is that right?
A No, Code A was admitted on the Saturday morning into the QA and I followed her about an hour later because I was not even dressed that morning and I followed down to the hospital and I was there every day until I went to Hammersmith.

Q Code A remained at the Queen Alexandra for a while and eventually there were discussions about where she was going to be transferred to.
A That is right.

Q Whilst she was at the QA, did she remain in a confused state or did she have periods when she was lucid? Can you tell us what her state was?
A She knew who I was. She was clearly not herself. She was in bed basically chatting, but I could not put my finger on it. She was not schizo-like; she was just not herself.

Q We have looked at her medical records obviously in some detail. We have seen reference in the notes to your mother both at Queen Alexandra and later at the Gosport War Memorial being on occasion confused, but also aggressive.
A Yes.

Q Did you ever see her in an aggressive state?
A I never saw her in an aggressive state.

Q Is it fair to say you did see her in a confused state?
A Confused yes, but not that she did not know who I was.

Q Did she know where she was necessarily?
A She knew she was in the Queen Alexandra Hospital.

Q As we have discussed, this was a very turbulent time for you because Code A was taken into the Queen Alexandra in October and on 19 October Code A was admitted to the Hammersmith Hospital.
A Yes.

Q What was the purpose of his admission?
A For a [redacted]

Q I want to turn to Thursday 21 October - this was two days after Code A had been admitted to the Hammersmith - was Code A transferred to the Gosport War Memorial Hospital?
A Yes.

Q There had been discussions about her going elsewhere; was there some discussion about her going to St Christopher's?
A That is correct, yes.

Q I am going to give you a bit of reign, you can tell us.

A A Code A never liked St Christopher's Hospital because Code A was there and there was an incident many years ago. I was about 13 and I remember Code A signing her out from that hospital.

Q So she had had a bad experience of St Christopher's, and you did not really want her to go there either.

A My thought was it was convenient even for Code A because it was on his way B home from work. He works in Portsmouth, he travelled by car all the way round. I said that I will leave it up to Code A to make the decision, but I clearly do not think she will be happy, but I do not want you to force her to go into a hospital or for respite care because my brother had not decided to have her now and look after her, so I understood that she was going to go somewhere for the six-week period and they were going to look for a residential nursing home.

C Q What did you understand she was going to Gosport for?

A The Gosport War Memorial Hospital?

Q Yes, when she went into the Gosport War Memorial on the 21st, what was your understanding?

A She was just going there to be looked after for the six weeks, because otherwise why would she be discharged from the QA.

D Q Was it ever your intention that Code A should be able to return home to live with you?

A Code A was always returning home and Code A knew that.

Q When you say she was always returning home, do you mean it was always your intention that she should?

E A Absolutely yes, definitely.

Q Because of what was happening with Code A were you able to go and see Code A Code A as often as you wanted?

A No. I went once a week, I travelled down from London with Code A One would stay with Code A and the other one would come with me.

F Q Were Code A quite good about going into see Code A ?

A Yes, they did. They were the first ones to go when she was first admitted, the two of them went together. They adored her.

Q They were very close to Code A

A They were very, very close.

G Q I want to explain something to you about the evidence that we are allowed to receive. I appreciate that you would have spoken, I expect, on an almost daily basis with Code A about how Code A was and they would give you reports of how she was doing in hospital. Is that a fair summary?

A Code A were with us in Hammersmith Hospital. They were in the hospital with me every day at Hammersmith. They lived just outside with friends and I actually slept in the same room as Code A on the floor.

H

Q They went on occasions to see Code A when you could not go.
A Only one occasion.

Q What I want you to stick you is what you yourself saw and heard when you went to see Code A rather than what they might have told you. You were able to go and see Code A Code A on 28 October. Is that right?
A That is right, I went with Code A

Q Can you tell us how Code A was when you got there?
A We got there about two, half past two, something around that time, because visiting hours were between two and five. We arrived in the lounge area. Code A was sitting there and she had her friend, Code A who lived almost next door to the War Memorial visiting her and also Code A They were both sitting there chatting and then Code A and I walked in.

Q And how was Code A?
A She was sitting there chatting to them but when she saw me and Code A she got quite tearful and we sat holding hands and it upset me as well because I knew that she did not want to be in the War Memorial and there was nothing I could do.

Q Were you able to hold a conversation with her?
A Definitely. There was a gentleman next door it transpired lived quite close to my mother; they owned a public house and we got into conversation with them.

Q Was Code A part of that conversation?
A Yes; they were talking about the old times.

Q So far as you were concerned, certainly on this day, was Code A making good sense?
A Yes, absolutely.

Q I think there came a time when visiting time was up; a bell rang or something like that, did it?
A That is right. Yes, a bell rang and I did not know what it was for, then she told me it was for tea.

Q I am going to lead you on this, if I may. I think you were a bit upset because you were going through this hectic time in your own life and you had travelled from London to see her and did you think that it was rather too short a visit?
A I did, yes.

Q I think on that occasion you did not make a fuss about it?
A No.

Q And did you leave?
A Yes, we did.

Q What sort of state was Code A in when you left?
A She was wiping her eyes and holding me and saying, "Don't worry about me,

A I shall be fine; you get off on back and take care of Code A Just don't worry about me, Code A I shall be fine."

Q I think the following Thursday, 4 November, Code A went to visit Code A
A Yes.

Q I think it was a Thursday.
B A That is right.

Q The following week, the Thursday you were able to go back down?
A That is correct, yes; I went down with Code A

Q During this intervening period had you been effectively living at the Hammersmith Hospital while Code A was treated?
C A The whole time, yes.

Q Tell us, please, about 11 November when you arrived; did you get there at about the some time as before, just shortly after two?
A That is right.

Q Tell us about that.
D A We went into the four-bed ward where Code A was and she was not there. We bypassed the lounge area, which was empty and I went into the four-bed ward with Code A and Code A s bed, she was not there, but very neatly in the centre of her bed were her clothes all folded. I said, "Perhaps Code A has been moved." So a nurse came in and I said to her, "Where is Code A ?" and she said, "She won't be long." I said, "Her clothes are all folded up on the bed," and she said, "Oh, she often does that, love." I said, "Oh, does she? Perhaps she thinks she is coming home today because I'm visiting," and she just did not
E answer me – she just left. Code A and I looked at each other and thought it was rather odd.

Q Did you find that a bit upsetting that Code A was packing to come home when you knew she was not coming home?
A I did, yes.

F Q Tell us about how Code A was when she saw you?
A I went to find out where she was and they said that she was having a bath, and ten minutes later I went in and I said, "How much longer is she going to be?" and she said, "She shouldn't be too much longer, love." I went back in and waited and
I started walking outside of the room and I saw Code A coming along the corridor. Her hair was sopping wet; she had a towel around her neck; she had no shoes on her feet but she was dressed – she had a skirt and jumper on. She saw me and raised her hand. There was a carer
G walking some distance behind her and she did not acknowledge me, the carer. I saw Code A and we hugged each other and she came and sat down and I took the towel off from around her and put on a dry towel around her neck. Code A then got up and rubbed her hair dry and then the carer came to put some rollers in her hair.

Q Again I am going to cut you short because we really have to concentrate on other things. I know that you were not happy about the rollers – you thought they were dirty. Was
H there a discussion about that?

A A I did not comment on that time; that feedback only come much later when I met up with the Trust and they said did I have any other complaints or feedback, and that is how that came up.

Q Can I ask you really on this visit about what state Code A was in; again mentally was she able to have a conversation?

A Mentally Code A was fine, absolutely fine. They brought the menu into her and B she read through it and Code A was reading through it with her and calling out and saying, "Look, you can have cottage pie here, Code A or you could have treacle pudding," just generally as one does when choosing a menu if you were sitting in a restaurant.

Q It is a good time to talk about food. What was Code A s appetite like at this time?

A She ordered cottage pie and she had ice-cream ordered for the next day's lunch. I did not notice anything. She had plenty of treats that we had taken into her; she had a cupboard C full of chocolates and biscuits and all sorts of things the family were taking in.

Q So no problems about her eating at this stage?

A No.

Q Can we move on, please, because I think when you left her did you have some discussion with Code A about how long she was going to remain where she was?

D A She said she wanted to come home and I said, "It won't be long now, Code A should be out in a couple of weeks." I said, "You'll certainly be home before Christmas."

Q So was it your intention, if all went well, that you would have Code A home to live with you and Code A ?

A Absolutely.

E Q Again I am going to lead on this and I will be shouted at if I lead you too far, but I think your next planned visit was for Sunday 21; that is when you intended to go back and see Code A

A That is right, which the whole family knew about because they knew the logistics about why I could not go down on that Thursday, which is the day I normally went.

Q There was a whole thing about collecting a car from abroad, which I am not going to F get to.

A That is what I said; it was a logistical problem and that is why Code A dealt with that.

Q But prior to your intended visit on the Sunday do you remember getting a call on Friday from Code A ?

A Yes, absolutely.

G Q Code A has not entered into this very much so far. Is Code A ?

A That is right.

Q Did Code A have a good relationship with Code A ?

A He did.

H Q Was he also visiting Code A at this time?

A A Every day; every single day.

Q I think Code A in fact lived in the Gosport area, did he?
A That is right, he did.

Q But you, I think, got a call on Friday 19 November. I do not want to ask you about the content of that call but that was a call from Code A y.
B A Code A

Q And as a result of that did you drive straight to the Gosport War Memorial Hospital?
A Yes, I did.

Q Tell us, first of all, what time approximately did you arrive, do you remember?
A It was about 2.45, 3 o'clock.
C
Q Who were you with?
A Code A

Q Tell us what happened when you arrived.
A We arrived at the Dryad Ward – we had to press a bell to get entry. A nurse came and escorted us in, which I believe was Code A now, and I was slightly upset and said, "Oh
D no, what has happened to Code A ?" and she said, "She won't know you, love; she has been sedated to be comfortable," words to that effect.
I rushed straight into the ward where she was – she was in a single ward then – and I rushed to the side of the bed and took her hand and started calling out, "Code A " and she said, "Code A won't know you, love." And she turned – because she was drawing the curtains open slightly and she turned and looked at me and looked at the hand and I said, "Code A does know me, she has just squeezed my hand," and she said, "Yes, I know; she
E does know you, love."

Q Apart from squeezing your hand did Code A give you any other reaction?
A No, absolutely none.

Q Were her eyes open or closed?
A Her eyes were closed.
F
Q Did she open them at any stage during this visit?
A Never.

Q Did she speak to you?
A Never.

G Q Since these events you have had access to all of the notes and I suspect you have spent hours looking at the notes and various reports and things like that.
A I did not get the full medical file for two years.

Q I understand. You have given evidence in other proceedings and I am not going to ask you about that, but I want to try and take you back to this point about your state of knowledge. You now know, I think, that Code A had been given a patch the day before, a
H fentanyl patch?

A A That is right.
Q And also she had received an injection. Whatever Code A may have been told did you at that time know that?
A We were not told, Code A or I. Code A told me and also he has put it in a diary.

Q I am going to stop you. All I can concentrate on is what actually you were told. But
B you did not know that Code A had ---
A No, I did not know.

Q Did you meet Code A that day?
A I did.

Q Can you remember approximately what time that was that she came in?
C A I think it was around 5 o'clock.

Q Can you tell us, please, how that meeting went? You were there with Code A and Code A as well.
A Yes.

Q Tell us how that meeting went; where did it take place and who was there?
D A Code A came into the room and said a doctor was here to see us and I said, "Okay." Code A said, "You and Code A go, Code A and I'll stay with Code A" So we walked out thinking that we were going to be directed somewhere by the nurse, but standing right in front of the door was Code A – who I now know was Code A, she did not introduce herself. She was standing there, bolt upright, looking at us, briefcase in front of her, and Code A was the first to enter out, Code A was standing to the left of the door, and Code A looked at her and she just looked at us and she said, "Oh …" She just turned on
E her tail to walk down the corridor and Code A said, "Good evening," and she did not respond; she said, "Follow me." So he said to her, "Have you come in specially?" and she said, "Yes, I have come in specially," in quite an abrupt manner which took us aback because we were there on a very sad occasion and it shook us, actually. We were taken down a corridor to a small room on the right , very cluttered and there were three chairs inside in a row and Code A Code A sat at the end and then I sat and then Code A and then Code A stood by the closed door.
F

Q Tell us about the conversation that you can remember with Code A
A Code A said to me, "You know about Code A don't you, and her problems?" and I said, "Yes." She said, "You know that she has multiple myeloma," and I said, "Code A Code A has not got multiple myeloma." I said I had a very good rapport with Code A and, no, she did not have multiple myeloma. She said, "Yes, yes, I know you had a good rapport with Code A because I have also spoken to her." Then I asked her when Code A
G Code A had her last blood test, and she told me I think it was 15 or – she got the result on 15 and she did not want to bother me because I had too much on my plate with Code A To be honest, I was in total shock and I just looked at her.

Q Just to interrupt you for a moment, she said to you – do you remember the words that she used as close as possible?
A The words she used as close as possible in reference to the whole conversation?
H

A Q Just in relation to this part about not worrying you?
A She said, "I don't want to worry you because we thought you had enough on your plate with Code A ."

Q What did she say about Code A ?
A She said that Code A had multiple myeloma; that is all, and I said she did not.

B Q How did the conversation continue after the comment about Code A 's position?
A It did not really. I just looked and I was in shock, and I said to Code A "I think we'll leave it there. Okay, thank you very much."

Q Did she indicate at any stage what was wrong with Code A ?
A No.

C Q How did that conversation finish?
A I just looked at Code A and I said, "That's it." And I said, "Thank you very much, I'll go back to Code A "

Q Did she say anything to you about Code A 's prognosis?
A No, she did not.

D Q Did you during that conversation – and it may follow from what you said that I ought to ask you, did she at any stage have any discussion with you about either what had happened the day before with a Code A or a syringe driver or fentanyl ---
A Never.

Q Or anything like that?
A Never.

E Q Did you know whether at that time Code A was on a syringe driver?
A No, I didn't

Q After that meeting with Code A where did you go?
A I went back to Code A and I sat with her and held her hand.

F Q Did her state change at all while you were there that night?
A Her breathing was slow but it became much worse the following day.

Q I think you remained until quite late that night.
A Yes, 11.30.

Q Then you returned the following morning at 9 o'clock or thereabouts.
G A That is right.

Q Tell us about the next stage, when you went in to see Code A First of all, did you see Code A again, or not?
A No. I never saw her again; and she did not come into the room at all.

Q Did you sit with Code A through the next day?
H A Yes, all day.

Q Again, did Code A 's state change at all during that day, the Saturday?
A Yes, her breathing was very laboured and it was very uncomfortable to watch her, and very upsetting. She did stop breathing for long periods of time and then suddenly she would give this huge deep breath.

Q Did you remain with her for much of that day?
A I stayed all day and never left her.

Q Did you see a pastor – Code A – at some stage that day?
A Other members of the family were in and out all day and then Code A came.

Q Again, did you return on a Sunday, the morning of 21?
A I did.

Q Throughout any of this period did Code A regain consciousness?
A No, she did not.

Q Did you see Code A again?
A No.

Q At what stage, if at all, did you become aware of the syringe driver?
A It was on the Saturday.

Q Tell us how that came about.
A Code A lifted Code A up and propped her pillows. Because of her breathing we wanted to lift her up to make her more comfortable; he pushed up the pillows and lifted them up on to them more and that is when Code A found the syringe driver under the pillow. Actually, I did not know what it was because although Code A was on a syringe driver it was very different to that.

Q I think you were not able to stay for the whole of that Sunday. You stayed for part of the morning and then you had to head back to London.
A Yes. About 11 o'clock/11.30ish, we had to go on back to Hammersmith.

Q Was Code A still in hospital at this time?
A Yes, he was.

Q I think you got a call later that evening form the hospital itself to tell you that Code A Code A had passed away.
A Yes.

Q On the death certificate, which is behind the last tab at the back of the bundle, Code A Code A 's cause of death was shown as chronic renal failure.
A Yes.

Q We know that you only had one meeting with Code A but can you remember if there was any discussion at that meeting about renal failure.
A Yes, I think she said that she was putting renal failure on Code A 's death certificate. She did say that.

Q During the conversation that you had in this funny room that you have spoken about, she told you what exactly? Can you remember her words?
A Yes. Initially, she started off, "Yes, I'll be putting renal failure on the death certificate."

Q Did you say anything in response to that?
A I do not think I did.

Q During the period when Code A was at Gosport War Memorial Hospital, when you went to see her up until that last Friday, you say that you were able to hold a conversation with her.
A Absolutely.

Q There clearly had been a period, which is why she was admitted to the Queen Alexandra in the first place, when she had been confused.
A That is correct.

Q You never saw her aggressive, but you appreciate that the hospital notes reveal that at times she was.
A Yes. And when I spoke to a doctor I was told that a urinary tract infection can cause confusion.

Q Whilst she was at the Gosport War Memorial Hospital, I think she sent you and your family a number of cards.
A That is right.

Q We are not going to produce them here, but I think you have produced them previously, really just to demonstrate that Code A was able to think and write out in clear sentences.
A Yes.

Code A That is all that I ask you for the moment. Would you wait there, please. Thank you very much.

Code A, you have been giving evidence for about an hour now. Would you like to take a break before you answer questions from counsel for the doctor?
A I am fine. Whatever is convenient.

Code A If it helps, sir, I have one question.

Code A There we have it. On that basis, if you are happy, we will carry straight on.

Cross-examined by Code A

Code A I am going to stay seated, Code A if that is all right. I am sure you can see me. You will remember what I look like because you were at the inquest for quite a lot of the time, I think.
A That is right.

Q Just the one thing, on the day that you saw Code A can I suggest it was seven o'clock in the evening. It would not have been five because she was seeing ---
A No, I am sorry, I disagree with that. It was not seven o'clock in the evening.

Q At five o'clock she would have been seeing her patients at her general practice. She had come in at about seven.
A I am sorry, I disagree. I am sorry, I disagree.

Code A There we are. Thank you very much.

Questioned by THE PANEL

Code A it is now that time when members of the Panel have an opportunity to ask questions of you and I am going to check to see if any of them do have questions.

First, Code A who is a lay member of the Panel.

Code A I am a little confused about the meeting that you had with Code A and what transpired at that meeting. You asked for that meeting, did you, with Code A?
A No, I did not.

Q But Code A was prepared to see you on that day, so you went with her to that room where the three of you were sat together.
A No, I was visiting Code A and while I was at the hospital the nurse Code A came in and said, "The doctor is here to see you," and we were shocked. We had not asked to speak to a doctor, but we just assumed that she had come to notify us of what was going on.

Q I do not really have the picture as to what you were told by the doctor at that meeting.
A She told me that Code A was in kidney failure. She told me that Code A had multiple myeloma.

Q That is the one to which you objected.
A I am sorry?

Q That is the one where you disagreed – that Code A did not have that.
A Yes, I disagreed with that.

Q Okay. It was at that meeting that you were told about Code A having the kidney failure.
A Multiple myeloma – which I knew she did not have. And that is when I questioned Code A

Q But also about the renal failure.
A I did not question her about the renal failure. She said she was putting renal failure on the death certificate.

Code A Thank you. I am clear now.

A Code A is a lay member of the Panel.

Code A Good day to you. I would like to pursue what my colleague has just asked you about because I am still a little confused with regards to this particular meeting. Was the only time that Code A mentioned renal failure when she said to you, "I will be putting renal failure on the death certificate."

A To me?

B

Q Yes.

A Or to the family.

Q To you.

A To me, yes.

C Q And that is the first time you knew about that particular condition that Code A had.

A No, because Code A had told me when he called up that Code A was in renal failure.

Code A Right. That clears up the confusion that I have. Thank you very much indeed.

Code A is a medical member of the Panel.

D

Code A I am sorry; I am going to come back to that as well, because I am trying to get a feel of that very distressing moment for you. You went into the room with Code A you sat down in the room.

A With Code A

Q With Code A Can you, again, tell us exactly what you remember being said, if you E can remember the nearest words.

A She said, "Well, you know about Code A 's illness, don't you?" I looked at her and I said, "Yes," and she said, "She's got multiple myeloma." I said, "Code A did not have multiple myeloma." I said I had a very good rapport with Code A and she said, "Yes, I know. I've also spoken to Code A " I said, "Oh." She said, "I'll be putting renal failure on the death certificate."

F Q She did not say to you, 'Code A is dying." You did not say, "Is Code A dying?"

A No, I did not.

Q Did you then say: "So Code A 's dying"?

A No, I did not. I did not even think about those words. Code A was comatosed.

G Q Yes. I am sorry if this is a distressing ----

A I am sorry, Code A had already told me on the telephone that Code A had told him that she had 36 hours to live.

Q No.

A Is that what you are ----

H Q No, we are not allowed to know what Code A told you.

A A No, but that is how I knew. That is why I rushed there.

Q My next question was going to be – and forgive me for putting it like this and I do not mean to upset you – why, faced with that situation, did you not say, "So Code A s dying?"
A I do not know. Because I assumed she was. I assumed she was, having been told by my brother. And when I got there and the nurse has already told me, "She won't know you, love," that was obvious to me that Code A was dying.

B

Q And that was the end of the ----
A I did not look up to the doctor and say, "So Code A s dying." It was obvious to me Code A was dying.

Q And that is the sum total of your conversation with Code A
A It is.

C

Q I do not want you to say any more than yes or no to this: Did Code A ask her any questions?
A No.

Code A: Thank you very much. I am sorry for taking you through that again.

D Code A, do you have any questions arising out of those from the Panel?

Code A: No, thank you.

Code A

E Code A: No, thank you.

Code A I am pleased to be able to tell you that that brings your ordeal today to an end. The Panel are very conscious of the difficulties and the stresses that witnesses in your place face when asked to give evidence to the Panel, and we are extremely grateful to you for your testimony. It has been most helpful. We understand also that there has been a certain amount of messing around, moving you from one venue to another in order
F to find facilities that would link with our own. We are most grateful to you for sticking with us through those times. Thank you very much indeed.
A It was important for me too.

Q Thank you.
A It was important for me too. Thank you very much.

G Code A: Thank you. You are free to go now.

(The witness withdrew)

Code A: For the rest of today we will be reading statements. Just to make sure that we have everything in order, could I ask for a longer break now. I want to be sure that when we read the statements to you, we read them with all the right references provided.

H

Code A: In so far as the statements that refer to this patient are concerned, do you need time to prepare those?

Code A: We have spotted one or two pages that you do not have.

Code A: It is your intention also to be reading to us statements ---

Code A: I see where you are going. We are moving on to Patient G.

Code A: It is really a matter of whether we first finish the reading of the statements in relation to Patient K, and then break, taking an extended period so that the Panel is able to read everything in relation to Patient G, and then hear from you.

Code A: You are absolutely right. If we have the normal break now, we can read the two statements in relation to the patient from whom you have just heard, and then we can move on to Patient G. In terms of managing what is going on and to help your understanding of the case, it is probably easier not to start reading into another patient before you hear back about Patient K.

Code A: Very well. We will break now for 15 minutes.

Code A: Sir, before you do, in other cases I have certainly taken the witness to the relevant documents. I did not do it with Code A because obviously she is a long way away and she does not have the medical records in front of her. So that the Panel know, the entry by Code A for 19 November 1999 is on page 157. I am sure you have flagged it up. The corresponding entry in the nursing records starts at page 223. At the top of page 224, you will see the reference to Code A being seen by Code A and there is an entry on page 224 timed at 2000 hours: "Code A has visited – seen by Code A"

Code A: Very well. Thank you.

We will return at just before five past 11, please.

(The Panel adjourned for a short time)

Code A: Sir, in a moment I am going to ask Code A to deal with the two statements of Code A and Code A but before I do, perhaps I could tell you that I have been having a rethink about Patient G. Having re-read again the two statements of Code A and Code A – they are both very short, I do not think either or them will take longer than two or three minutes to read – it seems to me much more sensible that we hear form Code A first.

When I created this list, I was worried about losing too much time today, but if the reality is that you are going to be reading Patient G's notes – and those, I can tell you, are pretty substantial and I think will take you a good part of today to read through – I would much prefer to delay the reading of those two witnesses until you have read Code A's notes and then we have heard from Code A and then we can read them in the normal order.

Unless the Panel are very keen that I should read those two statements today, that is what

A I would prefer to do.

Code A That certainly makes sense. We at the moment appear not to be in any great difficulties with time. In fact, it looks as if we are likely to finish somewhat earlier in the main.

Code A I would not take this week necessarily as being a prognosis for that.

B

Code A Very well. Would it be appropriate for us to read the notes today, Friday, and then not look at it until Monday when we hear, or should we read them on the Monday?

Code A I think Monday is going to be a very full day. We have Code A who has quite a bit to say, and Code A and then Code A when we are moving on to

C Code A That is quite a full evidence day.

Of course it is a matter for the Panel, but I think it would probably help you if you were to read Code A s notes at least once through and make your own highlighting and flags. Certainly my own experience is that when I have come back to things they are much easier second time round than they are on first reading. I would suggest that you spend a bit of time, if you are able to, reading on Patient G today and then perhaps refresh your memory

D on Monday.

Code A I have no difficulty with the first part. In terms of refreshing our memories on the Monday, are you suggesting that the Panel start at 9.30 and the parties arrive at ten o'clock so that that re-reading can have happened.

Code A Certainly I would like to start as close to ten o'clock as possible, sir.

E

Code A Unless there are any objections, that is how we will do it. When we finish formally today the Panel will stay to read, and then we will come back at the normal time on the Monday and have half an hour refreshing our memories before the parties join us at ten o'clock.

Code A Sir, I am about to read two statements, a statement from Code A

F Code A and Code A Before I do that, could I ask for the Panel to receive a few pages of additional notes from the patient records which I have here?

Code A Are they additional documents or are some of them replacement documents?

G Code A They are all additional.

Thank you very much. (Documents distributed and placed in bundles)

Perhaps I could make a very minor amendment at the same time to the chronology. At the front of the file of Patient K, on the third page of the chronology, the second entry relates to 14 October 1995 and in the third and fourth columns there is a reference to patient assessment running from page 395. In fact that runs from page 393 and

H those are most of the pages you have just been handed.

Code A We will make that amendment.

Code A Thank you. Firstly dealing with Code A made a brief witness statement for the purposes of the GMC proceedings, saying this,

> "I make this statement in relation to the General Medical Council investigation into Code A I previously gave a statement to Hampshire Police. Exhibited to this statement and marked 'JT1' is a copy of my statement dated 14 July 2004."

I will read that in a moment.

She then says:

> "I have had the opportunity to re-read my statement of 14 July 2004 and would like to make the following amendments..."

She then lists a number of amendments which I will simply amend as I read out the statement rather than going through them now. She said that she had no other amendments to make. She said that she understood that the statement may be used in evidence for the purposes of a hearing before the GMC's Fitness to Practise Panel and for the purposes of any appeal. She confirms that the facts stated in the witness statement are true.

Moving on to the witness statement, it is a statement of Code A dated 14 July stating her occupational as a staff grade psychiatrist. She says this:

> "I am presently employed by East Hants Primary Care Trust as a Staff Grade Psychiatrist working at St Christopher's' Hospital Fareham. I have two roles for the East Hants Trust at the moment, one is within the day hospital at St Christopher's that I have been doing since November 1999 and one in the community i.e. home visits which I have been doing since November 2003.
>
> I obtained a Bmed Sci degree (Basic Medical Science) in 1984 studying at Nottingham University. I also obtained a BMBS (Batchelor of Medicine and Bachelor of Surgery) in 1986, also in Nottingham. I also have a certificate of General Practice Vocational Training in 1994 that allows me to practise as a General Practitioner and was overseen by the Royal College of General Practitioners. I also have a diploma in Occupation Medicine. My GMC No is Code A I have recently, April 2004, obtained 'Section 2 Approval' I obtained this via a training course and you also have to have been recommended by two people to have a certain amount of experience in mental health, health care. This allows you to 'section' people, i.e. admit people to hospital under the Mental Health Act.
>
> After I qualified in 1986 I worked as a junior doctor from August 1986 to July 1987 at the Derby City Hospital and at the Royal County Hospital, Ryde.
>
> From August 1987 to January 1991, I was a senior house doctor at Derby City Hospital and Derbyshire Royal Infirmary. From February 1991 to January 1994, I completed my GP Vocational Training at St Richards Hospital, Chichester and at two GP practices.

From January 1994 I worked at General Practice as a locum in Fareham and Gosport and Brisbane, Australia until November 1999. Whilst working as a locum in the Fareham and Gosport area, I was also employed as a Code A in the Elderly Mental Health at the Gosport War Memorial Hospital, from February 1996 to November 1999.

Also from April 1998 to November 2003, I was an Occupational health Physician, at Tyco Health UK, Gosport, a private company.

Whilst employed at the Gosport War Memorial Hospital, I worked four, four hour ward sessions each week on Mulberry Ward, which was a ward which catered for elderly patients with mental health problems. I was working as Code A looking after the medical needs of the patients and also looking after the patients' psychiatric needs. I reported back to a consultant, the consultants had the overall responsibility of the patients and the consultants at that time were Code A Code A

At that time I was also doing one session a week of community work for Code A and St Christopher's Hospital. My work at the Gosport War Memorial Hospital involved the general patient medical care, i.e., admissions, asking for blood tests and treating and caring for medical complaints, i.e. pains, falls.

... I have been asked to detail my role in the care and treatment of Code A I have not personal memory of Code A but from referral to entries in her medical notes."

Code A then refers to the notes that we have and says that she can say various things. Referring to the note that the Panel has in the bundle at page 164, she says:

"I can say that [this note] refers to my visiting patient, in this case Code A on a ward at the consultant's request. On this occasion I visited Code A on F3 Ward at the QA Hospital on 14.10.99 and I recorded in her medical notes..."

Then Code A transcribes the notes for us and it may be helpful if I read that given that the note is in handwriting. It says this:

"14.10 Elderly Mental Health.

Thank you. This lady has settled a little in her behaviour. She has been deteriorating at home and unable to cook etc since Jan 99. It's likely that she has dementia and had an acute episode 2° to UTI. Code A is no longer able to cope because of her husband's illness and I would suggest that she is referred to social services for placement. She will need residential care with experience in dealing with confused patients. If her behaviour does not deteriorate again, we will need to transfer her for further assessment. MMSE 9/30 serve dementia".

Code A goes on in the statement to say:

"I then signed the entry. She has settled in her behaviour means what it says. She has been deteriorating at home and unable to cook etc since Jan 99. This would have

been deteriorating in her mental health and being able to look after herself. Dementia is an overall term in mental functioning usually caused by an underlying illness, it is memory loss and global functioning, i.e. putting on one's clothes, washing, writing, cooking, understanding and sequencing tasks. An acute episode is when you deteriorate quite suddenly. I believe that this was secondary to a urine infection (UTI Urinary Tract Infection). By 'placement' I mean putting into a residential home. I have finished the paragraph by saying that if she deteriorates further, she would have to be transferred to Mulberry Ward for further assessment.

MMSE means Mini Mental State Examination which is basically a test that is administered to test for dementia. Her score was 9 out of 30 which is very low and she would have come under the severe category."

Code A May I assist; it is page 401 in the documents.

Code A then refers to the notes that she made relating to this initial assessment which are the notes that run from pages 393 to 404 within which the page that you have just been referred to appears. These notes now starting from page 393, Code A says

"[They] relate to my initial assessment of Code A regarding her mental health that I carried out on 14.10.1999 at the QA Hospital. I signed the assessment as its conclusion".

In the statement Code A transcribes those notes, but then provides an explanation of the most salient points. I will give the Panel a moment or two to familiarise themselves with the notes.

(After a pause)

As I said, Code A goes on in the statement to explain some of the more salient points from it, starting at page 394, Code A says,

"[Page 394] shows that the referral was made to the consultant by Code A I went on the Code A s, behalf. The reason for the referral was acute chronic confusion, i.e., she had been confused but had deteriorated suddenly, also her daughter was finding it difficult to cope".

Then the next page, page 395,

"[Page 395] relates to what the patient, Code A said to me. I would have asked about her current situation and have recorded what she told me. It would not have been verbatim but the sense of what she said. On two occasions I have written notes and these entries relate to notes that I took from Code A s medical notes. This would have been a précis of what I read and I included these to assist in writing a letter of reply to the referrer and to get a sense of what was happening as people's mental conditions can change. 'From informant' [the centre of the page on the left] relates to information taken from the ward staff. The last entry reads 'taking medication" and the rest are self-explanatory. I have also spoken to Code A

A

regarding Code A s condition. I do not know whether this was a personal visit or telephone call, the entry again is self-explanatory."

This is on the right hand side of the page in the middle.

"An arrow down means a deterioration i.e., a deterioration since January and in her cooking ability and memory, Code A stated that she was going to London whilst
B Code A was in hospital there".

Moving on to pages 397, in relation to page 397, Code A says:

"I have recorded her past medical history. I have recorded multiple myeloma (cancer) and hypothyroid (a low thyroxine level). This history may have been taken from the patient's notes or from the patient herself. Past medical history means that these are
C medical conditions that the patient has or is suffering from. But the term by 'past' is used as these were conditions that had been diagnosed previously and I would not be treating that condition, but it is recorded as it may have a bearing on the condition I was concerned with, i.e. her mental health.

Past psychiatric history. I have recorded as 'Nil' again due to the reason that Code A had, as far was aware, never had a previous psychiatric problem."
D

Moving on to the next page, page 398:

"Her current medication, as far as I was aware, was Thyroxine 100 mg for treating hypothyroid. Frusemide 80 mgms and Amiloride 5gms for treating heart failure and Cefaclor 37.5mgs, an antibiotic. BD is twice daily, OD is once daily. I recorded these from Code A s prescription chart and were not prescribed by me."
E

Over the page to page 399:

"[Page 399] relates to her personal care, in this case it is most likely that I was able to complete the assessment by asking members of staff, and or I may have used the information from Code A but I cannot be sure. Carer needs relates to Code A s carer, i.e. Code A and I have recorded that Code A has
F [redacted] and is having a [redacted] in London. I have recorded six weeks. I unable to say whether that means in six weeks' time or for six weeks.

Physical examination for her sight I have recorded that she suffers from cataracts, again this may have come from her notes or from the patient. I have also recorded that her hearing was poor, that would have been my own observation.

G MSE is Mental State Examination, for speech I have recorded ñ which is shorthand for normal. My assessment of her mood is my observation of how she was; she was cheerful, friendly, cooperative, thinks that Code A is on holiday and she has no idea where she is. Hallucinations, I have recorded now settled, meaning at that time she was not suffering from hallucinations. Hallucinations can be caused by dementia, illness, medication side effects, psychiatric illness. Insight, I have recorded no problems with memory. That would be the patient saying that she had no problems
H with her memory.

A

Cognition 9/30 is her test score."

Moving on to page 401:

"401 is the MMSE test marks given in response to questions asked. The questions are designed to measure the patient's mental state. I have recorded at the top of the form 'V.deaf', i.e. very deaf, and the low score could have been as Code A did not hear me properly."

B

Moving on to page 403:

"403 is a risk assessment of what I think the patient may be at risk from. This is completed for what I had gathered from the patient, staff, Code A notes and my own observation. I assessed her risks as medical myeloma, hypothyroid and urine tract infection, her psychiatric risks as confused and wandering and further observation I made was that the patient would need residential care."

C

Lastly, page 404:

"404 relates to a summary of the overall assessment and a plan of care. I have made a list of the psychiatric problems as dementia and I have queried whether the cause of the dementia is SDAT, senile dementia, Alzheimer's type. Alzheimer's disease is an organic deterioration of the brain's function.

D

I made this diagnosis on the patient's history and the mental health assessment. The main physical problems listed as myeloma, chronic renal failure. I have recorded chronic renal failure as it was on the initial referral. From her initial management I asked that the patient be referred to social services for residential care and that if her condition deteriorates to transfer her to Mulberry Ward at GWMH."

E

Moving on from these notes Code A says:

"From my assessment I wrote two letters, one to social services ..."

And this appears at page 411 of the records. I will ask the Panel to read that quickly. (The Panel read)

F

Code A says:

"I dictated this on 15 October 1999 and it is my referral to them regarding Code A including a copy of my assessment on 14 October 1999."

G

The second letter is the letter to the referrer, Code A and this appears in the bundle at pages 29 to 30. It is a more detailed summary of the examination we have just been through and maybe I could allow the Panel a moment or two to read that. (The Panel read)

Code A: This is one that we have read before, albeit that we have a larger font copy now.

H

Code A I am very grateful. In which case I will go on. Code A says:

A

"It is signed by me; it says what it means, although the phrase 'put her away' would have come from the patient herself."

The reference for that is in the middle of page 30; the paragraph next to the top hole punch ends with the words "and feels that Code A has put her away".

The letter makes use of an acronym EMI and Code A says:

B

"EMI means Elderly Mentally Infirm and it is a title that social services use to identify a home that is capable of dealing with someone who is very confused or difficult to manage because of mental health problems."

EMI appears in the last paragraph of the letter. Code A moves on:

C

"On 18 October 1999 I received a phone call from Code A s daughter. I made a note in her mental health records."

And this appears at page 407. It is transcribed by Code A and she says this:

"It reads: phone call from Code A F3 are transferring Code A to St. Christopher's. Worried as Code A there 30 years ago, bad

D

experience, feels Mum will deteriorate. Has looked at Merry Hall as know owner ? able to cope ? confused pt."

Code A *(Sotto voco)* With.

Code A It is pointed out that that may more sensibly read as "able to cope with confused patient" and Code A has transcribed it as a question mark; but there it is. And it

E

says:

"Review patient at SCH."

Code A explains:

"Merry Hall is a local residential home. As she knew the owner ? means a query as

F

I was querying whether Merry Hall could cope with a confused patient. I made a note to review the patient when she got to St. Christopher's Hospital."

Then dealing with the other note that appears on the same page, 407, Code A says:

"On 18 November 1999 ..."

G

So a month later:

"... I made another note in this review mental health note that reads:

Code A now at Dryad GWMH. Transferred 21.10.99. Aggressive, wandering, moving other people's clothes, refusing medication, poor appetite.

H

A

Review in ward, happy, no complaints, waiting for Code A, not obviously paranoid; says tablets made her mouth sore.

Plan – transfer to Mulberry C when bed available.'"

Code A explains:

B

"Aggressive, wandering, moving other people's clothes, refusing medication and poor appetite would have been what I was told by other people or from the patient's notes. Reviewed on ward relates to my observations of the patient and what she said and is in general terms. I got the impression that she was happy, had no complaints, waiting for Code A not obviously paranoid. Paranoid is having an abnormal thought thinking people are doing things to you when they are not, i.e. stealing your property. She told me that the tablets made her mouth sore. I have recorded as my plan for her

C

to be transferred to Mulberry C Ward when a bed is available. This was following a visit to Dryad Ward."

Code A then refers to a note at page 157 of the bundle. It is the first entry in the clinical notes on page 157 and this note, she says:

"... relates to the same visit and is basically an entry into her medical notes to inform

D

them of what I found and what the plan was. It reads:

'18.11.99 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.

E

She does not seem to be depressed and her physical condition is stable. I will arrange for her to go on the waiting list for Mulberry Ward.'"

And it is signed by Code A

"By deteriorated I mean in her mental health, she was now more aggressive, more restless, refusing medication and not eating."

F

Code A goes on to give general assistance with what dementia is.

"Dementia is a syndrome due to disease of the brain usually of a chronic or progressive nature, in which there is disturbance of higher multiply higher co-dilate functions, including memory, thinking or coordination, comprehension, calculation, learning capability, language and judgment. Consciousness is not clouded.

G

Alzheimer's is a primary degenerative cerebral (brain) disease of unknown cause."

And that is the statement of Code A

Sir, I will now go on to deal with the statement of Code A She made a very brief statement for the GMC, signed by her on 3 March 2008 where she said this:

H

A "I am a Code A at the Queen Alexandra Hospital and have held this post since March 1994.

Exhibited to this statement and marked TC/1 is a copy of my witness statement dated 20 October 2004.

I can confirm that I have been given the opportunity to add to or amend this statement
B but do not wish to do so."

And she confirms that she understands that the statement may be used in evidence in these proceedings.

She says:

C "I believe that the facts stated in the witness statement are true."

Moving on to the statement dated 20 October 2004. The name of Code A occupation Consultant Haematologist; and she said this:

"I am Code A I am the Senior Clinician of the Haematology Department, Queen Alexandra Hospital, Portsmouth.

D

I am a Code A and I have been in post at the Queen Alexandra Hospital since March 1994.

In my post I have clinical responsibilities which include investigation, diagnosis, management and treatment of patients with haematological disorders (blood diseases) in outpatient, day unit and inpatient settings.

E

My laboratory duties include laboratory management, bone marrow sampling and data interpretation of the various tests carried out by the laboratory and communicating the results to the requesting clinicians.

I also provide advice in relation to the treatment of blood and bone marrow disorders. This would normally result in the patient being brought under the care of the
F haematology clinical team.

The clinical team comprises of four other consultants, two registrars, two ward based senior house officers and specialised nursing staff covering the haematology ward and day units.

I have been asked to detail my involvement in the care and treatment of Code A
G Code A I have no personal memory of this patient. However, by referring to Code A 's medical notes including letters written by myself and other doctors involved in her treatment I am able to provide the following information.

Code A date of birth Code A was referred to me by Code A Geriatrician in Elderly Medicine at the Queen Alexandra Hospital, Portsmouth.

H Referral was made following a clinic held by Code A on 15 April 1999 at

St. Mary's Hospital, Portsmouth, attended by Code A

The referral was made in the form of a letter typed on 19 April 1999. I have been shown a copy of this letter ..."

Sir, that appears in our bundle at page 89. Would you like a moment to read the letter?

Code A Again, this one we have had before and we have read it.

Code A says that the first page has been marked in manuscript, "Thurs" – Thursday – "13/5. 9.15. New patient soon." She says:

"Certain parts of the letter have been underlined.

The underlining and note of 'new patient soon' are markings made by me.

The note of 'Thursday 13/5, 9.15' is a note made by one of the secretaries in the office and is the date of an appointment sent to Code A to attend the haematology clinic at the Queen Alexandra Hospital.

Code A s letter, in short, details his findings so far, as a result of tests carried out, to date, on Code A

At the end of the letter on page 89, Code A states:

"Therefore this lady has nephrotic syndrome and a paraproteinaemia. I'm not sure whether she has myeloma, or perhaps she has some other haematological or lymphoreticular disease as a primary problem."

Code A explains:

"Nephrotic syndrome is the leaking of protein from the kidneys. This leads to low levels of protein in the blood.

The protein leaked from the kidneys would have been passed out of the body in the urine thereby causing a high level of protein in the urine.

The depletion of the body of protein would cause various problems to the whole functioning of the body, including swelling of the legs.

Paraproteinaemia is caused by the white blood cells within the body producing an excessive amount of a part of a protein antibody called immunoglobulin.

Code A s letter identifies that Code A is suffering from the above conditions and refers to Code A to me to try and identify the cause of these conditions, suggesting myeloma or other blood disease as possible causes.

Myeloma is a form of cancer of the white blood cells. Its presence would create a number of problems for the body, including bone breakdown, toxic levels of

A calcium, kidney failure. It can also be the cause of nephrotic syndrome and paraproteinaemia.

Code A referred Code A to me to consider if it would be appropriate for me to carry out bone marrow tests in order to establish if Code A had myeloma.

A bone marrow test would give a good indication of whether or not Code A had
B myeloma.

As a result of Code A 's referral Code A was sent an appointment at the haematology clinic for 09.15 am on Thursday 13 May 1999.

...

C On Thursday 13 May 1999 Code A attended the haematology clinic at Queen Alexandra Hospital together with Code A

At the time I had a tendency to make my record of a visit of a patient in the form of a letter which I dictated at the time. This would then form part of the patient's medical record. This creates a more legible and fuller record.

D On 13 May 1999 I have made a note on the medical record of Code A '

This is a note that appears at page 144. it is the note which occupies essentially the bottom half of that page. Code A transcribes the note.

"This note reads as follows:

E '13 May 1999 haematology clinic. Renal ultrasound shows both kidneys small. No other abnormalities seen in renal tract. Chest x-ray showed small right pleural effusion. Skeletal survey – osteoporosis. No lytic lesions. Code A Code A Oedema legs to lower back/sacrum. Blood pressure 140/80. Nil else. Only problem complaining of poor mobility due to legs swelling. Frusemide not making much difference.'

F From the above notes I dictated a letter to Code A which was typed the same day."

This is a letter that appears at page 75. You can see that it is a letter to Code A from Code A Code A with a clinic date of 13.5.99 at the top. Code A confirms that this is a copy of the letter "prepared from my notes of my examination of Code A on that day.

G "My examination of Code A on 13 May 1999 was in part to satisfy myself that the obtaining of a bone marrow sample from Code A was justified. Code A was 87 years old at the time. The obtaining of a bone marrow sample involves drilling into the bone, usually in the pelvis in order to extract the bone marrow.

This is done under local anaesthetic but it is uncomfortable and can also cause complications.

H

Having carried out my examination of Code A on 13 May 1999, I was satisfied that a bone marrow test was justified in her circumstances. I therefore obtained a bone marrow sample from her that day. Arrangements were made for Code A to attend the haematology clinic in two weeks time to review the results of the bone marrow tests.

During my examination of Code A I would have had the results of the investigations carried out by Code A or at his instigation. This would form part of my note and explains my markings [the letter at page 89 – the one with the underlinings]. My letter [at page 75] is compiled from Code A's findings and my examination to justify the bone marrow test.

I have been asked to explain in laymen's terms the meaning of my notes of 13 May 1999 and my letter of the same date.

On 13 May I saw Code A at the haematology clinic at the Queen Alexandra Hospital.

The previous ultrasound examination of Code A's kidneys showed them both to be small in size and no other abnormalities seen in her urinary tract.

A chest x-ray showed a small amount of fluid on the right side. A survey of Code A Code A's skeleton showed generalised thinning of her bones BUT NO HOLES which would have been an indication of myeloma. The generalised osteoporosis (thinning of the bones) was in my opinion more likely to have been as a result of Code A's age (87 years) as opposed to myeloma which can also cause thinning of the bones. Code A is a note of the name of the doctor who carried out the skeletal survey.

On examination of Code A I found that she had oedema (which is swelling caused by fluid retention). This swelling was apparent in both legs and extended to her lower back and waist area.

I my letter I describe her oedema as 'pitting'. This means that when pushing a thumb into Code A's swelling a hole or pit remained for a period of time.

Code A's blood pressure was taken and found to be 140/80 which is normal.

'Nil else' is a note I have made to indicate that Code A had no other apparent problems.

I have made a further note which summarises Code A's response to my direct question regarding any complaints of her condition.

'Only problem complaining of poor mobility due to legs swelling.' I have expanded on this note in my letter at page 75 to say:

> 'Her only complaint is of bilateral leg oedema (swelling due to fluid retention in both legs). Extending to her sacrum (lower back/waist). The swelling has been present for one year, causes her legs to ache and impedes her mobility. Frusemide (frusemide is a drug used in the treatment of water retention) has

made little impact on her leg swelling which is best controlled by elevation (putting her feet up). She had no other complaints on direct enquiry.'

Code A goes on:

"An appointment was made for Code A to return to the haematology clinic in two weeks time on 27 May 1999 .

I have been shown a document .... This document is the result of a skeletal survey of Code A conducted on 29 April 1999."

This is in the bundle at page 383.

Code A said:

"It is to this result that my note of 13 May 199 refers."

She refers to the note and the results of the skeletal survey.

"The content in layman's terms of this result I have already explained. This result was available to me on 13 May 1999 when I examined Code A .."

Code A says,

"A note has been made dated 27/5/99... This note I recognise as mine ..."

It appears at page 15. It is the note at the top half of the page of clinical notes. Code A transcribes it.

"... it reads as follows:

'7 May 1999 phone call from Code A .. [There is a phone number.] Unable to attend clinic (car broke down on motorway).

Told:

'No evidence of multiple myeloma to date. May evolve at a later date. Needs monitoring but no treatment.

Will probably require steroids for nephritic syndrome.

Will discuss with Code A and possibly Code A Then will arrange follow up.'

I have then listed the results of the tests carried out on Code A to date which I will deal with later in this statement.

To explain the first part of the note: on 27 May 1999 Code A was due to attend the haematology clinic to discuss the result of her bone marrow test.

A

I received a phone call form Code A ... explaining that her mother had been unable to attend her appointment as their car had broken down en route to the motorway. I then told Code A that there was NO EVIDENCE, at that time, of Code A having multiple myeloma (cancer of the blood), however that it may evolve at a later date and, therefore, there was a need to monitor her condition but at that time she did not require any treatment. I believe that during the conversation I implied that further results were still awaited.

B

I also told Code A that I would be discussing Code A s results with Code A (the consultant referring Code A to me) and also Code A regarding her mother's future treatment.

I told Code A that a follow-up appointment would be arranged.

C

Code A is a consultant renal physician at the Wessex Renal and Transplant Unit. It is often the case that patients and relatives, on receiving he news that they or someone close to them is not suffering from a form of cancer, are so relieved that they have not got an illness that they perceive as being fatal, they forget that they are still potentially very ill.

D

The remainder of my note [page 151, the bottom half of the page] are rough notes which are a summary of relevant results obtained to date. I have numbered these notes for ease of reference when giving my explanation of them."

She works down them, giving each line a number.

"1. IGA Lambda paraprotein with immune paresis: this is a note that the abnormal protein was present in the blood associated with suppression of normal antibody

E

protein levels.

2. No Bence Jones Protein: this is a note that there was no myeloma protein present in the urine.

3. Sterile pyuria: this note is that there are white cells in the urine but no evidence of infection.

F

4. Urine protein 4.5g per 24 hours: this note is an observation that the quantity of protein in the urine is indicative of nephritic syndrome.

5. No coagulopathy: this is a note that there had been no loss of the clotting ability of the blood.

G

6. Autoimmune profile – negative: this is a note that there was no evidence of any disease or condition leading to the auto destruction of the kidneys by the immune system."

She explains the acronyms that follow on that line as: rheumatoid factor; antinuclear antigen; compliment; and antinuclear cytoplasmic antigen, and explains that these are all tests carried out in relation to the autoimmune profile.

H

A

> "7. Deteriorating renal function and albumen: this is a note that the kidneys were losing albumen which is a further indication of nephritic syndrome. The kidney function was worsening and the condition was continuing."

Code A then goes on to the document that is at page 73. She says,

> "This document is a letter prepared by me to Code A dated 2 June 1999. The
B letter is a request to Code A to carry out a further test on the bone marrow sample obtained from Code A on 13 May 1999. In my letter I ask Code A to arrange for the bone marrow sample to be stained Congo Red and then for him to review the same for evidence of amyloid.
>
> Amyloid is a plasma cell disorder which is self cloning and is a disease associated with abnormal proteins.
C
>
> This which in turn may be a cause of nephritic syndrome which may be caused by the abnormal protein accumulating in an organ in the body (in this case the kidneys) causing the organ to malfunction.
>
> In my letter I detail the results of the examinations so far including the earlier bone marrow tests."
D

Sir, given that, in a sense, one has already dealt with the important points, I will seek to summarise as far as I can the remainder of this statement. Obviously if there is a matter of detail that the defence would like me to mention, then of course I will.

Code A then refers to the document at page 69 of our bundle explaining that this is the letter from her to Code A, the consultant renal physician, dated 2 June 1999. She
E explains that it details the diagnosis of nephrotic syndrome and the lambdaparaprotein.

She refers to a discussion on the phone that she did not feel there were sufficient criteria to treat myeloma, although she would be willing to offer chemotherapy if Code A felt the paraprotein was directly related to her renal damage. She clarifies in her statement that the tests carried out so far on Code A's bone marrow showed insufficient evidence for the diagnosis of myeloma or lymphoma.
F

> "Code A is a kidney expert, therefore as Code A s problems appeared to be caused by a problem with her kidneys I was referring Code A for her 'expert' opinion as to the cause of her illness".

There is a reference very close to the beginning of the letter to a cretainin level 160 MicroML. She says that the use of chemotherapy and steroids are both regarded as aggressive
G forms of treatment of a condition and are therefore not forms of treatment embarked on lightly, particularly in a patient of 87 years of age.

Code A then refers to the letter that appears at page 71 of the bundle and confirms that this was a letter dictated by her on 2 June 1999 addressed to Code A at the Queen Alexandra Hospital. It also contains the results of all the tests carried out to date, including the bone marrow test. The third paragraph of the letter ends with the sentence,
H

A "There is insufficient evidence for the diagnosis of myeloma or lymphoma".

Then:

"The fifth paragraph of this letter further states my reluctance to offer aggressive treatment such as chemotherapy and/or steroids to an elderly lady with a deteriorating kidney function when it was not clear what the cause of this was ...
B The final two lines of the letter are self-explanatory,

'I have arranged to see her again in two months with blood tests prior to monitor her paraprotein. I am happy to see her earlier if need be.'"

I am not sure if her small lambdaparaprotein is responsible for her nephrotic syndrome or is an incidental finding. The fact that both kidneys are small on
C abdominal ultrasound is against the diagnosis of amylordosis and there is no other clinical evidence to point to this diagnosis".

Code A then refers to the letter at page 67 of the bundle which is self-explanatory. She says in the statement,

"The purpose of this was to monitor Code A 's paraprotein as detailed in my letter
D to Code A '.

Code A mentions the letter at page 61 of the bundle next, a letter to Code A from Code A the consultant renal physician relating to a clinic health on 8 June 1999. She says,

"In the final paragraph of this letter Code A as a 'renal consultant' expresses her
E opinion that Code A 's small kidneys are likely to be a result of a longstanding problem rather than a new one. It then states, 'Therefore, I think steroids would be unlikely to help. In addition, she is a rather frail old lady to give the sort of high doses of steroids to that are normally required in renal disease. My preference, therefore, would be to treat her 'conservatively' for the present'.

The letter then continues regarding advice given to Code A about her diet and
F suggesting an increase in Code A s diuretics. Diuretics were the type of drugs being used in the treatment of Code A 's oedema of the legs".

... Diuretics are commonly referred to as water tablets. Code A 's oedema was caused by her deterioration kidney function. At this time, Code A 's only personal complaint was regarding her increasingly swollen legs which were impairing her mobility and causing her some pain and discomfort. Code A s opinion as a renal
G consultant was at this stage to treat Code A conservatively which is in this case meant treating Code A 's symptoms of her illness (her swelling legs) rather than the cause of her symptoms (her deteriorating kidney function and its cause)".

Code A simply pointed out in the statement that that approach coincided with her own view of not suggesting chemotherapy. Code A refers to a letter at page 53 of our bundle. She says refers to the letter from Code A Senior House Officer, to Code A
H

A the consultant renal physician. It is addressed to Code A and a copy of the letter was sent to Code A

"I note that the last 4 lines of the letter read as follows:

'I have discussed her Code A with Code A today and there is no therapeutic intervention which we may undertake at this point. Renal biopsy
B will probably not be helpful in this lady as she has very small kidneys and she should be given symptomatic treatment only at this stage. We will see her again in 6 weeks' time.'

Summarising this letter it says that Code A's kidney function was slowly worsening but that her clinical (physical) condition was stable. As a result of a change in Code A's diuretic (water tablets) prescription her oedema had
C stabilised".

I am asked to read from the third line of the letter. It reads,

"Her blood tests show that her creatinine is fairly worsening and was 192 on the test sample taken".

D Code A then refers to the letter at page 51, a letter from her to Code A typed on 29 July 1999 following a clinic held at the haematology clinic of the Queen Alexandra Hospital on 28 July 1999.

"Code A attended this clinic and was seen by me."

One can see that it had also been copied to Code A which is why there is a reference to
E Code A at the outset.

"My letter notes that Code A attended the clinic with Code A and that she appeared to be looking much better, I note the increase of her dosage of diuretics seems to be controlling her legs swelling. I also note that this has not had any significant effect on her kidney function. When asked Code A said that she had some tenderness and discomfort in the area of the base of her spine. I have noted that
F the blood tests showed no significant change from previous tests and therefore nothing to cause any immediate concern. The result of the 'Congo Red' staining test of Code A's bone marrow was now available to me.

This test had shown that a small amount of amyloid cells were present in her bone marrow. This was a cause for concern but did not necessarily mean that this was the cause of Code A's kidney problems. Amyloid like myeloma can be treated with
G chemotherapy, however despite these findings I was still very reluctant to start this type of 'aggressive' treatment in part due to Code A's age and in part that I was not satisfied that the 'amyloid' was the cause of Code A's kidney problem. In addition, I was of the opinion that chemotherapy in Code A's case may cause more risks to her health than provided benefit".

She noted that the use of steroids could be kept in reserve as a form of treatment if there was
H a significant change in her kidney function for the worse.

A

"Finally, I note that as a result of Code A s complaints of pains in her lower back that I had arranged for her to have an x-ray of her sacrum (lower back/waist area). On 19 August 1999, Code A submitted to an x-ray examination of her lumbar spine and sacrum. I have been shown a paper copy of the result of this examination. The examination date shows to be 19 August 1999".

Sir, this is a page to be added. It has just been copied whilst we have been going through the
B statement. May I hand out a copy of that page, please.

Code A That is marked page 373 and we will place it in the bundle in that position.

Code A Thank you. Code A states,

C

"This result in layman's terms showed that there had been thinning of the bones which is likely to be attributed to Code A 's age. It showed a slightly twisted spine. However, it showed no definite lytic lesion which would have been an indication of myeloma. Code A 's slightly twisted spine and thinning bones on that area are likely to be the cause of the tenderness and discomfort that she reported to me at clinic on 28 July 1999".

D

She refers then to the document at page 41 of our bundles, a letter from Code A to Code A for her information.

"In short, the letter informed me that Code A had attended Code A s clinic on 7 September 1999 and was found to have increased swelling of the legs. Code A would have liked to have changed her dose of diuretics in an attempt to try and treat this. However, Code A did not have a record of the drugs she was at that time
E taking so it had not been possible to do this. Code A s creatinine level has been noted by Code A as gradually rising. This together with her increasing oedema are indications of Code A 's worsening kidney function.

Code A was due to attend the Haematology Clinic at the Queen Alexandra Hospital at some time during September 1999. It would appear that Code A did not attend that appointment".

F

Code A refers to the letter at page 45 of the bundle. This is a letter to Code A at her home address giving her a new appointment for the haematology clinic on 20 October. It notes that Code A had been unable to attend the clinic recently.
Code A says,

"The last occasion on which I had any direct dealings with Code A was on
G 28 July 1999. I have been informed that Code A was admitted to the Queen Alexandra Hospital on 9 October 1999 that she was subsequently transferred to Gosport War Memorial Hospital where she died on 21 November 1999. I have been asked to give a 'prognosis' of Code A s condition. A prognosis is a forecast as to the probable outcome of an attack of disease and/or the prospect as to recovery from a disease as indicated by the nature and symptoms of the case. I first wish to state that it would be more the field of Code A as a consultant renal physician to
H provide a prognosis Code A s case as this is the field in which Code A s

illness falls. My observations are that Code A 's kidney function was gradually worsening. The cause of Code A 's nephrotic syndrome and lgA paraprotein which were probably responsible for Code A s failing kidney function were unclear. The options of treatment available were regarded as aggressive treatments which ran a high risk to Code A s health and well being against any possible benefit, particularly on an 87-year old frail lady. A decision was made that Code A 's symptoms of her illness would be treated namely her oedema and not the cause of her illness. This decision was made knowing that Code A s kidney function was likely to worsen. Therefore, future appointments had been made by Code A and myself in order to monitor Code A s condition".

That is the conclusion of Code A 's statement.

Code A Thank you Code A

Code A Sir, that therefore completes the evidence that we have for you today, but there is a fairly substantial bundle of patient notes in relation to Patient G that we will hand out to you now if we may. We are going to ask you to mark this C8.

Code A The Panel are now receiving the bundle in respect of Patient G and marking it exhibit C8.

Code A Sir, unless you need any of the lawyers to remain for the rest of the day – and we are happy, I am sure, to do so – unless you require it I expect we will all depart. We will be in and out of the room, if we may, just to sort out our papers.

Code A I am not going to ask any of you to stay; you are perfectly welcome to come in and out, however, should you need to do so. The Panel will simply be engaged in individual readings and there is no difficulty.

We will formally adjourn this hearing now until Monday morning at 10 o'clock for all parties; the Panel, though, will be here starting at 9.30.

(The Panel adjourned until Monday 15 June 2009 at 9.30 a.m.)

**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Monday 15 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 SIX)

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)

# INDEX

A Code A Good morning everybody. First of all there are a couple of quick things. Our Panel Secretary, Code A is required elsewhere today so, very kindly, we have a replacement in the form of Code A – thank you very much for coming in to help us today.

We have, as a Panel, both on Friday and this morning, acquainted ourselves with the notes on Patient G and re-read your opening on that. A small point: could I ask you to turn in the Patient G bundle to page 645? In my copy, at least, page 645 appears to be identical to page
B 646, although they are marked differently in terms of numbers. In addition you will note that page 645 and page 646 end with what appears to be an entry from Code A dated 24 September and yet page 647 opens with what at first sight appeared to be an entry dated 21 May 1998 but which may very well be, and probably is, 21 September 1998. Thus somehow we seem to have got out of order.

Code A I am going to ask for the originals to be brought in so we can have a look at
C this. Pages 645 and 646, I think – I have actually taken my 646 out.

Code A So that is clearly just a clerical error but there is also some difficulty with the chronology of the entries.

Code A We will get the originals, but it looks as if for some reason Code A had to swap onto another page, or did swap onto another page in error, so she starts on
D 21 September and then goes to another document for 24 September and then we are off and running, as it were, back on 647. We will get the originals and see if we can understand what has happened.

Code A: You are intending to call Code A and then read the witnesses – is that right?

E Code A Yes. I have the original. It is, in fact, a single piece of paper, double-sided and I think I had better exhibit it. That is the best thing to do. I will exhibit it, if I may. I am going to suggest Exhibit C8a if that makes any sense, so that we know it relates to Patient G.

Code A Yes, it does. We will mark that, ladies and gentlemen, Exhibit C8a.

F Code A In relation to documents like this which we exhibit, would you prefer us to retain them in a separate folder? I see the Panel Secretary nodding. Or would you like to take control of it as a Panel?

Code A I think neither of those, if I may opt for a third. I think it would be most appropriate if the Panel Secretary maintained a bundle of all such documents.

G Code A Very well. Can I pass the document round?

Code A Sir, may I say something which may assist?

Code A Please do, Code A

Code A It is what we have just been dealing with. The date is indeed
H 21 September. I realise it looks as though it is a "5" but it is clearly the date of admission to

Dryad and it may be – obviously it is a matter to be resolved in evidence – that if you look back at page 645 where the entry by Code A is on the 24th, the preceding entry is, of course, a record made by Code A which starts on the previous page, page 644 on the 21st – in other words, the same day as the admission date. It may be that Code A would have kept her note at that time in order to write the necessary letter to the GP, or whoever, but this particular bit of paper would not have been in the hands of Code A at the time the patient was admitted. That, I think, may be the answer but we need to resolve that.

Code A: Thank you, Code A

Code A: Sir, it may be that that is not right because it is the same sheet of paper that one can see photographs had to be put on, which may explain the gap, and so on. We can resolve it in evidence.

Code A: What I will do is this. I think we had better exhibit both sheets. We will exhibit also with that the previous record, as the same exhibit number if we may, by Code A of 21 September. That is also a double-sided sheet of paper, going back to 14 September. That is 643. We now have the originals – 643,644, 645 and 646.

Code A: And 647.

Code A: Yes, and 647.

Code A: We will mark it C8a, originals of pages 643 to 647. (Documents marked)

Code A: If the Panel are ready, I will now call, please, Code A

Code A Sworn

(Following introductions by the Code A

Examined by Code A

Q Is it Code A?
A It is, correct.

Q And Code A is hyphenated, so your name is actually Code A?
A Yes.

Q I think you yourself are a retired naval officer?
A I am.

Q I want to ask you, please, about Code A whom I think you knew as Code A?
A Yes.

Q Code A we know, was born on Code A and I think Code A was it, around 1977?
A Yes, round then.

Q Thus he became Code A Code A I think, died in 1989?
A Correct.

Q And there is just one matter of relevance so far as your evidence may be concerned. That is that she unfortunately died of cancer and you were aware that towards the very end of her life she was on a syringe driver?
A That is correct.

Q She was being delivered analgesia, particularly diamorphine. Is that right?
A Yes, it is.

Q So you had come across syringe drivers in those unfortunate circumstances back in 1989?
A Yes, that is correct.

Q I want to ask you a little bit about Code A whom I think you yourself have described as being a person who could be a difficult man?
A Oh yes, no doubt about that.

Q Just to deal with his background a little bit, I think he had worked abroad prior to the Second World War, and then during the Second World War did he serve in the Royal Air Force. I think he crash-landed in France?
A Yes. In fact he worked abroad after the war.

Q I am sorry – thank you. But during the course of the war – and this may also be relevant – he crash-landed in France and had a spinal injury. Did he have to have spinal fusion?
A Yes, he did. I think he was only the second such victim in the country, so it was rather experimental, but it worked pretty well for him.

Q Then, in due course, he came back obviously to live in this country and where did Code A live?
A Initially in Scarborough and then later they came to Gosport.

Q Did you yourself know the Gosport area?
A Yes. I was already living at Fareham nearby.

Q Following Code A s death, we know that Code A I think, stayed in various rest home.
A Uh-hum.

Q I want to move on to the late nineties. In July of 1998 we know that he was admitted to Mulberry Ward which is one of the wards at the Gosport War Memorial Hospital?
A Yes.

Q And after that he was discharged to a home called the Thalassa, is it, nursing home?
A Yes, it is. Correct.

Q Did you used to go and see him when he was at the Thalassa?

A A Yes, we did. We used to take him out when we could.

Q And "we" is who?
A Code A and I.

Q How did you get on with Code A?
A Very tolerably well. I think I have to say, to be honest, he was not in favour of the
B rest of the family – Code A – but I managed to cope with him quite well.

Q Is it fair to say he was a fairly difficult man to deal with?
A He could be. Not always, but he could be.

Q And he had, perhaps typical of his age, as it were, fairly strong opinions about a number of things?
C A Oh, no doubt about that, yes.

Q I want to move, please, to a time when you went along to the Thalassa Nursing Home on 21 September 1998. I think you were taking him some of his belongings from his previous residence. Is that right?
A Yes, that is correct. He had moved from mostly rest homes rather than nursing homes; he had moved from one to another in the recent past. I was actually still in the
D process of moving him from one to another at the time. I was actually moving one of these boxes, unprogrammed. I was moving them when I could and when he could cope with emptying them and sorting them. That is what I did on the Monday morning, on 21 September.

Q What happened when you arrived at the nursing home with the box?
A I saw whoever was in charge – I cannot remember who it was – and said I had a box
E for Brian in the car, could I deposit it in his room. And they said "He is not here. He is in the hospital" which I knew nothing about. I knew he had an appointment that morning, which is not unusual. He used to go to the day hospital on occasion.

Q Is that the Dophin?
A At the Dolphin day hospital, yes. That morning he had been admitted and I knew nothing about it till I arrived at this nursing home.
F

Q As a result of that information, did you take yourself off to the Gosport War Memorial Hospital where you had been told that he had gone?
A Yes. I left his box in his room and went immediately there, yes.

Q I think you found that he had been admitted to a ward called Dryad Ward?
A Yes, that is right.
G

Q And did you go and see him in Dryad Ward?
A I did.

Q All right. What sort of state was he in when you found him?
A Perfectly normal as I had previously remembered him. He was normally alert and lying on his side a bit. I asked him what he was doing, and he said, "I've got a sore butt."
H I knew he had a sore butt because he had mentioned it previously in a telephone

A conversation, I think it was. And they decided to take him in for aggressive treatment.

Q When had you see him prior to this when he had been at the Thalassa? Can you remember how long before you had seen him?
A It might have been a couple of weeks. I was working in London at the time and I could only see him at all at weekends, and usually it was just for a few hours.

B Q Up until this point, up until he got to the Gosport War Memorial Hospital, when you had seen him a few weeks before, what had his mental state been, for instance?
A I did not notice any serious deterioration in his mental state. It was perfectly normal, as I said. Lucid and able to hold a conversation.

Q I do not think he was a very big man, was he?
A He was for a long time overweight, I would say, especially with a disability, but he
C coped with that. Gradually he got weaker and he lost weight.

Q When he was at the Thalassa, how would you describe his build?
A I think by then he was quite frail. He had lost a fair bit of weight and he was quite frail, unable to get around in the way that we had been used to him getting around.

Q Was he still mobile?
D A I do not think he was on his own, no. No. I remember pushing him around in the wheelchair when we took him out occasionally, although he could obviously get out of it and transport himself to a restaurant chair, if you see what I mean – but we had to take him around in a wheelchair.

Q Let us go back, then, to the 21st. You went in and you saw him. Was he in a ward or in a private room, in a room on his own?
E A In a private room, yes. Sorry – where?

Q In Gosport.
A In the hospital?

Q Yes.
A He was in what I think was a four bed sub-ward.
F

Q Was there anybody else in the ward?
A No. He was the only one in there, yes.

Q He was able to talk to you?
A Oh, yes.

G Q He told you, as he put it, that his butt was a bit sore?
A Yes.

Q You mentioned also that he had been admitted for aggressive treatment. Is that something you have read in the notes since or is that ---?
A I think I read that, yes – those words. But yes, I knew he was in for treatment and it was a bed sore. He told me that.
H

Q It is fair to say that since these events, you have had access to his nursing notes and you have read through his medical notes. Is that right?
A To a large extent, yes. Those I have seen, that I have been allowed to see – put it that way.

Q On the 21st, how long do you think you spent with him approximately?
A Probably about an hour in the hospital. I was actually on the way to London and I delayed leaving the area. I took the opportunity of moving one of his boxes before I travelled and so consequently my departure from the area was delayed by finding him in the hospital.

Q When you were with him did you see him eat anything or drink anything? Can you remember?
A No, nothing whatever.

Q When you left, did he ask for anything in particular?
A Yes, I asked if I could get anything for him from the nursing home because of his rather unexpected admission, or anything else for that matter. And he said no, he had everything he wanted except perhaps I could get some chocolate for him and a box of tissues. One of the symptoms of his Parkinson's was the moisture on his lips, and he was very conscious of that. It was more or less habitual, I suppose, to wipe his lips frequently.

Q Did you go off and get him some stuff?
A Oh yes, I went to the shops, and then returned to the hospital with a supply to last a couple of days. This was the Monday morning. I was coming back on the Wednesday. I just bought enough to last a couple of days.

Q You took him his chocolate and then you were going to leave the hospital. Did you speak to anybody before you left?
A Yes I asked to speak to the doctor who had admitted him and I was told that I could not do that; it was Code A who would not be back until the following Monday, but an appointment could be made for me to see her then. It was also said there was a visiting doctor who would be in later in the day, at which point I explained that I was going to London, and I would not get to see her either. Nurse Code A then explained to me the situation.

Q We cannot hear everything that Nurse Code A said to you, but, in short, did you understand that Code A had a sacral sore?
A Oh, yes, she said it was one of the worst sores she personally had seen and I ought to take action and complain against the nursing home.

Q That was the Thalassa?
A The Thalassa.

Q For allowing him to get into that state presumably?
A Yes, that's what the implication was and I wrote a letter to the Nursing Home Inspectorate on the Wednesday, 23 September.

Q What happened the following day?

A A Well, I was in London and I initially telephoned the hospital myself, could not speak to anyone of consequence. They said they would call back, which they did, and I was told that Code A--

Q Let us see if there is any objection to this. I would have thought we could have it.

Code A (Nodded in agreement)

B

Code A Yes, you tell us what you were told.
A Code A had become aggressive to the staff, abusive, and they had had to give him something to quieten him down. And I fully understood that Code A could be abusive and aggressive to staff; there was nothing - - I said as a result not to be too concerned I would be there the following day and I would have strong words with him and sort it out.

C Q Because you had a relationship with him where you could talk to him.
A Yes, person to person I am sure we would have got through and quietened him down myself.

Q Had you been aware that when he was at the Thalassa that there had been some bad behaviour there as well?
A Actually, no, I was not, I was not aware of that.

D

Q Okay. Tell us, please, about the following day. Did you go back to see him at the hospital?
A On the Wednesday?

Q Yes.
A Yes, I did. As soon as I could I collected Code A from Fareham on the way to
E Gosport and we went together round about lunchtime.

Q This would now be the 23rd?
A The 23rd, yes.

Q Did you go up to the same room to see him?
A Yes, I went to the same place and he was unconscious.

F

Q Did you have try and speak to him?
A Well, of course, yes, but it was pointless, you know, the man was unconscious.

Q Was he rouseable?
A No, he was not. Indeed, the last time I spoke to him was the Monday morning before I left.

G

Q It may be obvious, but was there a significant difference between how he had been when you seen him two days before?
A A totally different person. He had gone from being a normal person who could converse to someone who was totally comatose.

Q When you had seen him on the Monday before he said that he had had a sore butt.
H Had he complained otherwise of pain?

A No, he had not. In fact he did not complain about pain when I saw him. He was not in any pain in the way that you describe it. If he had I am sure he would have said something.

Q You said you had an hour with him. During the course of that hour, did he indicate to you at any stage that he was in very significant pain?
A Not the slightest, no.

B

Q You found on the 23rd that Code A was unconscious and unrouseable, did you discover why?
A Yes, I did, I discovered, for whatever reason I went to other side of the bed and discovered the syringe driver.

Q You knew what a syringe driver was?
C A I knew instantly what was going on quite frankly and I went berserk. I got very, very angry. I demanded to see the person responsible in the hospital at that time and we had a row I am afraid.

Q Who did you speak to?
A It was actually Code A in the end. The doctor was not available of course and she was the most senior person available.

D

Q What did you ask to happen?
A I asked for it to be removed immediately so I could speak to Code A. Things were beginning to add up in my mind. One thing you have not asked me, which is relevant, that when I first went to the hospital to find Code A on the Monday morning --

Q I am going to stop you. There is a reason I did not ask you, all right. We can only
E hear what you directly saw and heard.
A I am going to tell you something I heard, and I think it is relevant I am afraid.

Q Well --

Code A Perhaps I may assist here and really support Code A in this.
A Sorry, I ca not hear what you are saying.

F

Code A If I may interrupt here as the Code A and really support Code A in this. One understands of course very much the strong feelings of Code A Code A but the Panel is, I am afraid, obliged to stick to rules of evidence. It does not really have a discretion about that here at all. It is important I advise that, although one understands the strong feelings very much, that Code A does restrict himself to the questions directly asked by Counsel and, in due course, by the Panel.

G

THE WITNESS: I am not sure I heard all that, but are you saying I am not to say any more about that subject?

Code A This Tribunal runs by criminal evidence rules. There is a rule about hearing evidence of what somebody else said to you, unless it is in very particular circumstances. I know you are very keen to tell us about a particular comment that was made, but it is not
H admissible.

A A Why not?

Q Well, you have to accept it from me--
A I am afraid it formed my opinion at that time, which is very relevant.

Q Well, I am going to move on and I am going to ask you how things carried on with Nurse Code A
B A Well, I trust the Panel will ask me later what I am talking about.

Q We will see. You had a conversation with Nurse Code A and you asked her to stop the syringe driver?
A I did.

Q Did she comply with that?
C A No, she did not.

Q How did that progress?
A She told me that only a doctor could authorise its discontinuation.

Q All right. It follows from that that you wanted to speak to the doctor.
A Of course.
D

Q Right. Did you get an opportunity of speaking to Code A that day?
A No, I accused Code A -- I accused Nurse Code A of killing Code A and I was told that she would speak to the doctor and would come back to me later, at which point from nowhere came the hospital vicar who invited me into her office, Code A and I, and she told me about death being part of life and rubbish of this nature, which was quite obvious to anybody.
E

Q Did you get an opportunity of speaking to Code A ?
A I was told she was supposed to be coming later in the day. After my interview with the vicar, Code A reappeared and said Code A would not be appearing that day after all, she would be coming the following day.

Q Right.
F A Which would be the Thursday.

Q And that was despite the fact you had made it very clear that you wanted the syringe driver to stop?
A Absolutely.

Q All right. Tell us what happened.
G A When?

Q After that.
A Well, I had no choice but to wait as long as we could before we went home ourselves for the night, came back the following morning and waited the rest of the day for Code A to show up which happened about 5 o'clock on the Thursday as far as I remember, late afternoon anyway.
H

Q During the whole of that time of course Code A remained on the syringe driver. How much of that time did you remain with him?
A All day.

Q At any stage did he become conscious?
A Not at all, no. The last opportunity I had to speak to him was the Monday morning before I left, he was totally unconscious after that.

Q Tell us about your meeting, please, with Code A on the evening of the 24th?
A Well, I very calmly asked her, I told her I wanted to speak to Code A "would you please suspend the syringe driver to enable him to come round so I could have words with him?" I wanted to ask him if there were any last wishes, realising that he was dying - in fact she told me quite bluntly that he was dying from the poison emanating from his bed sores is what I was told. I also wanted to ask him if he realised what was happening to him and was he happy with that. If I had known that I would have walked away at that time. But I was not allowed to ask those questions.

Q You wanted an opportunity of confirming with Code A that the treatment that was being given to him was the right treatment?
A Absolutely.

Q Which was to keep him unconscious?
A Absolutely.

Q Code A said what to you?
A She refused bluntly and said she could not authorise the removal due to the pain he would experience at which point I accused her of murdering him and the interview terminated rather quickly after that.

Q Was there any discussion about the responsibility of lowering the dose so that he could become conscious?
A Not at all.

Q You accused Code A of murdering Code A Presumably that brought the interview to a fairly abrupt end?
A Yes, it did.

Q Did you return to Code A's bedside?
A Yes, we stayed there, apart from going home to sleep ourselves, we stayed there until he died, which was the inevitable as well, I was never going to speak to him again. There was no point in pressing it any further.

Q Were you there at any stage, can you remember, when he was moved by nurses? Did you remain in the room?
A I do not think I remember that happening personally, no.

Q Did you see from him any sign of pain or increased pain?
A None whatsoever, no.

Q We know that Code A s death was recorded as 23:15 hours on Code A
A Yes.

Q Did you see him that day?
A Oh, yes, we had stayed with him all day again and we left I think sometimes in the early evening, I imagine. We were certainly back at Fareham, we had eaten and were back at Fareham and we got the telephone call to go to the hospital immediately.

Q When you got to the hospital--
A He was already dead.

Q I think following this, and I am not going to spend a lot of time on this, did you see the Death Certificate?
A On the Monday morning following I collected the Certificate of Death - I do not know what exactly you call it - but the Certificate of Death from the hospital in a sealed envelope and took it to the Registrar, and the normal Registrar was not actually there, it was a deputy that was standing in. Would you like me to go on?

Q Yes, certainly.
A She looked at the certificate and said "do you know what he died of?" I said "no, please tell me" and she said "Bronchial Pneumonia". I said "that is utterly ridiculous. There is nothing wrong with his bronchial system whatever".

Q I think you challenged that?
A Of course.

Q Did you ask for a post mortem?
A Yes, I did, which was eventually carried out under duress I think. The coroner was not at all happy for me asking for a post mortem, and I wanted a test done for drug overdose. And the following day when it was done no such tests were done at all. I spoke to the pathologist afterwards and he said he was not asked to do any tests of that nature. He could only act on the coroner's directions and the coroner had no intention of carrying out toxicology tests at all.

Q You wanted a toxicology test?
A Of course, that's the reason why I asked for a post mortem.

Q And none was done?
A None was done.

Q Thank you very much. Would you wait there, please?

Cross-examined by Code A

Code A Hello, Code A
A Just a point, I would like to express some objection, I am afraid, Code A Code A was at the coroner's inquest and questioned me there, and he is quite apt to throw in slanderous personal comments which I objected to at the time, and I have no intention of subjecting myself to on this occasion. If you ask him to please restrain himself to direct questions I will try and give direct answers, but nothing more.

Code A Well, I am sure that in these surroundings there will be no slanderous questions put to you. This is a very experienced member of the Bar and I would hope and expect that we will see from him absolutely the standards that one expects.

A Yes, it did not show at the coroner's inquest.

Code A Well, I am afraid I was not there and I have no access at this time to what may or may not have been said. I note what you say, and I am sure that he also notes what you have said, and we will proceed and I hope we will get through the process without any difficult.

A Thank you.

Code A Would you like the Panel to see the transcript of my cross-examination of you in the coroner's inquest?

A I have got no concern at all about that.

Q Because that would either bear out or refute what you have just suggested, would not it, Code A ?

A If you want to show it, please do. I have got no preference whatsoever.

Code A With the greatest respect, he is just challenging the witness to an argument. I cannot see how that sort of invitation is going to help this Panel in any way in relation to the issues it has to decide.

Code A I agree. Thank you, Code A Please confine ourselves to the issues that are in question here.

Code A I think what you have suggested in your statement to the police was that the coroner's office was corrupt in the way in which they approached a post mortem for Code A Code A ?

A I came to that conclusion as a result of what was not done in light of the evidence that was facing me, yes.

Q What you asked for was a post mortem and that was done. The pathologist who undertook the post mortem came to exactly the same conclusion as the doctor, Code A who had certified Code A 's death, namely that the medical cause was Bronchial Pneumonia?

A Yes, but it was artificially induced Bronchial Pneumonia as I now know.

Q Do you accept that it was Bronchial Pneumonia?

A I have got no choice, but I still think he died from an overdose of drugs.

Q Yes.

A Indeed the drugs caused the Bronchial Pneumonia.

Q What you have suggested in your statement is that this was a conspiracy involving doctors, nurses, a corrupt corners' office were the individuals who caused the death, and who were aided and abetted by Code A who had signed the Death Certificate, and had indeed treated Code A ?

A I suggested that, yes.

Q Do you think the Code A was in on this?
A I do not know about her. I feel that she has been manipulated possibly as well, yes, quite possibly.

Q. Code A deteriorated quite considerably over the year 1998 and the months leading up to his admission to the War Memorial Hospital, did not he?
A Yes, he did.

Q He was seen fairly regularly on approximately a three-month basis by Code A during that last year?
A Yes, that's correct.

Q Would you agree? I do not know if you were there for any of those assessments--
A No.

Q --or whether you simply read the documents at a later stage.
A No, I was not there.

Q Sir, I know the Panel have the records, but the first assessment in time by Code A is at page 140. I do not need to take you to it, but I will just give you the reference. The next one in time is three months later, this one in June 1998 and the letter is page 134. I am going to invite people to turn that up. The documents are just in front of you if you want to look at them, Code A You do not have to look at them at all if you do not wish to.
A I have no need to look at anything. It is embedded in my mind, the whole process.

Q That is fine. The Panel are dealing for the first time today with these medical records. What Code A says in the second paragraph was that on that occasion in June, having last seen him in March, she was most struck at the amount of weight Code A seems to have lost since she last saw him. Would you agree that physically there was that deterioration in the first half of 1998?
A I think I have already said that I think he had lost weight, yes.

Q Again, just for the sake of completeness, the next time that Code A saw him we have two references, one is her clinical notes at page 92, and page 98 is the letter. Again, the Panel have read it before you started giving evidence, Code A but one sees at the bottom of the letter, page 98, that Code A anticipated reviewing Code A at the Dolphin Day Hospital on 14 September to monitor his Parkinson's disease and other matters.
A I imagine you are correct.

Q We have heard the suggestion from Code A that there may have been some problems at the Thalassa Nursing Home, but you were not aware of those?
A No, I was never informed, I do not believe, of any problems.

Q How often would you see him at the Thalassa Nursing Home?
A I would say it was probably no more than once a fortnight. Perhaps a bit more on some occasions. I cannot remember what I was doing in 1998, to be honest with you. I may have been aboard at times for a few weeks. I just do not know.

Q If the Panel were to turn to page 322 they can follow the chronology. Code A was seen at the Dolphin Day Hospital on 14 September 1998 and was asked to attend again on Monday 21 September for review by the doctor. He was told to bring everything all his medications with him.
A Is that the statement where he told Code A he wished to end his life?

Q I was not going to deal with that.
A Well I am, because that is something I discovered during the inquest. I did not know about that. Code A actually asked Code A to end his life for him.

Q I am not going to ask about that. If people want to turn on over a page they see the clinical notes for 14 September. They are also at page 643. There is actually quite a lot of repetition in this bundle. We go on to page 644, 21 September, when he is seen by Code A at the Dolphin Day Hospital but, as you have told us, Code A you were not aware that that was due to happen.
A No. I knew he had an appointment but as far as I was aware it was just another review of his Parkinson's medication.

Q Yes.
A That is something that has always been tinkered with, I have to say. His medication was the reason why he moved from one rest home to another. I think there are a lot of misleading statements around the various literature which imply he was unhappy with the treatment he was being given. It is not at all true. He was actually hallucinating very badly in his last few months. He thought there were ghosts in his room and snakes at the bottom of his bed and things of that nature and could not settle. That is why he was moving from A to B to C to D.

Q We have Code A's note who on 21 September, again, page 644, describes him as "very frail". Would you agree or disagree with that?
A I think he was frail but he was certainly normally mentally lucid and able to manage a conversation.

Q I am talking physically, as I anticipate Code A was when she called him "very frail".
A I would not disagree with that.

Q All right. We know that some tablets were found in his mouth on that day, some time after they had been given to him.
A I do not know what you mean by some time. The fact is tablets dissolve. How long had they been there? You make a big issue of nothing, I think.

Q The issue was they had not been swallowed, I think.
A It is quite likely he had not been given any water to swallow them with, I suggest.

Q There was a concern, I think, at that point about giving him oral medication and the risk that that might pose. Did anyone say anything ---
A Code A produced a perfectly normal care plan on the Monday morning of 21 September, which advised Oramorph at 5-10 mg if required. He was given a 5 mg tablet at two-fifteen in the afternoon which apparently had the desired effect, and he was given a 10 mg tablet at eight-fifteen in the evening, and he was noted

A as being comatose by ten o'clock and given the syringe driver at eleven-ten that evening.

Q I was not going to go through all the medical records ---
A Well I am afraid I am because it is very relevant to what happened.

Q There we are. The prognosis was said to be poor by Code A
B A What does that mean? It is a subjective statement.

Q I hope we will hear from her, but I suggest what it meant was just that.
A What is poor? What is good? What is normal? What is fair? It is a ridiculous statement. It does not mean anything.

Q He was quite a proud man, I think, Code A ?
C A I would say he was proud, yes.

Q What did you know of the detail of the medical problems?
A I knew he had a "sore butt", as he described it.

Q What did that mean, as far as you understood?
A I knew he had Parkinson's for about fifteen years, which had progressed very gradually over that time. It started off with a very minor finger tremble. It
D was controlled. Code A I believe, had it under control. I knew he had constipation at times, as we all do. Nothing unusual about that. He also had a kidney stone removed at some point. I remember that. Again, nothing unusual, I do not believe. I do not think there is anything else of significance I can think of.

Q What did you understand the "sore butt" related to? Did you know it was a bed sore?
E A Yes, I think I did know but I had no idea how serious it was. I understand from Nurse Code A it was a very serious bed sore. The most serious she had seen, according to her.

Q It was so bad she was suggesting that would be appropriate for a complaint to be made to the nursing ---
A Yes, she was, and this is what I did, as I said.
F

Q Did you know it was photographed because of the concerns?
A I did not know that, no. I know now because the photographs are in the medical records. I have seen those.

Q Did you know that Code A was given Oramorph before the dressing on that bed sore was changed?
G A On the Monday?

Q It is page 861. You do not have to look at the medical records but I hope the Panel will.
A Are we talking about 21 September?

Q Yes.
H A I guess that is one of the reasons they gave him the Oramorph because of the likely pain due to the dressing they were putting on, I suppose. If it was

A aggressively treated I imagine they were putting something on that would sting rather. You know?

Q On 21 September, the day he was admitted from the Dolphin Day Hospital, part of the War Memorial Hospital, he was noted to have a large necrotic sore on his sacrum by a nurse called Code A and seen by Code A
A On the 21st?

B

Q Yes.
A That is what you are telling me, yes.

Q He was given Oramorph 5 mg before the wound dressing was changed.
A This is some time in the afternoon. I know he had the 5 mg, I think it was at about two o'clock, plus or minus fifteen minutes.

C

Q When did you stay till that day, do you remember?
A I said I had to leave to travel to London. I left around midday, again, plus or minus half an hour. I cannot remember exactly when.

Q You had gone, if his dressing was dealt with, at ten to three in the afternoon?
A Yes, I was away.

D

Q You cannot tell us what his state was after that time?
A Only what the nurse I spoke to told me the following morning.

Q Did they tell you what his state had been for the afternoon and the early evening?
A No, I was just told very generally that he had become aggressive to staff, very abusive and they had to give him something to "quieten him down" were the

E words they used.

Q Was that a description of what had taken place on the 22nd or whether he had been agitated on the 21st?
A As a result of my leaving after I left is what I was told, on the 21st.

Q I think there had been problems with Code A Again, he was a man

F of strong opinions. Put bluntly, he was a man with racist views.
A I think he was an old-fashioned colonialist.

Q We can put it in different ways but the result may be the same. Would you agree?
A He worked on the tea plantations in Ceylon after the war and he had a very firm master/slave relationship with the people at that time. I am aware of that.

G

Q Code A was from that part of the world originally.
A Yes, she was.

Q Were you ever present when Code A and Code A were in the same room?
A No, I never met Code A She managed to avoid meeting me.

H

Q When you were told over the telephone on the 22nd that Code A s

behaviour had been a bit out of order, what did you think was being referred to?
A I just thought he was being his normal - I say normal, difficult self. That is not what I mean. I would say he is quite reasonable most of the time but he could very quickly turn on someone if they were doing something to him that he did not like, and I suspect that is what had happened. I suspected the dressing they put on his wound was hurting him and I imagine the staff were being rather - I would not say cruel, that is the wrong word, but being very firm with him which he maybe would not appreciate.

Q If he was turning on staff, what did you think that referred to? That he was doing things physically or was saying things that people might object to?
A I did not know and nothing was said to me at that time.

Q Are you sure nothing was said to you?
A I have just told you.

Q I am entitled to ask you, Code A and I am asking, are you sure nothing was said to you about ---
A About what?

Q I suggest you were told, effectively, what the Panel have at page 861, that Code A had tried to wipe sputum onto a nurse, saying he had HIV and was going to give it to her.
A I cannot remember the words that were used, but certainly his behaviour had been totally unacceptable.

Q It was not just what he was saying though, was it?
A I really cannot remember in detail. It was a telephone conversation eleven years ago.

Q You were told as well that he tried to remove his catheter and empty the bag. Do you remember that?
A I cannot remember that either.

Q He took his sacral dressing, removed it and threw it across the room.
A I think I remember something about that, yes. That suggested to me the dressing was hurting him in some way, but, clearly, his behaviour was unacceptable and I said, "Please do not be too concerned. I'll be back tomorrow morning and I'll have strong words with him, if necessary".

Q I think there were a multiplicity of problems with Code A Some of them physical, like his lack of mobility because of his war injury, because of his bed sores, because he was completely immobile. He had been assessed for his mobility. You have heard of the Barthel score, have you not?
A I have heard about it. I do not know much about it.

Q The Panel have it at page 867. This is an index to show how much someone can do for themselves. At that stage on that day, 22 September, is this not your understanding, that Code A effectively, could do nothing for himself?
A No, he was perfectly capable of eating and drinking and having a normal conversation. Those three things I know for sure there was no problem with.

A Q I suggest the view from the medical professionals was rather different. Part of his problems was his Parkinsonism and there were difficulties in controlling that in the past. You have told us ---
A I said there were drug alterations which made his hallucinations worse on some occasions and had to be frequently changed to try and overcome that problem.

B Q Was it not explained to you that if Code A was removing his catheter or ripping off bed sores that that caused a real problem in trying to maintain his position and improve his bed sores? To treat them properly.
A I am sorry. I was not there.

Q Was that not explained to you?
A At that time I had a telephone conversation and I was told his manner had C been unacceptable and that they had given him something to quieten him down.

Q They were concerned for his health and the nursing of his bed sores. That was what you learned, was it not?
A I have learnt a lot since. A lot came out at the inquest which I was not aware of.

D Q He was still uncomfortable when being moved and treated by nurses. You were aware of that too, were you not?
A No, of course not. I said he was unconscious when I next saw him.

Q You say, "of course not".
A He was unconscious when I next saw him and he never regained consciousness after that.

E Q You had conversations with Code A
A A conversation with Code A

Q What we have are entries for 23 September ...
A Which is the Wednesday.

Q ... to say you saw Code A and Staff Nurse Code A Do you F remember that?
A I remember Code A definitely but not Code A

Q Your previous experience with a syringe driver was in relation to Code A Code A who, I think you told us at the inquest, had had cancer for nine years before she died.
A I do not think I said that, but she certainly had cancer for some considerable G period. She was in and out of Queen Mary's Hospital in Portsmouth perhaps two or three times.

Q What you told the inquest, is this right, was Code A was on a syringe driver for six days in the period just before she died?
A Yes, she was put on a syringe driver on the Monday morning and died on the following Code A It may be coincidence but Code A was put on a H syringe driver on the Monday late evening and died Code A Almost to the hour between them.

Q What you told us at the inquest was notwithstanding the cancer Code A had had for years, it was your view that it was the syringe driver that had killed her.
A In Code A s case?

Q That is what you told us at the inquest.
A I learnt a lot about Code A 's case, I said.

Q I am sorry. I missed that.
A I learnt about syringe drivers from Code A er's experience with them.

Q It was your view, was it not, that syringe drivers meant death rather than the treatment of pain or ---
A I came to realise they could be seriously misused, quite frankly.

Q That is why when you were told by the nursing staff that Code A was on a syringe driver for pain and for treatment to control his symptoms that you became very angry?
A Yes. It was total overkill.

Q So you were accusing Code A of murdering Code A
A I did not use those words with her.

Q You told the Panel that you did.
A I did not. I told the Panel that I accused her of killing him.

Q I beg your pardon then. I thought it was murder. Was it just murder with Code A ?
A Yes, it was.

Q We have an entry dealing with night staff ---
A Uh-hum.

Q --- on 24 September.
A Uh-hum.

Q The night staff were reporting that Code A was in pain when being attended to, and also in pain with the day staff?
A Well, they would. They were pushing up the diamorphine levels without reason, in my view. By then I had already given up hope of ever seeing him. After, I spoke to Code A Code A it was quite obvious to me Code A was being put away and there was nothing more I could do about it. I resigned myself to that.

Q Did you make any comment on the reports from night staff?
A I have no comment to make.

Q Forgive me. And day staff?
A I discovered ---

Q Excuse me. Can I ask the question?

A A Yes.

Q Do you make any comment on the reports from night staff and also day staff that your stepfather was in pain despite the medication that he was on?
A I think that is a fictitious statement. The man was unconscious so how would they know he was in pain?

B Q Then you spoke to Code A on that date, 24 September?
A No. Yes, there was – on the 24th, yes.

Q And you accused her of murder?
A Yes.

Q Did you think that the conversation would be a long one after you made that
C accusation?
A Of course not. I expected her to be a bit more sympathetic to my situation, and to have at least interrupted the process, perhaps using different analgesics, or whatever, to allow me to have a final conversation with him, but that was not on offer and it was made quite clear to me.

Q Did you think that if Code A was on medication because of pain, and the
D assessment was that he needed the medication that he was on, it would be cruel to put him in pain?
A No, because I think the pain was mostly imagined. They were making a big issue about pain. If he had been in serious pain, I would have known on the Monday, I am sure about that. Code A was not slow in coming forward when there is something wrong, I can assure you.

E Code A Thank you very much, Code A

Re-examined by Code A

Q The Barthel score that my learned friend was relying on – can I just confirm. Is it the one on page 867? Yes. Code A you have been asked about the Barthel score showing zero capability on 22 September 1998?
F A I do not know what that means. Zero capability is, again, subjective. The thing is ---

Q Wait for the question.
A When you say what "zero" means, I will accept it, but I cannot accept it as it is.

Q What I was going to ask you is this. We know from the records that in fact your stepfather had been on a syringe driver since the night before, because that was started at ten
G past eleven in the evening, so when a Barthel score is taken from him on the following day, the 22nd ---
A You would expect it to be zero, would you not?

Q --- he is not able to do much.
A Yes.

H Q But when you saw him on the 21st, did you think he was capable of feeding himself?

A A Oh, of course. Yes. He was perfectly normal in that respect, yes.

Code A Sir, there is a matter of law I think that arises because I stopped Code A Code A from dealing with a comment that was made to him when he went to the hospital, 21 September, because it was then, it seemed to me, irrelevant. The way he is being cross-examined is to put to this witness that he has made serious allegations effectively without foundation.

B

Code A Can I help? I do not object if that comment comes out.

Code A Thank you very much. (To the witness)

Code A Code A wants to say it, so I do not object.

C Code A Not only that. It seems to me whether the witness wants to say it or not, it is now admissible so, Code A I am going to ask you what the comment was that you were keen to us about and how it came about?
A I am just trying to tell the whole story.

Q I understand.
A I saw what happened from a different perspective to anyone else. I saw it from my
D own unique view.

Q Tell us ---
A And I was struck by the most ridiculous statement, I thought, at the time, when I first arrived at the hospital. I asked where Code A was, and they told me he was in Dryad Ward and directed me to it, and someone else in the reception box, probably a cleaner or something like that, said, "Ah, that is the death ward". And I thought, "What a stupid statement anyone
E could make; Code A is nowhere near death." It just seemed utterly ludicrous.

Q At the time I think did you dismiss it?
A I am sorry?

Q At the time did you dismiss it?
A I dismissed it at that moment, of course, and I walked in to see Code A Again, in
F retrospect things become clearer because before I actually left to drive to London I went to the toilets, which led me along a long passageway, to the far end of this, if you like, ward, where there were maybe half a dozen similar sub-wards to the one Code A was in. Each one of those sub-wards had a single person in them, all a funny colour. It seemed to me they were all comatose, all quite close to death it seemed to me.

Q All right.
G A And I thought that was rather odd. I thought what a cruel place to put Code A in, because he was a gregarious personality.

Q And when you made the allegation that you did against the various people, all of these matters, I expect, did they inform your opinion, from what you heard and saw?
A It did. The thing is later, by the Thursday I saw Code A All the ticks were in the box. I thought, "Hey, this is very, very serious".
H

Code A All right, Code A thank you very much. Would you wait there, please.

Code A This is the time now when members of the Panel, if they have any questions of you, may ask them, so I am going to look now to see if there are questions. It appears I am the only Panel member who has a question.

Questioned by THE PANEL

Code A It concerns the conversation you had on the telephone with the nurse on 22 September. It might assist you if you looked at page 861. You will see that that contains the nursing note, and it is signed by what looks like Code A

A I have the page. Can you direct me to where I should look.

Q Yes. Would you look at the dates column on the left hand side, you have three entries. It is the third one, the 22 September 1998, and it appears to be signed, as I say, by Sister Hallman. Do you happen to recollect the name of the nurse you spoke to?

A No. I thought it was Code A but I am not sure about that.

Q They are very similar and there is a Code A and a Code A in this case. For what it is worth, the Panel will be hearing from both of them in due course. At this stage, of course, we only have yourself in front of us and we have to find out what we can from you. But you told us very clearly that you were shocked when you found the syringe driver under Code A s pillow ---

A Uh-hum.

Q --- when you subsequently visited and your description of this particular telephone conversation on 22 September, I think you said that the nurse had told you about his poor behaviour and had said that they had given him a little something to calm him down.

A Yes.

Q What she has recorded here is that she explained that a syringe driver had been commenced the day before. To the best of your recollection, was that mentioned?

A To my recollection, absolutely not. This is why I went berserk when I saw it, when I arrived on the Wednesday.

Q Given your previous experience with syringe drivers, had it been mentioned what would your reaction have been?

A "Please do not do it until I have had a chance to speak to him." Quite honestly, I knew from that experience with my mother what the consequences could be – not would be necessarily, but could be.

Code A That certainly helps me very much, thank you. I am going to ask now first of all Code A whether any questions arise out of my questions?

Code A No, sir.

Code A And Code A any questions arising out of mine?

Code A No, thank you.

Code A Thank you very much, Code A That completes your testimony. This hearing, of course, will roll on for a considerable period as we see other witnesses and build up our own picture, but we are most grateful to you for coming today to assist us in that process. You are now free to go. Thank you very much.

(The witness withdrew)

Code A I think the Code A has something he would like to ask.

Code A Thank you, Code A It is simply this: I had the impression from something Code A said earlier that he was expecting Code A to be giving evidence in the case. If I have misunderstood that ---

Code A She may be.

Code A She may be?

Code A Yes. The GMC are not calling her, but whether the defence are calling her or not, I do not know.

Code A I simply raise it because the Panel does not normally know who the defence are going to call, but that comment was made.

Code A Yes.

Code A I think it would be helpful for the Panel, particularly given some of the issues which have arisen, to know whether Code A is definitely going to be called by somebody. Whether they may be... I do not know whether the Panel can be assisted any further about that.

Code A You will remember when I opened it, I explained Code A's role and the fact that she was now in New Zealand, and we had reviewed the patient notes, and the view we had taken. We cannot control who Code A and Code A are going to call, and if there is an indication that she will be called by the defence, then all well and good.

Code A I think the Panel should anticipate that they will be hearing from Code A

Code A I am most grateful and, of course, that does deal with a third possibility, which is that as we get further into the case, the Panel may itself take the view that evidence from a person referred to who is not planned to be called by the GMC might indeed be a welcome witness. With that understanding, we will say no more.

Code A In fact on that topic, I think I heard you say that we were going to be hearing from Nurse Code A I think we can indicate that is most unlikely. Among other reasons, Nurse Code A is very unwell, but I do not know if the defence have anything to say about that.

Code A There will be evidence in some form for the Panel from Sister Code A

Code A We will be hearing from her, but not necessarily as a live witness.

Code A It might be a statement read from her or there may be some way of getting her evidence. It is unlikely she is going to be arriving here and giving evidence.

Code A That is most helpful. Thank you very much.

Code A The next two witnesses are going to be read to you. The first is the statement of Code A Her first statement simply produced her original police statement. The police statement was dated 25 July 2005.

STATEMENT OF Code A, Read

Code A It says:

> "I am Code A and I live at an address known to Hampshire Police.
>
> Between 1968 and 1972 I was a student nurse at St Mary's Hospital Portsmouth where I did general training and qualified as a registered general nurse, my nursing and midwifery number is..."

And she gives the number.

> "Between 1972 and 1973 I was a staff nurse at the Renal Unit at St Mary's Hospital Portsmouth where I worked with patients in chronic and renal failure.
>
> Between October 1976 and September 1981 I was the Matron of Thalassa Nursing Home Western Way Alverstoke Gosport. My responsibilities included the general management of the home, recruitment of staff and selling bed space. I also developed a working relationship with the Area Health Authority and local Environmental Health Authority in order to promote care practices and procedures in accordance with RGN training and local recognised standards.
>
> Between September 1981 and June 1985 I was the Matron of Bury Lodge Nursing Home ... for Thalassa Nursing Homes Ltd. ..."

Then she says:

> "This post coincided with the purchase of Langdale Rest Home, which at that time was registered for 17 residents and my role at Bury Lodge extended to maintaining occupancy levels at all three homes for the group.
>
> Between 1985 and April 2001 I was the Code A to Thalassa Nursing Homes Ltd..."

and she talks about capacity. I am then going to move on to the bottom paragraph, if I may, of page 2. She says:

"I have been asked to detail my involvement in the care and treatment of Code A Code A was a patient at Thalassa Nursing Home in 1998;"

She produces a copy of the patient notes, which we have incorporated into our bundle, which you read – I think – this morning.

"From memory and referral to those notes, I can state the following. In August 1998 Code A was a patient at Mulberry C ward, Now Collingwood Ward at Gosport War Memorial Hospital. He became suitable for discharge and a vacancy at a Nursing Home was sought. At the time I was Code A at Thalassa Lodge Nursing Home and I went to see him to assess his suitability. I became aware that he had both psychiatric and nursing problems. I believe his nursing needs outweighed his psychiatric needs. He was a 78 yr old with Parkinson's and blood sugar problems. He was not on insulin. He appeared uncooperative and displayed difficult behaviour. He was settled on the ward. I remember him as quietly spoken taking a long time to speak. I connected that to his Parkinson's disease.

We agreed to take him to Thalassa Nursing Home and on admission on 28th August 1998 it was noticed that he had a large red sacral area with Granuflex on it. At the time of the pre-assessment, it was my understanding that he did not have any pressure sores, however I was on Collingwood Ward the day that Code A was admitted to Thalassa, and I recall having a conversation with a nurse who informed me that Code A had been on the floor all of the previous night. This probably exacerbated the likelihood of Code A developing a pressure sore, something we all try to avoid. He was subsequently nursed on a Quattro mattress at Thalassa. These mattresses are extremely expensive but the best for persons with pressure sores.

On the whole staff at Thalassa coped well with Code A and he was not perceived to be a management problem. His Parkinson's drugs were administered 6 times a day. Code A Code A the Community Psychiatric Nurse saw Code A at Thalassa and decided that he was quite settled and no changes were required with his psychiatric treatment.

Code A's sacral sore was a worrying factor and continued to be treated and dressed accordingly. He attended the Dolphin Day Hospital on 17th September 1998 where he had a swab taken from the wound. He was also prescribed 200mgs Metronidazole, 1 tablet three times a day. This is used to treat fungal infections.

On 21st September 1998..."

And we have this on our chronology at page 3-

"Code A attended the Dolphin Day Hospital as previously arranged and was admitted to Dryad Ward as a result. I can recall that on that day he appeared to be unwell. This may have been because of the Metronidazole which can cause nausea and flu like symptoms as a side effect. He had his chin on his chest and was not as bright as he had been; he may have had a possible chest infection, or indeed the start of one.

On 23rd September 1998 we received a telephone call from Dryad Wad at the GWMH to inform us that Code A's condition was quite poorly.

A

On 28th September we received a further call from Dryad Ward to inform us that Brian had died at the weekend.

I know that Thalassa Nursing Home was investigated by the Nursing Home Inspectorate .... as a result of Code A 's demise. Everything was deemed however to be in order."

B

We now have the statement of Code A who describes herself as a friend of Code A Code A and acted as his domestic carer until he was placed in a rest home. She made a statement to the General Medical Council exhibiting her statement to the police, which was dated 12 May 2004.

STATEMENT OF Code A Read

C

She says:

"I am retired and live at the address stated overleaf.

Approximately 20 years ago in the early 1980's I was introduced to Code A and Code A Code A was suffering from cancer and I became her domestic help. Code A died at home several years later. I continued as Code A's domestic helper until

D

he was placed in a rest home. Code A was not an ignorant man, he was knowledgeable. Code A was very 'tactile' and I know that this had caused problems with some of those who knew him. It was also I believe a reason for him leaving one of his rest homes.

His last residence was the..."

And it reads the "Thalena", but I think it must be the "Thalassa" -

E

"... Thalassa Nursing Home. He only went into the homes in the last years of his life, I have been told that this was 1998.

I went to visit Code A at the Thalassa but was told he was a Gosport War Memorial Hospital, again I have been told that this was in September 1998. I know that he was only in the hospital for a short while before he dies, perhaps a week.

F

I visited him twice, once after a few days of his admittance. On this occasion he seemed fine, he had bed sores, obviously he was frail, he had had Parkinson's for some years.

He was quite normal and I did not imagine he was close to death. I was therefore greatly shocked when a few days later I received a phone call from somebody at the

G

hospital telling me that Code A was close to dying. They had phoned me as I was marked down as the next of kin. I told them that I was not and suggested that they phone Code A who is Code A

I had visited Code A the day before this call, this time he asked me to leave as he was very drowsy and was being given Diamorphine. He was not his normal self at this

H

time.

A

When I took the phone call from the hospital it was about 10.00 pm. I believe it was Code A who phoned me to tell me that Code A had died. I did not discuss his treatment or the hospital staff with Code A on either of my visits.

Code A did have a social worker dealing with the rest home side of matters and I believe his name was Code A'

B

Sir, that deals with the evidence at this stage of the proceedings that we call in relation to Mr Code A We are now going to move on to deal with our next patient. We have got two live witnesses that we are going to call in relation to Code A who is Patient H, and I am not sure if you have had the opportunity of reading Patient H's file?

Code A No, we have not. Indeed we do not yet have it.

C

Code A Could I ask for copies to be handed out to you? (Same handed)

Code A We receive this, Code A, as Exhibit C9.

Code A Yes, exactly, thank you. Obviously this would be a convenient point at which to break. It is a reasonably substantial file. It is a lever arch file about half full, so I would think

D

it is about 250 odd pages in total.

Code A Possibly an hour.

Code A One hour to start with?

Code A I think an hour to start with would be fine. It is 11.30 now and the Panel

E

would in any event be taking a break first. I think if we were to say that we will take an early lunch until half past 1. Then we could have a clear run at the witnesses. Would that be acceptable?

Code A Yes, of course.

Code A Very well.

F

Code A (Agreed)

Code A Thank you, Code A We will break now. The Panel will continue with some pre-reading and we will all resume at 1.30 pm, please.

Code A Thank you very much.

G

(The Panel adjourned for a short time)

Code A Welcome back everyone. Code A the Panel have taken the opportunity to refresh their memory of your opening in respect of Patient H, Code A and we have also spent time individually working our way through bundle H, so we are ready for you to proceed.

H

A Code A: I am grateful. Could I call, please, Code A?

Code A, Sworn

Code A Thank you very much indeed, Code A Take a seat and make yourself comfortable.

A Thank you.

B

(Following introductions from Code A

Examined by Code A

Code A: Is it Code A?

A Yes.

C

Q Code A I wanted to ask you about Code A, and I just wanted to deal with a little bit of background about him first of all?

A Yes.

Q I think he was born on the Code A so at the time of the events we were going to be considering he would have been 75 years old, is that right?

D A Yes.

Q I think you were Code A You met him in the early 1980s after he had Code A Code A and you Code A 1985?

A Yes.

Q Code A I think by Code A

E A Yes.

Q We are going to hear, in one form or another, from Code A Did you know those Code A?

A Yes.

Q When you Code A I think he was working in double glazing, but

F prior to that had he been in the Royal Navy?

A Yes.

Q I think he had taken part in the D-Day Landings. Did you know that?

A Yes.

Q Did there come a time when he was about 65, so in about 1988, shortly after you

G got married, when he retired?

A That's right.

Q I think he was a smoker?

A Yes.

Q Fairly heavy smoker?

H A Yes. In a way, yes.

Q It depends what you mean by a heavy smoker. What about drinking; was he a drinker?
A Yes.

Q Would it be fair to say he was a fairly heavy drinker?
A Yes.

Q After he had retired, what did he tend to do with his time?
A Not a lot.

Q Did he belong to the local Working Men's Club?
A Yes.

Q Where were you living in the nineties?
A Where I am living now, it's Sarisbury Green.

Q Where is that?
A Southampton.

Q All right. How would you describe his build? I think he was not particularly tall, he about 5 foot 6?
A Something like that, yes.

Q Again dealing with the back end of the 1990s, what was his build by that stage of his life?
A A normal size.

Q What does that mean?
A Well it he was not ---

Q Was a big man, was he thin?
A He was not a big person, sort of in between, you know, average size.

Q All right. I think in 1997 he had certainly a suspected heart attack?
A So they say.

Q All right. After that did he stop smoking for a while, or did he stop smoking for good?
A No, he did not stop.

Q He did not stop at all?
A Not if I can remember rightly.

Q It may not matter. I want to move, please, to September of 1998 when I think you went away on a week's holiday in Plymouth?
A No.

Q All right. You tell us what happened in September of '98?
A Myself and Code A went to Plymouth for a week, he stayed behind.

Q Yes. I understand that. Was it a short holiday for you?
A Yes.

Q All right. Code A stayed at home and he was looking, or trying to look after himself?
A That's right.

Q I think you received a call during that period to tell you that Code A had been admitted to Accident & Emergency at the Queen Alexandra Hospital.
A Yes.

Q We know he was admitted on 21 September 1998, and did you get a call on that day or shortly thereafter?
A No, not on that day. When we went on the holiday, I was, we went to France overnight in a day, and stayed there and I did not know until the Tuesday evening.

Q Right. You heard that he had been admitted to Accident & Emergency and as a result of that did you telephone the steward of the Working Men's Club who you knew?
A Apparently he kept ringing me to speak to me to tell me what had happened.

Q Right. Did you understand effectively that Code A had broken the upper bone in his arm, he had had a fall and he had broken his arm?
A I knew he had a fall, yes.

Q All right. In any event, when you heard about this accident, what was your reaction? Did you head home or what?
A I asked the hospital if I needed to come home and they said "no, no, just keep ringing through", which I did do every day, two or three times a day.

Q When you got back from Plymouth did you go and see him at the Queen Alexandra Hospital?
A Yes.

Q When you first saw him what sort of state was he in?
A Terrible. He did not even know who I was.

Q Right. We know I think that the arm was not operated on, was it?
A No, not as far as I know.

Q Did you see the arm?
A Yes.

Q Did you see what sort of state it was in?
A Yes.

Q Just describe it.
A It was all swollen and he was black and blue.

Q Right. Did you continue to visit him at the Queen Alexandra Hospital?

A A Yes.

Q Did his position change at all?
A Slightly, slightly, yes.

Q Tell us what happened.
A Well, he soon remembered who I was, that I was Code A

B

Q Right.
A He seemed to get quite, to be getting on quite well, actually.

Q We also know, and I am going to remind you of the date, that he was transferred to another hospital, the Gosport War Memorial Hospital.
A Yes.

C

Q And that transfer took place on 14 October?
A Yes.

Q All right. I think you actually travelled with him?
A I certainly did.

D Q Okay. I want to deal with the period just before that transfer. You have told us what a poor state he was in when you first went to see him. By the time he came to be transferred to the Gosport War Memorial Hospital what sort of state was he in then?
A Not too bad, he seemed to be okay.

Q Right. How mobile was he? Was he able to walk or not?
A I ca not really remember. I know he was in a wheelchair. As I got to the hospital,
E he was coming out in a wheelchair to go into the ambulance.

Q Right. What about his brain? How alert or not was he?
A Sorry?

Q Were you able to hold a conversation with him?
A Oh, yes, yes.

F

Q Was it a conversation that was structured, did it make sense?
A Oh, yes, yes.

Q All right. You told us that you travelled with him. What sort of vehicle was it that took him to the Gosport War Memorial Hospital?
A Just sort of like an ambulance come mini bus.

G

Q Right. He was not lying down presumably?
A No, no.

Q You travelled with him?
A Yes.

H Q Was it a fairly lengthy journey? I think you went round the houses a bit.

A A We did, we did go to a hospital, St Christopher's in Fareham and then we dropped off other patients till we got to the Gosport War Memorial which was about an hour and a half.

Q Right.
A Not four hours as the papers say.

B Q All right. When you got to the hospital can you remember then what Code A's state was?
A Exhausted.

Q He was exhausted?
A Yes.

C Q Do you remember if you had any conversation with a doctor or somebody who seemed to be a doctor that afternoon?
A Yes.

Q Can you remember what time you got to the hospital approximately? What sort of time of day was it?
A It was in the morning.

D Q Do you know who you spoke to, who the doctor was that you spoke to?
A Yes, I think so.

Q All right. Tell us who you think it was.
A Code A

E Q All right. Can you remember if she had any conversation with Code A Code A?
A Yes.

Q What was the conversation with Code A? What did she say to him?
A "Get straight into bed and I'll give you something to calm you down". She was not very nice about it.

F Q Did he do as he was asked?
A Yes.

Q He went to bed?
A Yes.

G Q When you left him, was he in bed?
A Yes.

Q When you left him lying in bed what sort of state was he in then? You have told us he was exhausted, but what was his mental state?
A By the time he had this sedation, or whatever it was, he seemed to be okay. He had his lunch. He was fine.

H Q Did you then leave him at the hospital?

A I left late afternoon, early teatime.

Q That was the day of his admission on 14 October?
A Yes.

Q Did you go and see him the next day?
A Yes.

B

Q Was he in the same ward where you had left him before?
A No, I do not think so.

Q Can you remember, was it in a ward with several beds with it or was he in a room on his own? If you cannot remember just say so.
A I can vaguely remember it, yes. It was like a small ward, I think. I think so.

C

Q When you went to see Code A the following day, first of all, what sort of time was it? Do you remember that?
A Just after lunch-time.

Q How was he when you saw him?
A In less than 24 hours there was a big difference. He had food hanging out of
D his mouth, he was mumbling something and I asked a nurse if I could see somebody.

Q Just before we get to that bit I just want to concentrate on Code A for a moment. You say there was food hanging out of his mouth and he was mumbling something. Were you able to make any sense of what he was saying?
A No.

E

Q Presumably, it follows you were not able to hold a conversation with him?
A No, I was not, no. I was quite surprised.

Q Was he conscious though?
A Semi.

Q Semiconscious. You told us that you wanted to speak with somebody. Who
F did you end up speaking with?
A I think it was a Code A

Q What did the Code A say to you?
A She took me into the kitchen to speak to me and she turned round and she said, "Code A is dying". I said, "Pardon", she said, "Code A is dying. He'll be dead within a week". I could not believe what she had said. Honestly,
G she said, "You do not know what is going on", and I said, "No, I have not been told anything". I think they were a bit surprised that I was Code A because I was a lot younger than Code A was.

Q All right. As a result of that, did you make some telephone calls round the family?
A Yes.

H

Q Did you leave the hospital that day for a while?

A A Yes.

Q Did you go back the same day?
A I think so, yes.

Q Whether it was the same day or the following day, what sort of state was Code A in when you next saw him?
B A He was still about the same, I think. He was not very good.

Q Do you remember seeing him on the 16th, the following day?
A Yes.

Q Then was his state any different or had it changed?
A No, it had not changed. I had a phone call from the hospital to say, "Come
C straight over".

Q What happened when you arrived there? What did you find?
A You could not even speak to him. He could not speak.

Q Did the family arrive and come and see Code A?
A Yes.

D Q In short, after that first time when you had seen him at the Gosport War Memorial Hospital, thereafter, were you able to have a conversation with him at any time?
A From the Thursday right the way round till the Sunday, no.

Q Was there any explanation given to you of what was wrong with him?
A Not really.
E

Q We know that Code A was put onto a syringe driver.
A Yes.

Q He was put onto a syringe driver on the 16th.
A That is correct.

F Q Do you remember any conversation about a syringe driver with any of the staff?
A Yes.

Q Who did you speak to?
A One of the nurses. I cannot tell you who it was.

G Q Did you know what a syringe driver was?
A They had more or less explained what it was. It was medicine. You know? Medical (sic) going through the system.

Q Can you remember if you were spoken to about the syringe driver before Robert was put on it or after?
A No, nothing at all. I did not know anything.

H Q Let me just ask you again, I want to be careful not to lead you: prior to being

aware that Code A was on a syringe driver was there any conversation with any of the nursing staff about it before he went onto it?
A Not as far as I know, no.

Q So any conversation that you had with nursing staff would have been after he had gone onto a syringe driver?
A Yes.

Q You have mentioned meeting a person you thought was Code A on the first day that Code A was admitted when she told him, effectively, to go to bed and she would give him something. Can you remember having any further conversations with that doctor?
A No.

Q At any stage as your husband deteriorated, can you remember any time when Code A came in to talk to you?
A I never saw Code A after then. Not as far as I can remember.

Code A Thank you. Would you wait there, please?

Cross-examined by Code A

Q Code A I am going to ask you some questions on behalf of Code A I do not think you were at the inquest?
A I was one day.

Q I think you turned up at lunch-time.
A I did.

Q Your - do I call him Code A ?
A Call him what you like.

Q I do not think you and he get on very well?
A No.

Q He had given evidence that morning and you turned up at lunch-time?
A Well, there was a confusion about it with the coroner.

Q I do not need to pursue it. You did not hear his evidence?
A No.

Q Can I come back to Code A s position?
A Yes.

Q We know that when you were not with him, because you were taking a break away, he fell, he broke his arm.
A So they say.

Q You saw his arm afterwards, did you not?
A It was just swollen. You know? It was not bandaged or anything. Not as far as I can remember.

Q What we have been told is the break was never set. Yes?
A (No verbal response)

Q We know he broke his arm in September, I think the 21st, and what we have seen in the medical records is the suggestion that the swelling stayed there for many, many days.
A Yes, that is right.

Q Would that be fair?
A Yes.

Q From what you saw?
A Yes.

Q What is your understanding as to why it was not dealt with by surgeons or medical staff? Why they did not set his fracture.
A I think it was because it looked too swollen, I suppose. I did not realise that he had broken his arm while I was away. It was not until I saw him when I got back.

Q No, but you went to see him quite a lot, I think, at the Queen Alexandra Hospital. Yes?
A Yes.

Q He had this fracture all the time he was there. Yes?
A Yes.

Q From 21 September through to 14 October.
A Yes.

Q Was his arm swollen through all that period?
A Yes.

Q Why was it not being set? Do you know?
A No.

Q Did he tell you he did not want it set?
A I cannot remember.

Q Did anyone tell you that he was not a suitable candidate to have it set?
A Honestly, I cannot remember.

Q All right. It is a long time ago. If there are things you do not remember ---
A There are. It is a long time, but it is like as if it was yesterday sometimes.

Q Okay, but there are some things that, clearly, have not stayed in your mind.
A Probably not, no.

Q Just so the Panel understand, I am looking at a note at page 335 towards the back of the bundle. Code A you can follow that in the bundle if you wish to. You have the same notes as the rest of us. If you want to follow it you are certainly welcome to do so.

A A Which page is it?

Q It is page 335. There are lots of page numbers on some of these documents. Right at the bottom of the page. Do you have it? It is not very easy to read.
A No.

Q It is dated 6 October 1998.
B A Yes.

Q It is an entry below that date written by a doctor called "Code A. If we want to see who Code A is we can turn to page 339 which will explain it to us. He is a specialist registrar in trauma and orthopaedic surgeon we see from his letter. If we go back to the note he made on page 335, he talks - and this is, I think, eighteen days or so after Code A had had his fall, there is still gross swelling of the
C left arm, he has various other entries that I do not need to go through with you, but on the bottom couple of lines the doctor has written:

"Plan - requires physio input",

- meaning physiotherapist's input -

"to mobilise",
D

- and he asks the ward to arrange that and says -

"not wish surgery & not suitable candidate",

- is what he is suggesting of Code A So he is not fit enough, I think was the suggestion, for the surgery. Yes?
E A Yes.

Q Was that ever mentioned to you by Code A or any of the doctors when he was at the Queen Alexandra?
A Everybody tried to keep everything quiet. They would not tell me anything. I was told nothing really very much.

F Q That is at the Queen Alexandra?
A Yes, as if I was a stranger. They seemed to have kept everything from me.

Q You were there regularly?
A Yes. I think it was my husband's request, from what I can gather.

Q What do you mean?
G A That they did not want to tell me anything, "Do not let them tell you anything", and I think that is what happened. It seems a bit strange, I know.

Q We know Code A had been Code A and in Code A he had Code A
A Yes.

H Q Most of them were in this country. Yes?
A Yes.

Q A number of them went to see him in hospital. Yes?
A Yes.

Q I think Code A used to go and see him in hospital as well?
A Yes.

Q Then there was you and Code A Yes?
A Yes.

Q You used to go and see him in hospital too?
A Yes.

Q Were you the next of kin?
A Yes.

Q You were the one that they phoned if there was a deterioration, were you not?
A Not as far as I can remember. I think I had one phone call and that was on the 16th.

Q All right.
A I cannot remember if anybody rang me from the QA.

Q Let us go back to the QA. He was there for a number of weeks, clearly, after his fall.
A Yes.

Q Until being transferred to the War Memorial Hospital. Yes?
A Yes.

Q Are you telling us that Code A did not really want you to know what was going on?
A Yes.

Q You think that the hospital staff had been told not to put you in the picture?
A Yes. I know it seems quite strange.

Q But here he was being transferred away from the Queen Alexandra Hospital with his arm still swollen. It had not been fixed.
A That is right.

Q You were with him?
A Yes.

Q You told us that was in a sort of ambulance/minibus?
A Yes.

Q It was a journey that went to a number of different locations?
A That is right.

Q Ended up at the War Memorial Hospital?

A A Yes.

Q You were the last ones off the bus, I think.
A Yes.

Q Was he in a wheelchair for that or was he sitting in an ordinary chair?
A No, in a wheelchair.

B

Q Was that the first time he had been out of the hospital since he had gone into it, so far as you knew?
A Yes.

Q Was he being buffeted about with a still broken arm whilst he was in the back of the bus?
C A A little bit, yes, but it was not too bad.

Q What state was he in, after however long he was in the minibus, by the time he got to the War Memorial?
A A bit tired.

Q I think you spoke to family members later on.
D A I did.

Q Did you speak to Code A?
A Possibly, yes.

Q We know you do not get on with him.
A No.

E Q Would you have told him that it took about four hours to transfer from the Queen Alexandra Hospital by the bus to the War Memorial Hospital?
A No, it was not four hours.

Q Would you have told him that it did take four hours?
A No.

F Q By the time he got to the War Memorial Hospital, he was not in too good shape?
A No.

Q He was seen by a doctor there and you have told us it was Code A Yes?
A Yes.

G Q What was he getting for pain relief before the journey? Do you know?
A No.

Q Why is it that you do not know? Is it because people were not telling you?
A I did not get up to the ward in time. I just got to the lift. He was coming out the lift as I was going up so I got straight into the ambulance with him.

H Q Tell us about his arm. Was he wearing anything?
A A dressing gown.

Q I do not mean clothes. My fault. Did he have any protection for his fracture?
A I think he did, yes.

Q What did he have?
A I think it was like a sling or something, I think. It is vague. You know?

Q I understand. For the Panel, I am looking at page 266.

Code A I do not know if there is any significance, Code A but we have a 266A and a 266B. There is a subtle variation.

Code A I think the page numbers differ but other than that they are pretty much the same.

Code A Either one will do.

Code A Yes. You can never have enough medical records, I always find. (To the witness) What you have told us is Code A was given something by the doctor.
A Yes.

Q He was fine after that?
A Well, he was not too bad.

Q What you told us is, "After the sedation he seemed to be okay. He had had his lunch and he was fine". Is that right?
A Yes, he seemed to pick up a bit. I think it was the journey, sort of. You know?

Q It is the first time he had been out of hospital for weeks and weeks.
A Yes.

Q He had been in the back of a bus for whatever the journey was, and I have suggested he would have been buffeted about a bit and he had a broken arm still.
A Yes.

Q You saw him the next day?
A Yes.

Q The 15th. You told us you saw the nursing sister there.
A Yes.

Q How long was your discussion with the Code A? Do you remember - roughly?
A Hour.

Q An hour?
A Roughly. Could be less, could be... I would say an hour.

Q And this was the room that she took you to?

A A Yes.

Q What did you discuss during the course of that hour?
A What they were going to do.

Q And what was that?
A She said, "As much as possible".

B

Q The plan, I think, for Code A had been to gently get him mobilised?
A That is right.

Q We have the medical records, page 180. The Panel will have Code A 's note. It is the last line of Code A 's note on 14 October. "Plan: gentle mobilisation".
A Yes.

C

Q I do not want to ask you about her note, but the conversation you had with Code A Code A Yes?
A I cannot remember the name. I cannot remember her name.

Q But it was the Code A on the ward?
A Yes.

D

Q Did she discuss Code A 's cardiac failure, his heart problems, and fluid that he had on his body?
A Yes, I think she did.

Q And what did she say about that?
A I cannot remember. I cannot remember what she said now.

E

Q It is a long time ago?
A Yes.

Q But was she telling you that your benzodiazepine's condition, sadly, was rather poor?
A Yes. He was... I cannot think of the ward at the moment.

F Q What did it relate to, the word that you are trying to think of? Was it talking about his heart or his medical condition generally?
A Yes.

Q Was anything said about his liver problems?
A No.

G Q No?
A Not if... I cannot remember.

Q Was anything said about use of alcohol in the past and problems that that might have caused?
A She may have done.

H

A Q Did it seem to you as if anything was being held back? What you have told me is that at the Queen Alexandra Hospital it seemed as if people were hiding things from you, including Code A?
A Yes. No ---

Q Whereas here at the War Memorial ---
A They were different at the War Memorial.

B

Q I understand.
A In fact, I stayed the whole weekend.

Q Yes?
A I slept with Code A, with Code A was in for three nights. Two nights, sorry.

C

Q What Nurse Code A's note reads – and I would just ask you to comment on it – for the 15th is that Code A was commenced on Oromorph – and she gives the dose – four hourly for pain in his left arm. Yes?
A Yes.

Q "Code A – that is you – "seen by Code A who explained Code A's condition is
D poor." And you have agreed with that?
A Yes.

Q "Please call day or night if any deterioration"?
A That is right.

Q Now that, I suggest, is what they told you they would do ---?
E A Yes.

Q --- if there was any deterioration?
A Yes.

Q They would ring you?
A Yes.

F

Q They would let you know?
A Yes.

Q And was it clear that you were being treated as next of kin – as you were?
A Yes, yes.

G Q You were Code A?
A That is right.

Q You were in seeing him again, I think, on 16th, were you?
A Yes.

Q And were you there when another doctor, a Code A was there in the morning?
H A I honestly cannot remember.

Q But were you told about Code A having deteriorated overnight?
A Yes.

Q This was the call, I think. The suggestion is that you were informed and that you would visit?
A Yes.

Q That morning. And you did go in?
A Yes, I did. Yes.

Q There is an entry for the second half of the day on the 16th relating to Code A 's condition. It says that the syringe driver was commenced. There is reference to Code A Code A having a very bubbly chest. That was explained to the family – the reason for the syringe driver?
A Yes.

Q You have agreed, I think ?
A Yes.

Q You were told about a syringe driver?
A Yes. I think.

Q The note suggests – and tell us if this is right or not – that you were informed of Code A 's continued deterioration?
A Yes, that is right. I think it was the tea-time. I was at work, and I got a phone call, and I got a neighbour to take us over.

Q Which other family members were there, or relatives of Code A were there? Did you see his children there?
A I think some of them were – I think. I cannot quite think who it was.

Q Code A you have made it clearly to us, you have made it clear to us – you would remember him?
A Yes. Probably, yes. Code A was okay at the time then.

Q Oh, was he?
A Yes. He was okay with everything until the inquest came up.

Q Why? Did you get on with him then?
A Sort of, yes, while I was Code A yes.

Q And he got on with you?
A Okay. Not too bad.

Q Do you remember if Code A was there during this period? The period that you were seeing Code A at the War Memorial?
A Yes, I do. Yes. I can remember seeing him there, yes.

A Q Just tell us: we have a note on that page, 266, four lines up from the bottom, that on the 17th, it says: "Code A stayed last night". That is you and Code A ?
A That is right.

Q Stayed the night of the 16th?
A That is right.

B Q The entry suggests that at the second half of the 17th there was a slow deterioration in Code A s already poor condition?
A Yes.

Q Is that right?
A Yes.

C Q You were there, and you saw it?
A Yes.

Q If we go over what might be two pages to page 267 there is a reference to the syringe driver being renewed and it says:

"Code A visited again this evening and is aware that his condition is poorly".

D

A Yes.

Q

"She will remain on the ward"

I think it is –

E

"one night."

That is you again, is it not?
A Yes.

Q Again, on the 18th the note reads here,

F

"Further deterioration in already poor condition. Code A has remained overnight."

Again, that confirms ---?
A That is right, yes.

Q You agree with that?
G A Yes.

Q Were you there and did you speak to a Code A ?
A Possibly. As you say, it is a long time ago. Some of it.... Who the doctors are...

Q And the note suggests that sadly Code A s condition continue to deteriorate as the 18th went on?
H A Yes. Code A was sent for from Los Angeles.

A

Q Code A?
A That is right.

Code A: Thank you very much, Code A

Re-examined by Code A

B

Q Do you still have 266?
A Yes.

Q I just want to ask you a couple of questions about the 16 October. Can you see the second entry down, after the entry by Code A which says:

C

"Patient very bubbly chest this pm. Syringe driver commenced."

A Which page was that – sorry?

Q Page 266. Would you look at just below half way down the page, do you see a first entry for 16.10.98?
A Yes.

D

Q Then there is another one underneath that "pm"?
A Yes.

Q

"Patient very bubbly chest this pm. Syringe driver commenced ... Explained to family reason for driver. Code A informed of patient's continued deterioration."

E

Do you remember a discussion about the syringe driver?
A No, I cannot. No.

Q You told us that as you were there, that you stayed the night of the 16th and then there is a note about if on the 17th ?
A That is right.

F

Q Then there is a comment "deterioration or slow deterioration in already poor condition." You agreed with that?
A Yes.

Q That there was a deterioration?
A Yes.

G

Q What sort of deterioration are you talking about? How are you able to tell that your husband was deteriorating?
A He was not talking.

Q Was he conscious at any stage?
A No.

H

Q So how are you able to tell that he was deteriorating? What do you mean?
A You could see a difference each time.

Q What was the difference you could see?
A He just would not speak. You know, he could not speak. He could hear, I think, but in the back of his mind, but he never said a word.

Q I just want to understand: when you agreed with Code A that there was a deterioration, I just want to have your understanding of what that deterioration that you could see was? We he saying anything? What was his breathing like? What was his skin colour like?
A He was still black and blue.

Q Right.
A Probably had a little bit of bubbly in his chest, I should think. Never said a word. Never said anything.

Q Did he indicate that he was in pain at any stage?
A No. He could not. He could not speak.

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

Code A you will remember that I said that the time would come when members of the Panel could ask questions of you if they had any. That time has now come and I will look to the members of the Panel to see if any of them do have questions.

Yes. First of all, Code A is a lay member of the Panel.

Questioned by THE PANEL

Code A I wonder if you can just help me. Can you help me to understand why you wanted to stay overnight at the hospital? What was your intent in staying overnight at the hospital?
A To be with Code A

Q Yes. What lay behind that?
A Sorry?

Q What was lying behind that? You wanted to be with Code A What were you doing for Code A ?
A I was just there to be with him. That was all. I asked if I could stay and they said yes.

Q Is that because you were expecting him to die any time?
A No, not really. No.

Q But you were told that he was deteriorating?
A Yes.

Q And is that what was behind your mind in staying overnight?
A I would think so, yes. Yes.

Code A Thank you.

Code A is a lay member of the Panel.

Code A Just one question. When Code A first asked you questions about the time that you arrived at the Gosport War Memorial Hospital, I have taken a note that you said that when you got there he was exhausted?
A Yes.

Q But when Code A asked you, you said he was tired. There is a big difference between "completely exhausted" and "tired". Can you help me to paint a picture?
A I think it was because of the journey, you know. It was a bit... He kept saying, "Are we there? Are we there?" I said, "No, not yet." He just seemed to be tired and exhausted sort of thing – you know.

Q And you said that you noticed a difference in him, a change from when you left him on that first day and the next day that you went back. How big a change was it? Was it a huge change?
A Yes, it was.

Q Remarkable to you? You could see it straight away?
A No, no. When I got over there to see him, I spoke to him and he mumbled something and I called a nurse and I asked him what was wrong with Code A She said, "Code A Code A ?" I said, "Yes, Code A " I said, "Why, what is wrong?" She said, "Nothing." I thought, "Ah, I know the reason. I am 23 years younger than Code A '

Q Yes, but I am trying to ask you the difference was so significant, then, from one day to the other?
A Oh, yes.

Q A huge difference?
A Yes.

Q When that nurse took you into the kitchen and said to you that your husband was going to die?
A Yes.

Q That was a complete shock to you?
A Yes.

Q You never for one minute considered that had covered the situation before?
A No, no.

Code A Thank you.

Code A is a medical member of the Panel.

A Code A Can I take you back to something that was said, and I just wanted to clarify this. At some time you were told he might have had a heart attack. Do you remember when that was?

A Before he went into hospital, before the fall.

Q Yes, some time in the past. I did not quite understand when that was.

A There was something happened. Let me think. He went into hospital at QA. I think it B was two years before that, I think. Something like that.

Q Do you remember that he was in hospital in the QA in February of the year he died?

Code A February two years before.

Code A It was 1997.

C A Yes, yes. I can remember that, yes.

Q And it was very swollen?

A What – 1997?

Q Yes. His legs were very swollen.

A Yes, they could have been.

D

Q You do not remember very well?

A No, no. I know he was taken into hospital a year or two beforehand, yes.

Q If you do not remember that he was swollen, I will not ask any more questions about that. I am sorry to come back to the few days before he died. I just want to be quite clear that I understand what he was like, so on the first day when he arrived he was tired or E exhausted?

A Yes.

Q He perked up after some medicine and after lunch he was not too bad?

A That is right.

Q The next morning you went in and he was mumbling and food was coming out of his F mouth?

A That is right.

Q And you were told that he was dying?

A Yes. She said he could be dead while I am talking to you.

Q Do you remember, as that day went on, what was he like in the evening?

G A No different. No change.

Q Was he still awake?

A No.

Q He was unconscious?

A Unconscious.

H

A Q And did he, as far as you saw, gain consciousness at all after that?
A No.

Q So he was unconscious from the second half of the second day?
A Yes.

Code A That is very helpful, thank you.

B

Code A Thank you very much indeed. Are there any questions, Code A arising?

Further cross-examined by Code A

Code A Just one. You told Code A in relation to your husband that he was not
C conscious at any stage, he was not speaking, but what you said was he could hear, I think. Why did you say that?
A I think the nurses sort of said "he probably can hear you because, in a normal sort of way", that's all I can sort of, you know, say, sort of thing.

Q Did you see him moving or reacting in any way to suggest that he could hear when you spoke to him?
D A I think his hands moved a little bit, not a lot, you know.

Q If you were speaking he would move or if the nurses were moving him?
A No, no.

Q When would his hands move?
A When I was talking to him.

E

Q I understand.
A Just slightly.

Q I understand. Yes, thank you.

Code A, anything arising?

F

Code A Yes. I just want to try and clear something up. I think it may have been my fault. I was asking you about the suspected heart attack back in February of 1997.
A Yes.

Q Do you remember that?
A Yes.

G

Q If you keep in the same bundle and go back to page 130 with the two lines either side of it, this deals with that admission back in February 1997. We can see that in fact the history is that he presented - do you see under history?
A Yes.

Q It says: "The chap presented with a one-and-a-half hour history of epigastric pain."
H Code A would know rather better than the rest of us in this room, but I think he epigastric

A pain is pain in the upper abdomen, so it can seem like a heart problem. Can you remember if he in fact, as far as you were told, did have a heart attack or was it just what he was, that was what was originally thought to be happening?
A I think so, yes.

Q What?
A Originally happening, I think.

B

Q Did you ever understand that in fact your husband had had a heart attack or not?
A No.

Q Thank you. Thank you very much indeed.

Code A Thank you. And, thank you very much, Code A It is extremely
C good of you to come to assist us today. The Panel is always greatly helped by hearing live testimony from witnesses such as yourself. We know it is a strain but we were very grateful that you were able to come today. Thank you very much indeed. You are now free to go.

THE WITNESS: Thank you very much.

(Witness withdrew)

D

Code A The next witness is Code A and I will ask for him to be called, please.

Code A Affirmed

(Following introductions from Code A )

E

Examined by Code A

Q Is it Code A ?
A Yes, it is.

Q Code A it is right to say I think you were present at the very beginning of this case.
F A (The witness nodded)

Q Is that right?
A Yes.

Q To hear the charges read?
A Yes.

G

Q And you have not attended in the room since then?
A No.

Q All right. As you know, I want to ask you, please, a little bit about Code A but first of all about your family, generally. I think that Code A had Code A in all, is that right?

H

A A Yeah, there was Code A and Code A [redacted] one as well to make up the Code A.

Q And there was Code A there is yourself and Code A and Code A and then Code A [redacted]?
A Yes.

B Q You, I think, have made a statement in relation to the events that unfolded at the Gosport War Memorial Hospital and so did Code A
A Yes.

Q I want to ask you a little bit please about Code A We know that he was born in 1923, he was a Glaswegian?
A That's right, yeah.

C Q And he joined the Royal Navy when he was quite young and he saw active service. We know he was in Royal Navy I think for 22 years?
A (The witness nodded)

Q And Code A was a Wren?
A That's right, yes.

D Q Did Code A in the war?
A No, I think just after the war Code A

Q Just after?
A Yeah.

E Q Many years later I think in 1982, after 32 years of being Code A unfortunately they Code A and they Code A
A (The witness nodded)

Q Code A and Code A
A Yes, that's right.

F Q All right. Code A called Code A from whom we have just heard. I know that there are family tensions. I am going to seek to avoid going into those, if it is inevitable that we have to deal with those then we will, but it is no part of my questioning to delve into those areas, but you understand why?
A Yes.

Q Code A I think, you accept was a heavy drinker?
G A Yes, yeah.

Q Indeed I think you make the comment in your statement that Glasgow and the Navy together may have pointed him in a certain direction?
A It seems to be that way.

H Q All right. But certainly once he had retired and into the eighties and nineties you would describe him as a heavy drinker?

A A A regular heavy drinker, yes.

Q Was he also a smoker?
A He was up until I think about five years before he died, and when I say he was a heavy smoker, I think he smoked on average between 60 and 80 a day at one stage. But about five years before he died, I think there was a bet - Code A being a Glaswegian was not about to lose the bet and he gave up smoking.

B

Q Right. That is one way of doing it.
A Amazing, hope for everybody.

Q But unfortunately he did not take a bet about his drinking?
A No.

C Q And he carried on?
A Yes, he did.

Q I want to move on, please, to the time when he was admitted to the Queen Alexandra Hospital, having broken his arm?
A Yes.

D Q I think you did not hear about it for a little while until after the event itself had happened?
A No, that's right. It was about a week after he had been admitted into hospital.

Q All right. That of it, I expect upset you a bit.
A It did, because we went down the same road the year previously when Code A decided that it was not important enough to tell us that he was in hospital, exactly the same
E happened this time.

Q All right. How did you find out that Code A was in hospital?
A I am not a hundred per cent sure whether it was via Code A at the Club or via my Code A , Code A contacted I think Code A

Q All right.
F A And as far as I can remember I went into the club.

Q All right. There is a family network I expect in such a large family and you found out.
A Yes.

Q How often were you seeing Code A prior to this accident in September of 1998,
G how often were you seeing Code A ?
A Prior to the accident nowhere near as much as I had seen him prior or previously to that. I had had a fall out with Code A and I was banned from his house, so, realistically I did not take Code A up there, I did not take Code A up there, I used to go and see Code A in the club.

Q The Club was a local club?
H

A Yes, it was a local Working Men's Club about 150 yards down the road from where he lived.

Q I was going to ask you that, where were you living at that time?
A I was living in Gosport at the time, he lived in Code A

Q The Working Men's Club was where?
B A Sarisbury Green.

Q You used to go there?
A Yeah, I used to go there.

Q How often did you see him at that club?
A I do not know. I used to go over there fairly regularly.
C

Q Once a month, once a week?
A I would say probably every three to four weeks.

Q Okay. Can you recall prior to September of 1998 when you had last seen him before you had seen him at the Queen Alexandra, can you remember, before he broke his arm when you had seen him?
D A No, I ca not actually.

Q. Okay. Up until that point when he broke his arm, what was his general health like? We know that he was drinking too much.
A Mm hmm, I would say, I mean, obviously I'm not a doctor, I would say that he was quite happy, quite healthy. When I had been up to the house he did eat well. I would say that as far as I am aware he did not have any medical problems that were outstanding.
E

Q Was he mobile?
A Yes, he was.

Q Was he able to walk without sticks?
A Yes, yes.

F Q I expect he did not take a huge amount of exercise?
A 150/200 yards to the Club.

Q Right, and then back again.
A And then 200 back again.

Q Right. So far as his mental function was concerned, was everything there?
G A Code A was very, very alert, always had been, he had quite a sharp mind on him.

Q All right. Now there comes a time, about a week after the accident, which we know was on 21 September, or rather that's when we know he was picked up by ambulance, when you go and see him at the hospital?
A (The witness nodded)

H

Q When you first went to see him at the Queen Alexandra Hospital after his accident, what sort of state was he in then?
A This was, he had been in hospital, as far as I am aware about a week, and I was shocked when I saw him. If he had died that afternoon, if he had died the following day, I would not have been in the slightest bit surprised. I looked at him, he looked very, very old and he did not look like Code A that I had seen previously, he looked very, very ill.

Q That must have been a considerable shock to you.
A Yes, it was.

Q Were you there on your own or was somebody else with you?
A No, I was there on my own at that particular time.

Q All right. Tell us how things progressed at the Queen Alexandra. We know that he remained there for just over three weeks before he was transferred to Dryad Ward at the Gosport War Memorial. First of all, did you see him reasonably regularly at the Queen Alexandra?
A I saw him virtually every day at the Queen Alexandra.

Q You told us how he was when you first saw him. How did things progress from there?
A When I first went in and saw him, as I say, I was shocked and I spoke to a doctor and I asked him what the problem was, and he said, "well theoretically he has just fallen over and has a fracture". He said "that's the medical problem, but unfortunately with older people sometimes they give up the will to live" and he said "I would say that probably with Code A he has given up the will to live". This sort of brought back to me that Code A over many, many years of rowing and whatever, Code A had always thrown at Code A that he would alienate all his kids and he would die a sad and lonely old man. And here was Code A he had been in hospital on his own, he did not know that none of us knew that he was there, he did not know that Code A had not contacted us, he did not know that Code A had let him down, but there he was a sad and lonely old man in hospital on his own.

Q That was your reaction when you first saw him. How did things progress after that?
A Between myself and Code A we contacted all the other members of our family, Code A and between us, I think we were at the hospital every single day, there was at least one or two of us at the hospital every single day, and Code A picked up. I can only explain it that he got the will to live again. He suddenly realised that he was not a sad and lonely old man. He did have a lot of people around him that really did care, all his kids were there and Code A was there as well, and that had a huge effect on him.

Q Dealing with the period just before he transferred, what would you say, first of all, about his state of mind and his physical health?
A Code A was quite a big person at the end and there is no doubt about it, he was retaining fluids, so he was not as mobile as he had been. When I first saw him in hospital he was very, very quiet. He did not talk, he did not argue back. Prior to him leaving the QA the nurses turned round and commented that they knew he was getting a bit better because he was argumentative, he was jokey with them. Code A was almost back to his old normal self. He might not have been able to move round quite as agile as he was but in mind and spirit he was back to the way

A Code A was.

Q What about eating and drinking? Did you see whether he was able to eat and drink at that time?
A Yes, to start off with he certainly was not. To start off they certainly had a lot of problems getting anything into him whatsoever, but towards the end he was eating, probably not full meals as we would but he was certainly eating. He
B was picking stuff off the menu, he was quite happy to eat things and a lot of fluids were then going through him.

Q What was his pain threshold like? Did he complain to you of pain while you were there?
A Yes, I did. He said his arm hurt. There was no doubt about it, he was in pain from his arm, but Code A for the whole of his life, was really, really anti
C drugs, except smoking and drinking, he did not class them as drugs, but Code A was anti drugs and Code A would not take paracetamol or painkillers or anything like that. I suppose he had a fairly high pain threshold.

Q I am not going to be able to find it, I am afraid, but we know there is a drug chart in the records that demonstrate - I will see if I can find it just quickly. Yes. Just for the Panel, page 109, and you are welcome to turn this up if you want to. It
D is in that file to your left. We know, of course, he was admitted to the Queen Alexandra on 22 September and if we look at page 109 we can see the drugs that were being offered to him and we can see that your father was consistently refusing even paracetamol as a pain killer.
A Yes.

Q The reason for that would be?
A Code A was anti drugs and the pain was not sufficient enough for him. He
E was not in severe pain, I would say. I would say that most of what his pain was was aches and pains. The only time he was in severe pain is if he moved it or he banged his arm, which was fairly obvious. There was a couple of times I was there when he banged his arm and there was no doubt about it, he was in pain then.

Q I think you went to see him on the evening before he transferred on the Gosport War Memorial Hospital.
F A Yes, I did.

Q Tell us a bit about that evening, what sort of state he was in then.
A I got into the ward about teatime-ish, I think. Code A was already there. He had eaten, he had been drinking and he was sat up alongside his bed. I think for the previous week to ten days he had spent most of his time sat alongside his bed rather than in the bed. Code A was there and they had
G the *Daily Sport* and between Code A and the other gentlemen that were on the ward there was quite a jovial atmosphere going on. It was quite light-hearted. It was not a death ward, that is for sure.

Q We know, of course, that so far as Code A 's arm is concerned he did not have an operation on it.
A No, he did not.

H Q The fracture was never fixed and if it was going to do anything it was going

A to fuse itself, as it were.
A Which is what happens in 80 per cent of cases, as I understand it.

Q Did you know on the night of the 13th that he was transferring the next day to the Dryad Ward at Gosport War Memorial Hospital?
A No, I was under the impression that he was being transferred to St Christopher's at Fareham.

B

Q We have seen that in the notes. I think there were discussions about him going to St Christopher's.
A Yes.

Q But at the end of the day he did not go to St Christopher's, he went to the Gosport War Memorial Hospital.
C A Yes, for some reason at the very last minute, instead of going to St Christopher's he was transferred over to the War Memorial.

Q I do not think you saw him the next day when he actually transferred. Code A Code A went with him apparently.
A No, I did not.

D Q You went to see him on the 15th?
A Yes, I did.

Q When you got in to see Code A on the 15th, the day after his transfer, what sort of state was he in then?
A He was laid in bed, and I suppose the best way to describe it is a comatose state. He did not appear to be able to move himself. He was just laid in the bed.

E Q Did you have a conversation with him of any sort?
A Yes, I did. I was shocked to see that he had gone down hill again so quickly and it did not make a great deal of sense. I lent over to give him a cuddle and he actually spoke his very last words to me.

Q What did he say to you?
A "Help me, Code A They're killing me".

F

Q Did you respond to that?
A Yes, I did, but probably not in the way that I should have done, looking back now. At the time I thought my dad was scared of dying, I thought he was dying and I tried to put him at ease and told him that ---

Q Can you remember the words you actually used?
G A Yes. I said to him, "I do not think they're killing you, Code A They're doing the best they can for you".

Q Was anybody else in the room with you at this time?
A Code A was in the room.

Q The words that he said to you, can you remember what sort of voice he used? Was it a loud voice, a soft voice?
H A No, it was very, very low. It was almost a whisper. It was as I lent over.

A I think by that time he was struggling to do anything at all. He was struggling to talk, struggling to move. He was basically in a comatose state.

Q Did you speak to anybody following that discovery, as it were? Finding him in the hospital in that state.
A I spoke to a nurse. I am not sure whether it was a nurse or whether it was actually Code A but I spoke to a nurse there at the time. I asked what was
B the matter with Code A and if it was possible to see a doctor. When I did not get the answer that I wanted I then did kick off a little bit.

Q The answer that you wanted was what?
A I wanted to know what was going on, why Code A had gone down hill so bad so quickly.

C Q Did you get angry and upset?
A Yes, I did.

Q The result of that was?
A I was threatened that if I did not leave the hospital I would be arrested.

Q Forgive me for asking you, and it may be obvious but we want your
D evidence: what were you angry and upset about? We can understand you being upset. Why were you angry?
A I was upset and angry because of the state of Code A but I was angry because nobody would talk to me. I was told that I was not the designated family member. At that time the designated family member was Code A

Q All right. I am going to stop you. I suspect you may want to say things about it but it may not help the Panel. Did you go back and see Code A the
E following day, on the 16th?
A Yes.

Q What sort of state was he in then?
A On the 16th when I went in he was laid in his bed, he was comatose and he had a syringe - I did not know it was a syringe driver at the time. I now know it was a syringe driver. He had wires going into him and he was not moving at all.
F
Q Were you able to rouse him at all?
A No.

Q That is, I think, Friday the 16th. Did you go in and see him again on the Saturday?
A I cannot actually remember going in and seeing him on the 17th but I know
G that when I saw him on the 16th I contacted Code A and we started making arrangements for all of us to be there. So whether I was there on the 17th, I cannot honestly remember but I would have thought that I did go in at some stage. Whether I was allowed to go in and see him or not is a different matter.

Q Did you see him again before he died?
A I went in on the ...
H
Q Just to help you, we know that he died at twenty minutes to midnight on the

A Code A which would have been the Code A
A Code A evening.

Q Yes, Code A
A Yes, I did go and see him. I cannot remember which day it was but I know that Code A was there so that must have been on the Saturday.

B Q That actually would have been on the 17th, I think.
A Yes. She had just got in from Los Angeles.

Q Was Code A there as well, can you remember?
A Yes, Code A was there and I think Code A was there also. Again, I think Code A was also there as well, I think.

C Q First of all, can you remember how long you spent with Code A on whatever day it was? It looks like the Saturday, but how long did you spend with him?
A I honestly do not know, because it was - I think I had gone in there earlier on and then I was there when Code A turned up from Los Angeles and I think once she turned up then we sort of backed off - we had seen Code A quite a lot in between times and I think - certainly, I came away and left Code A with him.
D

Q It may be obvious again, but from that very short conversation that you told us you had with Code A on the 15th when he made that comment to you, you never spoke to him again?
A No, that was the very last words I ever spoke to Code A

Q You did not hear him speak again?
E A No.

Q Did you speak to Code A at any stage?
A No, I never spoke to Code A never saw Code A In all the time I was there Code A was never seen in the hospital by me at all at any stage whatsoever.

F Code A Thank you. Would you wait there, please?

Cross-examined by Code A

Q As you know, I am asking questions on behalf of Code A Can I just go back to the start of this picture? Code A s fall in September. You did not see him for about a week and you have told us why, but when you did see him, about a week after he had had a fall, you thought he was extremely ill?
G A Yes, I did.

Q He was still black and blue, I think?
A He had bruising, yes.

Q He did not want to know?
H A When you say he did not want to know, did not want to know what?

A Q He was not interested in anything people wanted to do with him. The expression you have given us, from a doctor, was that he had given up the will to live.
A Yes. It apparently happens with old people.

Q We have the records but I want to know what you saw. Was it clear that he was not eating?
B A During that first week ---

Q You were not there for the first week, but ---
A When I first went in there and saw him, yes, it fairly obvious that he was not eating and he was struggling to take any fluids.

Q I think he was having problems sleeping in that he was not sleeping at night
C but was asleep during the day and in the morning certainly. Did you see that?
A I think he was drowsy during the day, yes. Whether he was sleeping at night - according to his records he was struggling to sleep at night but he was struggling to get comfortable.

Q I think there were problems about where he would go after the Queen Alexandra. There were discussions and a social worker was involved. Yes?
D A Yes.

Q There were lots of you, if I can lump you all together, of Code A and I think Code A went to see him as well, together with Code A Code A ?
A (No verbal response)

Q There were doubtless many conversations between you and other members
E of your immediate family, with Code A I do not know how much information was going between you and Code A or Code A Code A ?
A Very little.

Q Was that very little, if you were told something you would not tell her?
A No, I did not have a problem telling Code A I did not have a problem. If Code A
F was there I was quite happy to talk to her.

Q Were there discussions about whether he could go to a rest home or a nursing home when he was at the QA?
A When he was in the QA Code A first of all turned round and refused to come home from holiday. Had she come home from holiday then he probably would not have stayed in the QA as long as he did.
G

Q Forgive me. We have heard a different account from her and I am not interested in hearing you describe her. I just want to know about the plans for Code A Code A Were there discussions about a nursing home or a rest home?
A I think it was important as to the reason why those discussions were, and the discussions were because Code A had refused to take him home. So, yes, the discussions were between my siblings, Code A and the nursing staff and the
H social services to look at a nursing/rest home that he could go in, and, primarily, one that was ex-Services so that he would feel at home.

Q What did he want to do?
A Originally, he did not want to go into a nursing home, he wanted to go home, but it was fairly obvious that Code A was not going to let him go home. She said she could not manage him - or would not be able to look after him, her and Code A Code A

Q What was the doctor's view about whether he should go to a nursing home or a rest home or back to his own home? Do you know, from conversations you had with doctors at the Queen Alexandra, or is it all going to be second or third-hand?
A No, when I spoke to the nursing staff up there it was looking at rehabilitation. It was primarily into a nursing home because he would need ongoing care.

Q You have told us that you did not actually know where he was going. You thought it was St Christopher's.
A No, I did not think it was St Christopher's, I had been told it was St Christopher's.

Q Who told you that? Do you remember?
A The nursing staff.

Q That was the day before he was discharged from the Queen Alexandra?
A That was either on the 12th or the 13th.

Q Just so we can follow that up, do you remember which member of the nursing staff told you he was going to St Christopher's?
A No, we are looking at ten years ago.

Q Yes. You remember some of the other characters. Do you remember any of the nurses from the QA?
A I cannot remember any of their names and cannot put names to faces. All I was talking to was the nursing staff that were on the ward that were dealing with Code A

Q I understand. You were talking to Code A every day, you told us, at the QA. Yes?
A Yes.

Q What did he think was the plan for where he was to go?
A He wanted to go home. He did not want to go into a nursing home and the reason why he did not want to go into a nursing home is because Code A and his Code A worked in nursing and care homes and he did not want to be looked after by them, to be honest.

Q Forgive me. I put the question badly. You were told by nurses that he was going to St Christopher's. Yes?
A Yes.

Q You were there the day before he was discharged from the Queen Alexandra.

A Where did he believe he was going?
A The last time I spoke to him up at the QA he believed he was going to St Christopher's until the day before, when he knew he was going to QA. When he knew he was going to War Memorial Hospital, when I knew he was going to the War Memorial Hospital, and the only thing – the only good thing – that I could say about that was, it was close by for me.

B Q Sorry. Have I misunderstood? I thought you told us that you believed he was going to St Christopher's?
A Yes.

Q And that you only found out after he had gone to the War Memorial?
A No, no, no. I found out ---

C Q Is that ---
A No, I found out before he went.

Q All right. Why was that switch done, so far as understood?
A No idea whatsoever. Absolutely no idea whatsoever.

Q You did not see him on the day of the transfer, I think, on the 14th?
D A No.

Q But you saw him the day after?
A Yes, I did.

Q What did you understand was that transfer that he underwent?
A How do you mean?
E

Q Did he drive there? Was he driven there?
A As far as I understand it, he was put into hospital transport and transferred down from the QA to the War Memorial Hospital.

Q I think what you said at the inquest was, it took three and a half to four hours?
A I would say... I have heard four hours. I have heard two and a half hours.
F

Code A: This really is pure hearsay. Code A has been very keen to get this out. We have allowed a certain latitude but we ---

Code A I am not sure ---

Code A I missed that last point.
G

Code A I am not sure it is helping us anyway, the length of the journey, Code A

Code A We have heard this was reported in the press. I just wanted to follow that up. (To the witness) What did you understand about Code A s condition after the journey?
A How do you mean, what did I understand by his condition?
H

Q Did you understand that he had had a pretty torrid time on the transfer?
A No, I do not. I have been waiting for the police to come out with the statements from the two people that transferred him down. The police totally refused to hand over those statements. So really it is very, very difficult to find out what that transfer was. What I can tell you is that Code A hated being in transport. Code A had driven for a lot of his life and Code A did not get into cars. He hated being transported around. So much so that he would not come and visit us; he would not get on a bus to visit us; he would not get into a car and visit us; he would not get into a taxi and visit us. If we wanted to see Code A we had to go and see him. Code A got very, very agitated about being driven around.

Q I understand.
A So I would say that when Code A got to the War Memorial, whether it took two hours, whether it took three hours, whether it took four hours, Code A would have been in a very agitated and aggressive and pissed-off state.

Q I understand. What you told us as well was that if he moved his arm, or banged it, it caused him severe pain?
A I think when we were talking about that, that was two weeks previous. It was not on the day that he transferred. That was not on the day before he transferred. That was prior to. On the day that he transferred, I do not know. Yes, if he banged it it would probably have still hurt, but when I was saying about noticing that it was hurting, that was certainly a week earlier, ten days earlier.

Q What treatment had he had for his arm, so far as you understood, from the day he broke it on 21 September to the time when he was transferred to the War Memorial?
A Not a lot.

Q What treatment did he have?
A Not a lot.

Q He had none, did he, really?
A Umm....

Q He had not had it operated on?
A No.

Q He had not had it operated on or set?
A No, no. But eighty per cent of people who have that fracture do not have it operated on. I believe, in actual fact, that the fracture that he had is very much similar to the one that the Queen has just recently got. We are not suggesting she is going to die of a fractured shoulder, surely?

Q You asked me questions at the inquest, and I told you then, it is not easy for advocates to answer them. All right?
A That is true.

Q You made a statement subsequently to the police, I think, in 2004?
A Could have been. It was eventually.

Q And in that statement you gave an account of the conversation you say you had with Code A on 15 October, the day after the transfer?
A Yes.

Q And in that statement, if I can find it, you suggested to Code A that Code A said to you, "Help me."
A No. "Help me, Code A they are killing me."

Q You did not say that to the police, did you?
A Yes, I did.

Q And this has been well well documented which is why I have refused my police statement. I have had huge rows with the police over it and when the police actually came to take that statement, eventually, there was a huge row with the two coppers that came to my house because I wanted to tape record the conversation. They made me sign an affidavit to say that I was not secretly taping them and that any time that they thought I was taping them they would terminate the conversation. I said that I wanted a complete and utter word for word statement that I had given. I have never received that. From that very first moment, I have always, always denied that the police statement that the police have got is not a true statement that I gave them.

Q I understand that, but my question was, is it right that a statement was prepared for you in which you said that Code A said to you, "Help me", and you told us that was wrong?
A Yes. Code A said, "Help me, Code A they are killing me." I know you are not allowed to answer, you cannot answer, questions but put yourself – like I said to you at the inquest – in my position. The very last words that Code A says to you. They are not words that you are going to forget.

Q The suggestion I make to you is that if you had said that to the police, "Help me, Code A they are killing me," they would definitely have put it into a statement?
A You would have thought so but by that time we already had the police making a huge, huge big fuss that we did not have another Code A here.

Q If that was the concern, and you had said to them, Code A said, "Help me, Code A they are killing me," they would have put it in the statement, would they not?
A I am telling you they did not.

Q Thank you.
A And I am more than happy to bring the two police officers into here and have it out with them, because they know what I said to them.

Re-examined by Code A

Q I think when you came to review that statement in May 2008, you endorsed it with the words, "I do not believe this is a true transcript of my interview with the police. In fact I think this is more likely the policemen's version of what I told them," and you signed that?
A Yes.

Code A As I said, May of last year. Thank you.

A

Code A Thank you. Code A You have had the barristers. Now you have the Panel. I will look to see if there are any questions from any of them. Code A is a medical member of the Panel.

Questioned by THE PANEL

B Code A: You said a number of times this afternoon that 80 per cent of these fractures do not need operation. Can you tell us where you got that from?
A When we had the inquest at Portsmouth, Code A and the coroner made a huge big then about how serious a fracture this was and Code A was very, very ill. In fact the coroner, if you actually look at the transcript, made a huge, huge thing about it – so much so that I went home and I looked on the internet. I looked ---

C Q I am sorry. Can I interrupt you? That does not interest us. Let me just go backwards a bit though. When Code A was in the QA with his broken arm, did anyone talk to you there about how he was to be treated and why?
A They actually turned round and they said that Code A would not have an operation to fix it but in the majority of cases, especially with elderly people, it is not operated on but it is actually left and it actually fuses itself.

D Q Fine, that is helpful. Do you remember that Code A was in hospital about almost two years earlier, in February 1997?
A Yes.

Q Do you remember that?
A Yes.

E Q Do you remember how he was then?
A In what way?

Q What recollection do you have, for instance, as to what was wrong with him?
A I think that was when Code A had fallen off his motor bike and the original thing was they thought he had had a stroke down his left side.

F Q Can I just help you this way: he was taken into hospital because he had some pain in his stomach and he was very swollen. Do you remember that?
A No, I do not know.

Q You do not remember?
A I did not know at the time why he was taken in. I thought he had fallen off his bike and that might...

G Q No, that is fine.
A But that might have actually been slightly earlier. When he went into hospital in 1997, Code A and I – Code A and I – spent a lot of time up there with him and we did know that the concern of the hospital then was his drinking and his liver and kidneys. There are no ifs and buts about that.

H

A Q Then I just ask you one other question about that. Do you remember at any time anybody expressing any concerns about his heart?
A I do not recall it at that time, no.

Q Sorry. The very last question then. Do you remember the doctors or the nurses explaining why he had swelling?
A What? When he went into hospital?

B Q At the time?
A The first time?

Q Nearly two years ago.
A No, I do not. I think at that particular time most of the conversation between the nurses and the doctors was to do with his drinking, and the fact that if he did not change his
C drinking habits, then he would end up killing himself.

Code A Thank you very much.

Code A Thank you, Code A is a lay member of the Panel.

Code A I just wanted to go back to the time when you were having discussions about
D the rehabilitation of Code A Firstly, did you have discussions about that? Is that something ---? Did you have any information about it?
A No. Social Services: I spoke to the nurses on the ward at the QA and I think basically we all managed to speak to the nurses up at the QA, but the follow-on treatment that he should have had or they were planning to put him in a nursing home, that primarily was talk between Code A and Code A and I think Code A had some involvement in that as well. But dealing with the Social Services, I did not have
E any dealings with them.

Q Did you have any view yourself about how long you thought the rehabilitation would take, from having seen Code A and knowing what had happened?
A When he came to leave the QA, the rehabilitation from what I understood and what we were under the impression of was really more to get him mobile and moving and being able to do things for himself. Prior to that his left hand side – he would not move it at all. It
F was going to cause him a lot of problems in the fact that he was not able to do things for himself.

Q Did you have any idea how long it might take, or any views about it yourself?
A We were expecting a matter of weeks. I think Social Services said they were looking at three to four weeks before they would be able to get him either a nursing or a rest home.

G Code A Thank you.

Code A is a lay member of the Panel.

Code A I just want you to confirm, in a way, for me because do we understand that at no time whilst he was at GW that you had any conversation with any of the medical staff to help you to understand why Code A was deteriorating?
H

A A The only conversation I had with Gosport War Memorial Hospital with any medical staff was with Code A or the nurse on the very first day when I wanted to know what was wrong with Code A why he had gone downhill and why I could not see a doctor. The only conversation I had was when I was threatened with being removed and arrested by the police.

Q What made that build up in that sort of way? How did it come to build up in that way?

B A I was angry. I make no bones about it, I have a bit of a temper of me, and I kicked off.

Q And what precipitated that? Seeing Code A ? Yes – and what was it about Code A Code A s condition that precipitated that?

A It was the fact that the last time I had seen Code A he was sat up alongside his bed. He was laughing and joking. He was as near normal, other than being in hospital. He was as

C near normal as Code A ever was. Had we not been sat in a hospital, we could have just as easily been sat in the club. The conversation was light-hearted. Code A were there. They were laughing and joking over, as I say, *The Daily Sport* newspaper. Code A was his normal self.

Q Okay. And so as you saw Code A , and you saw that he could not communicate with you, what was it? Was there anything in particular that you really worried about – the

D way he was being cared for? Or what was happening to him?

A No. I could not understand why had had gone downhill and what wound me up was the fact that nobody would explain to me. The nurses turned round and said I was not the designated family member. They said that they only spoke to the designated family member which, in this case, was Code A There was certainly a lot of tension between us at that particular time and so probably information was not being passed on the way it should have been.

E

Q Okay.

A But I do not think it is unreasonable, as Code A to be able to ask nurses, or a doctor if there is a doctor available , what the problem is. I found that very, very... That wound me up. I am not allowed to talk to anybody because I am not a designated family member and then, when I kicked off, I am threatened with arrest. I am sorry; that is not the way I see hospitals working.

F

Code A Thank you, Code A

Code A any questions arising out of those from the Panel?

Code A No, sir.

G Code A any questions arising out of those of the Panel?

Code A No, thank you.

Further re-examined by Code A

H Q When Code A went into the Gosport War Memorial, you told Code A one of the Panellists, that you thought he was going to be in for three or four weeks. Is that right?

A Yes.

Q Where had you got that from?
A We had been told QA.... Originally, they had hoped to be able to move him, transfer him, straight from the QA to somewhere, but there was some conversation about waiting to find him somewhere, and it could be a case of three to four weeks before they could find him somewhere where they could put him into.

B

Q I see.
A So it was not a case if it was going to take three to four weeks for him to get better. It was going to be a case of a number of weeks before they could find somewhere to fit him into.

Q So what was your understanding of the purpose of him going into the Gosport War
C Memorial?
A I thought he was going there for rehabilitation and continuing care.

Code A: Very well. Thank you very much indeed.

Code A that completes your testimony. Thank you very much indeed for coming to assist today. It really does help the Panel enormously when they have
D the benefit of live testimony from witnesses such as yourself. We appreciate that it can be a distressing and upsetting experience for you, but I do assure you that everything that is said is taken on board and considered most carefully by the Panel. Thank you very much indeed for coming, and you are free to go.

THE WITNESS: Thank you very much.

E (The witness withdrew)

Code A: Just before we stop for a break, as I expect you will want to, could I just take you back to page 109 because I do not want the Panel either to be misled or feel they are being misled. There is the note of the patient refusing paracetamol, which I pointed out through the witness a bit earlier, but it is right to say that if you go to the page before, you will find in fact the patient does appear to have been on codeine. I am afraid I had missed
F that, frankly, but he does appear to have been on codeine on the 8th, 9th, 12th and 13th, I think – just so the Panel is aware of that at this stage.

Code A Yes, thank you, Code A That is very helpful.

Code A Can I also mention that we are digging out the notes, the original notes, of the January 1997 admission because it seems, certainly from Code A s questions, there is an
G element of interest about that. We will have those copied as far as we feel relevant, and we will discuss this with Code A and his team and then make those available to you, and add those to the bundle.

Code A That is very helpful, thank you.

H

Code A The last statement this afternoon would be that of Code A but I think we perhaps could take an opportunity of just discussing with Code A and Code A how much of that we need, or should read to you.

That will in fact complete the day's work. We have actually gone very well today as you will probably appreciate. If we could have a little time to perform that exercise and then perhaps reconvene in due course. There is still some evidence to call in relation to this patient, but then we will be moving on to Code A But we will have to make an application to you in relation to the statement of Code A I think it is probably at the top of page 4 of your schedule. That witness is unavailable for reasons that I will reveal in due course, and we will have to make an application to read his statement. That, I think, we had best do tomorrow when we have all the information, and I expect we will then have to make a decision about whether to allow that statement to be read or not. But in the meantime we could hand out the Patient I bundles to you. In the meantime perhaps we could take a short break so we can discuss how best to progress this afternoon.

Code A Yes. We will take a break now and return at twenty to four.

(The Panel adjourned for a short adjournment)

Code A Welcome back everybody. Yes, Code A

Code A Sir, the next witness is going to be read to you and it is the statement of Code A Code A His police statement which is dated 13 April 2004 reads as follows:

> "I make this statement in relation to Code A who was born on 8 March 1923 and died on Code A Although Code A Code A and someone I always see in that light."

He then speaks about Code A, but in terms that you have already heard from two of the witnesses. He then goes on:

> "I think out of all of the children I was the one closet to Code A and Code A got divorced in the early 1980s and I joined the Army. I served with the Green Jackets, the Signals and Airborne of which Code A was very proud. In the mid 1980s Code A was remarried to a lady called Code A She was considerably younger than by about 30 years. Of all of the children I was the only one Code A told about the wedding. Although I was unable to go, this amongst other things has caused fall outs within the family. We are not a family that has constant rows, we just don't have a great deal to do with one another.
>
> In about 1996 Code A had his first stay in hospital. He had had a fall which I think was as a result of his drinking. He had hurt his shoulder and was admitted to the Queen Alexandra Hospital in Portsmouth. I saw Code A in hospital and he was to remain in there for three to four weeks.
>
> Whilst he was in hospital, dad had treatment for his shoulder and was also put on a diet. Code A was about 5'7" but weighed 18 stone. Whilst he had been working Code A had been a strong man, but since he stopped he had gone soft and spread out a bit.

A

Code A returned home to Sarisbury Green after he left hospital with Code A Code A and Code A got on well. The house was only three doors from the local club and Code A seemed quite content with his lot. He was quite comfortable financially.

I would always see Code A at weekends and speak to him during the week on the phone. I was having more contact with Code A than the rest of the family.

B

In September 1998 Code A was away on holiday leaving Code A at home alone. I tried to get hold of Code A several times at home but hadn't been able to do so. In the end I phoned the social club and was told that Code A had been taken to the Queen Alexandra Hospital having had a fall. At this time no one else in the immediate family knew, things were left to me to sort out at the hospital. I think I told Code A who made sure everybody else knew.

C

When I got to the Queen Alexandra Code A was on a ward. He had an injury to his right shoulder and hip from the fall. Although fed up he was quite lucid and able to hold a conversation. He was quite tired and fed up. Code A didn't want to be in hospital for as long as he had been last time. He did not like the food and was not eating that much."

D He does not put a date as to when he went to see Code A

"The doctors and nurses were being quite strict with him about his diet. Code A clearly didn't like being told what to do. He was moved to a quieter room towards the rear of the hospital, that was a mixed room. It was a geriatric room, it was a good deal quieter.

E

Whilst he was at the QA Code A on very mild pain relief. I think he was on paracetamol but it almost had to be forced upon him. I could tell from visiting Code A that he was in some pain and discomfort but it was not in any way extreme.

Over the first few days Code A was quite down. He started making plans for his funeral, stating what his wishes would be. Code A thought he had been put in the ward to die. However, one of the nurses in charge started giving him some

F

direction. She arranged physio and social support with regard to rest homes and rehabilitative care. Code A began to realise he would leave the QA and probably go into rehabilitative care somewhere prior to going home. Whilst in the QA there was talk about changing his front room at home so he didn't have to go up the stairs. I and the rest of the family saw some light at the end of the tunnel. I was fully expecting Code A to go home at some stage in the future.

G

Whilst at the QA dad had several visits from a social worker and I also spoke with this person about the best options for Code A In the end it was decided that the best place for Code A would be the Gosport War Memorial Hospital. It was quite close to his home, other family lived nearby, and the plan was that this would be a stepping stone on to a nursing home.

I think it was Sunday 11 October 1998 when I last saw Code A at the QA. It was the day before he was being moved to the GWMH."

H

A

He gets some his dates wrong, as will become apparent, because we know that Code A was not transferred in fact until 14 October. He says:

> Code A was his normal old self. He would do the crossword in the paper and crack the odd joke. He was still poorly from the fall and was not as mobile as he had been, but generally he seemed well and happy.
>
> B
>
> I spoke with a male doctor whose name I don't know. The doctor said Code A had had a shock from the fall and would need to make some life changes. He would need to continue losing the weight and come off the booze. The doctor said that another fall at his age with a weight could cause immense problems that could kill him. However there was an upside that if Code A changed his ways the future was positive. Code A was moved by mini bus to the GWMH on Monday 12 October 1998."
>
> C

We know that to be wrong. We know it was in fact two days later.

> "I went and saw him on the same evening. I do not know the name of the ward he was on. There were five or six other people in there. It was in the late afternoon when I got there and I was told Code A was asleep. I went and saw him for a few seconds. I could see he was asleep, so I left some bits and bobs at the end of the bed.
>
> D
>
> On Tuesday 13 October 1998..."

Again we know this must be wrong, but it may be the day after his last visit:

> E
>
> "I went to the GWMH. Code A was laid out on the bed. He was still in the ward but seemed totally out of it. I could hear his breathing was very laboured and he was gurgling. I have had quite extensive first aid training in the Army and this sounded as if his lungs were filling up with fluid.
>
> I asked a nurse who seemed to be in charge if I could speak with a doctor. The nurse told me that the doctor only came once a day, would not attend as the
>
> F
>
> doctor had already spoken to Code A I expressed my concerns about Code A s position and why he was on a general ward.
>
> The nurse told me that he was being cared for and was on pain relief. I thought this was odd because Code A had been on minimal and manual pain relief whilst at the QA. The nurse explained that dad was on pain relief to make him more comfortable. She did not tell me what he was on, but it was being administered
>
> G
>
> by some sort of a drip."

Just pausing for a moment, we know, going to the chronology, that the syringe driver was started on 16 October at 16:10 hours.

> "I was not happy with what I was being told. I made my feelings clear to the staff. Code A was also at the hospital and he was clearly upset. I then spoke to another female nurse who seemed to be in overall charge. I think she was either a
>
> H

A South African or a Kiwi, I asked her what was happening. She replied 'his kidneys and liver are not functioning properly'. I said 'it sounds as if he is drowning from the backfill of fluid'. She said 'that's right', but he is being treated for it. I asked why he was not on a lung drain and if his liver and kidneys aren't working why was he on medication that was sending him into a coma?' The nurse said I would have to take that up with the doctor. I knew that the doctor was a lady and she was local, but I don't know her name, nor did I ever B meet, despite several attempts over the following days.

The nurse told me that Code A didn't have long to go. She was kind in the way she did this and said that Code A would be put in a private room. At this stage I began to accept that Code A did not have long left. I phoned some of the family to tell them. I also phoned Code A in America so she could come over and see him.

C I wanted sometime alone so I went home. I went to the hospital on Wednesday 14 October 1998 [the day of admission in fact]. I had hoped to see the doctor but she had already gone. Code A was now in a private room. I spent some time with him but there was not a lot I could do. Code A did not respond to anything I said or did. Code A was spending quite a lot of time with him so I left them do it.

Over the next few days all the family went and saw Code A at the hospital. The D nurses were speaking to Code A as his next of kin which left the rest of us in the dark.

Code A did not change much until Saturday 17 October. I had gone to the airport to collect Code A from America and on the way back Code A phoned and said that Code A wouldn't last much longer. I got to the GWMH as fast as I could, arriving at about lunchtime. The rest of the family were there. We all stayed until the E evening at which point Code A said for us to go. She would call if things changed. Although Code A was still in a coma, it appeared to all of us that he knew Code A had arrived.

Having gone home in the evening I got a phone call in the early hours of Code A Code A from Code A to say that Code A had died. I went to the GWMH, I think all of the family were there."

F Again, just to correct that date, we know that in fact this patient, Code A died on the night of Code A, the death being recorded as 23:40. That completes that witness's evidence.

That is all we have for you today. Tomorrow we are having to call a nurse, Code A Code A as you will see, rather out of turn. Tomorrow is I think the only day, although there may be one other day, that she can, for some reason I do not know what, attend. We G would have much preferred to call all of the nurses. Certainly primarily she is dealing with patients B and E, Code A and Code A We are going through the notes at the moment to try to identify who else she might deal with, but we very much hope that you will have read already all of the patient notes of the patients that she is dealing with. If we find that you have not, what we might encourage you to do, rather than go through all the notes, which you will do in due course, is at least read the opening, although it is a matter for the Panel. If they want to read all of the notes in advance then they must do so.

H

We are not calling, or able to call, Code A tomorrow. She unfortunately is not available. I know it shows that she is being read but I think Code A wanted her and we are making attempts to bring her here. Code A however, is coming along to give evidence.

As I have indicated, there is going to be an application in relation to Code A s statement, and I can also indicate that, so far as Code A is concerned, that the defence have asked for him to attend. We have had a number of different days set up for him to come, but none so far have proved possible. He is an orthopaedic consultant surgeon. It is going to take some arranging but we think we will be able to get him here at some stage. So tomorrow I am afraid is going to be somewhat of a bitty day, but at the moment we are at least making very good progress.

Code A Is it right, Code A that both Code A and Code A are to be removed from the list for tomorrow?

Code A Yes, I am going to re-jig this and present you with a new one because I have got so many marks on mine now that I am beginning to lose sight of where witnesses are. I am going to redo the list and I will provide you with an up-to-date version, I hope tomorrow.

Code A Very well.

Code A The I bundle is ready to go out. I suspect you may want to hear from Code A Code A who is now coming in the morning - it shows PM but she is now coming in the morning - before you go on to read Patient I, Code A s, bundle.

Code A Yes, I think that must be right.

Code A Then we can take a break so you can read that and then we can make the application.

Code A Yes, if we can get at least that degree of separation it will help keep our minds on the appropriate tracks.

Code A Thank you very much. We can pass the bundle up now.

Code A It is a matter for you. I am not going to ask the Panel to read it as it is late in the day.

Code A We will do it tomorrow.

Code A Yes. Anything from you, Code A

Code A Nothing, Sir, save to point out that when we get to the witness, Code A Code A it may be that in her case the Panel will not have to be too concerned about looking at other patient records because I think, without having checked all of them, and my learned friend and I are in discussion about it, that a number of other notes that she may have made are absolutely non-contentious, they are just recording an event. I do not think it will be necessary for the Panel to understand her evidence and to break off and look at a particular patient at a relevant time. Hopefully we will get through without that difficulty.

Code A At the moment it is likely to be concentrating on Patient B and Patient E?

Code A Yes, that we have already looked at and hopefully the other references can just be noted rather than anybody having to concern themselves with patient history.

Code A Very good. Thank you very much indeed, Ladies and Gentlemen. We will rise now and resume at 9.30 am tomorrow morning. Thank you.

(Adjourned until 9.30 am on Tuesday 16 June 2009)

**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Tuesday 16 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 SEVEN)

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)

# INDEX

Code A Good morning everybody welcome back. Code A ?

Code A I have provided to the Panel and to my learned friends a revised witness order. We are now on Day 7 and it was hoped to have called Code A first because she deals, albeit briefly, with the patient, Code A , who we were dealing with yesterday. I gather Code A has not yet arrived.

Code A Is anybody in contact with her.

Code A We have left a message for her on her mobile, but she has not responded. The other witness we have for you today is Code A She is here, so I am in the hands of the Panel as to whether you want to give, say, 15 minutes to see if Code A arrives and we can then deal with the end of the evidence in relation to Code A or whether you are prepared to embark on a fresh witness.

Code A I have a suggestion. Given that Code A is apparently to be dealing in particular with Patients E and B, what the Panel could do at this time is re-read your opening in respect of those patients. If by the time we have finished the Code A Code A is still not here, we would go straight on with Code A

Code A Can I also mention that we thought we would have something of a legal argument in relation to the statement of Code A I am glad to say that we have resolved our differences. There were not many differences and we are going to be able to read that to you by agreement. We will have a relatively short day today, depending I suppose on how much my learned friends have for the two witnesses.

Code A That makes it all the easier to give the extra time now. We will take 15 minutes to re-read your opening in respect of Patients E and B and assess the situation at the end of that time.

(The Panel adjourned for a short time)

Code A sworn

(Following introductions by the Code A

Examined by Code A

Q Is it Code A ?
A Yes.

Q I think you are a nurse. Can you tell us a little about your background. How long have you been a nurse?
A I trained in the 70s at Portsmouth School of Nursing and I worked at the Royal Portsmouth until it was demolished. We moved to Queen Alexander Hospital and I worked for a length of time. I left the hospital at one point and worked for the Hampshire Autistic Society in Alverstoke for two years and then in 1983 I took a job at the Gosport War Memorial on the Children's Ward.

A Society in Alverstoke for two years and then in 1983 I took a job at the Gosport War Memorial on the Children's Ward.

Q I will ask you about the Gosport War Memorial Hospital in a moment. Have you come along today with a nurse representative?
A I have, our RCN representative.

B Q Is that Code A who is also a nurse at the Gosport War Memorial Hospital?
A Yes.

Q Is that the lady sitting at the back with Code A ?
A Yes, it is.

C Q The Gosport War Memorial Hospital has a number of wards and it has changed through the years. We have heard about something called the Redcliff Annex and, at the time of the events that we are going to be dealing with, I think the Redcliff Annex had closed. Did you ever work at the Redcliff Annex?
A No.

Q You told us that when you started you worked on the Children's Ward at Gosport War
D Memorial Hospital?
A Yes, I did.

Q How many wards did the hospital have?
A When I started there were three wards. There was the Male Ward, the Female Ward and the Children's Ward – oh, and a theatre.

E Q In our bundle 1, behind tab 11, we have the most enormous plan of the hospital and I am going to suggest that you put that to one side and I will hand out one which is more manageable. I tried to open the plan that you have and it will subsume you all. Could I hand out a smaller version of small same thing. I am going to ask Code A to give us some assistance about where the various wards were.

Code A do you wish us to discard---
F

Code A I suggest you get rid of the one behind tab 11 and replace it with the one I am handing out now, if the defence are content with that. At the moment you might want to keep this plan out, it is easier to keep it where it is. I am not going to give it an exhibit number, it can just go into our file. You will get one of these in a moment. I am holding it so the Dryad and Daedalus are on the right-hand side of the page, which is upside down. I think someone has written the words the wrong way to which the plan is meant to work. Dryad and
G Daedalus are on the right-hand side. This, I think, shows us the whole of the ground floor plan of the hospital. Since you are the first nurse witness that we are calling, I am going to ask you to try and help us. I am going to give you a moment to see if you can understand the plan. The part which is outlined and, I expect, coloured in on the original, is Dryad Ward, or meant to be Dryad Ward. Does that make sense to you or not?
A What date is this?

H Q It is 2000.

A A I was thinking of the old hospital previous to this.

Q No. Is this the hospital as it was in 1996, 1997 and 1998?
A It changed, did it not?

Q It did change, but when did it change. Can you help us?
A I do not think I can help you.

B

Q You cannot ask Code A (Witness turning towards Code A. Can you help us as to when it changed of your own knowledge?
A No, ten years perhaps.

Q Did the position of Dryad and Daedalus Ward change. Did they continue to exist after the change?

C A Yes, the Children's Ward disappeared.

Q Can you see where Daedalus Ward is marked on the plan?
A Yes, I can.

Q Does that seem right to you at the time that we are going to be discussing, which is 1996 through to 1999?

D A I cannot really make a lot of sense of it.

Code A If it assists, I do not mind if my learned friend leads and puts what his case is because I am trying to manage with the larger one which helps in the sense it has colour coding. I do not know if my learned friend wants to put to the witness what the location is or not.

E Code A I cannot at the moment, no, but thank you for the invitation.
A I can tell you the general layout.

Q That would be excellent. Would you do that for us?
A If you came in through the main doors, the doors where A&E were, you walked up a long corridor and Dryad Ward was off to the left of the corridor. At the top of the corridor you actually turned right and then sharp left again into Daedalus Ward. On that floor also

F was physio and a Mental Health Day Ward to the left.

Q That is not Mulberry?
A Mulberry was upstairs and another ward.

Q How many wards did you have on the ground floor. Can you remember?
A Two on the ground floor.

G

Q Was that Daedalus and Dryad?
A Yes.

Q Were they inter-linked?
A No.

H Q At the time we are discussing, was there any Accident & Emergency there?

A A Yes.

Q Where was that?
A That was at the entrance, the front entrance.

Q You told us that in 1983 you, I think, started working on the Children's Ward?
A Yes, I did.

B

Q Did there come a time when you found yourself working on Daedalus Ward?
A Yes, when the whole hospital was changed and we no longer had a theatre and Children's Ward, then I worked on Daedalus Ward.

Q So there came a time, did there, when there were no operations being conducted?
A That is right, yes.

C

Q Did that mean the closure of the Accident & Emergency as well?
A No.

Q The Accident & Emergency kept going throughout, did it?
A Yes.

D Q What was Daedalus Ward used for?
A Daedalus Ward, I think at the time we are talking about, was partly stroke and partly long stay.

Q How many beds did it have?
A It had 24 beds.

E Q What about Dryad Ward?
A I do not think it had so many. I think perhaps it was 20, possibly 22.

Q What was that used for?
A I think it was mostly, then mostly long stay patients.

Q Did you ever work on Dryad Ward?
F A No.

Q Were you a permanent member of staff?
A Yes, I was.

Q What was your seniority as a nurse?
A Code A

G

Q Can you help us what the grades are?
A Managers G-grade. The manager of the ward is G-grade, then there is a senior staff nurse who would be F-grade and then I think we have two Code A

Q You were one of those?
A Yes.

H

A
Q Does that denote a certain level of seniority?
A Yes.

Q Meaning you had been doing...
A A small amount.

Q ... the job for a while and you were experienced?
B A Yes.

Q You know and knew Code A ?
A Yes, I worked with Code A

Q For how many years did you work with Code A ?
A A long time, ten, maybe more, years.
C

Q I want to deal with her role as clinical assistant as you saw it. We know that there were Code A who did rounds on the two wards---
A Every week.

Q Who did rounds on the two wards, Daedalus and Dryad?
A Yes.
D

Q You said "every week", I am not sure what that refers to?
A I think it was one day a week that we had a round, a ward round.

Q You cannot turn to Code A I am afraid, for assistance.
A I know, I did not mean to, I am sorry.

E Q You think once a week a Code A would be doing a ward round on each ward?
A Yes.

Q Or on one of the wards?
A Yes.

Q Which is it?
F A I think it is once a week on each ward.

Q Do you remember who the Code A were?
A Yes, the Code A was Code A

Q Anyone else you can remember?
A I cannot. We did have a male and I cannot remember his name.
G

Q Does Code A mean anything to you?
A Yes, I remember Code A

Q What about Code A ?
A Yes, I did not see them very often.

H Q So it was mainly Code A ?

A A Yes.

Q Did you ever go on one of the ward rounds with one of the Code A
A Yes.

Q How often would Code A come into the hospital?
A She would come every morning.

B

Q At about what time?
A About eight to half past.

Q How long would she remain at the hospital?
A Every morning she would remain, I would say, about half an hour.

C Q Can you remember, did she divide her time equally between the two wards for which she was responsible?
A I should imagine so, but as I was working on Daedalus, I do not know what went on.

Q You just saw her on Daedalus?
A Yes.

D Q Apart from every morning coming in between eight and 8.30, are you saying she came in at eight and left at 8.30, or you saying she arrived ---
A I am saying roughly. Possibly she was there three quarters of an hour some mornings depending on the work she actually had to do.

Q Always arriving at about eight?
A Yes.

E

Q Did you go round with her when she visited patients?
A It depended. If I was in charge of the ward that morning, then, yes.

Q Tell us what role Code A played. You tell us she was a Code A She visited once a week you think?
A She did, the ward round once a week.

F

Q That would mean what?
A That would mean that she would see each patient, she would see each patient as to any problems they had, she would look at their notes, she would look at their treatment card and prescribe any further treatment she wanted for the patient. If she had asked for x-rays or blood tests previously she would look at the results you.

G Q You told us that on Daedalus there were approximately 24 beds?
A Yes.

Q Is it quite a busy ward?
A Yes.

Q Would Code A visit some of the patients each morning?
H A She would see the patients who had had problems, basically.

Q When you said she would see the patients who had problems, either, presumably, when they came into the ward or if they were getting worse or better?
A If they had problems overnight.

Q Who would attend these ward rounds with her? Let us take it from your own experience.
A It would be the Code A the nurse in charge, so I did not do the round every week.

Q You say 'Code A' but you tell us the Code A comes round once a week, so I want to concentrate on a ward round that Code A is doing on her own?
A The daily?

Q The daily ward round?
A It would be the nurse in charge.

Q So it would be Code A and the nurse in charge?
A Yes.

Q Where were the patient notes kept?
A They were kept in the office; in a filing cabinet in the office.

Q How would the notes be made available to Code A?
A The nurse in charge would take them out for her, or she would go and help herself.

Q Was there a trolley or something like that?
A Yes.

Q Would all the patient notes for all of the patients on the ward come out with the nurse, or just for specific patients?
A It would depend. If it were a weekly ward round, all the notes would go round. If it were in the morning, when Code A was seeing the patients with problems, it would be their notes which would be out.

Q But who would be directing Code A to the patients with problems?
A The nurse in charge.

Q Who had authority to write out prescriptions?
A Code A and Code A

Q Who had the authority to administer the prescriptions as written out by Code A?
A The nurse on the drug round.

Q Tell us about the drug round.
A They were certain times of the day: in the morning; lunchtime; in the evening; and a night-time round.

Q That would mean what? Just imagine we have never been to a hospital before and there are no nurses or medical people on the Panel. Just imagine that for a moment. It is not

quite right, but imagine that for a moment. We want to know what actually happened. What happens on a drug round?
A The nurse in charge or one of the senior nurses will go round with the drug trolley to each patient, would check the treatment card, check the patients – patients all have a wrist band with their name on – check the treatment card and administer the drug for that time.

Q Where would the treatment card be?
A Probably at the end of the bed.

Q So each patient would have a treatment card at the end of the bed, which would be checked by the nurse on the drug round.
A Yes.

Q Were you able to do drug rounds?
A I did.

Q So you were able to administer drugs.
A Yes.

Q Would that include controlled drugs?
A Controlled drugs requires two trained nurse. They are in a locked cupboard in a locked cupboard, and we have a controlled drug register.

Q Tell us a bit about the administration of controlled drugs, please. You would be able to administer controlled drugs, with another nurse?
A With another registered nurse.

Q Before you issued controlled drugs to a patient, what sort of authority would you need to have?
A I do not understand.

Q You would need a prescription presumably?
A Yes, of course, written by a doctor. It would have to be the right date and the right time, et cetera.

Q As I am sure you know, we have heard quite a lot already in this case about variable doses. You know about variable doses, do you not?
A I have heard about it, yes.

Q If a variable dose has been written out, just tell us how you would decide what to give.
A I would give the lowest amount.

Q What does that mean?
A Supposing it said 5 to 10 mg, I would probably give the patient 5 mg, if that were suitable.

Q And if it says 80 to 200 mg, you would give 80?
A Say that again.

Q If it says 80 to 200 mg ---
A I would give 80, yes.

Q Are you allowed to give less than the minimum dose on a variable dosage?
A It is not normal, no.

Q Would you ever have done that?
A Probably not, no.

Q What about increasing within a variable dose? Say you have started off at the minimum dose, how and why would you make a decision to increase that dose, or would you need any special authority for that to happen?
A I would probably talk to Code A about it.

Q The Code A at the time – was that Code A ?
A Yes. It is not something that I can recall doing.

Q You cannot remember increasing a dose?
A No.

Q Nurse Code A we are going to be hearing a bit about. What was her role?
A She was a Code A I believe.

Q You believe?
A She was a Code A

Q Does that put her a grade, in the pecking order, above you?
A Yes.

Q Would that mean she was an Code A ?
A Code A

Q So she actually is a Code A grade?
A Yes.

Q If you were thinking about increasing drugs for a patient, would Nurse Code A have the authority to allow an increase in the dose – provided it is within the variable range?
A Probably.

Q Can you help us? "Probably" does not help us a lot. If you cannot remember, you cannot remember.
A I can remember, yes, but I have told you that – that I did not have to increase any drug dose.

Q How long were you on ---
A Quite some time.

Q ...Daedalus Ward.
A (*Correcting pronunciation*) It is Daedalus Ward.

Q Daedalus, all right! How long were you on Daedalus Ward?
A Over ten years.

Q During that period, can you ever remember increasing a dose?
A No.

Q I think you made a statement to the police about a patient called Code A Do you remember that?
A Yes, I can remember the statement.

Q Do you remember the patient at all?
A No.

Q What I am going to do is try to direct your attention to some of the entries that I think you made in the patient notes. One of the difficulties we have had is reading people's writing, and even more difficulty reading signatures; so if you see an entry that you have made that I do not point out to you, would you please just tell us? Do not sit quiet and let it pass by. All right? I am going to ask you to take up the notes. To your left you will see a row of files and I am going to ask you to take up file B, please.

Just to bring this patient back to mind for everybody, she had a fall on 5 February 1996. You will find a chronology right at the beginning of that file. I understand that you cannot personally remember her, but it may just help us all if we very briefly recap. She had a fall and she was admitted to the Royal Hospital Haslar. How far away was the Royal Hospital Haslar from Gosport War Memorial?
A About ten minutes in a car.

Q She was looked after by, among other people, Code A Then she was transferred to Daedalus Ward on 22 February, where she was reviewed. In the notes, which you now have, you will find some nursing records towards the back of the bundle. I am going to take you to the beginning of those first of all. If you go to page 1001 first of all, and then I will take you to an entry you made on 1022 – but I want to use you, if you would not mind, to introduce us to these notes. The document you are looking at on page 1001 – do you recognise that? That sort of document?
A Yes.

Q I do not think that has got your writing on anywhere, has it?
A I cannot see it, no.

Q Is this an admission form, effectively, for this patient?
A Yes.

Q We can see that there is a brief summary of the patient's condition. We can see that she is coming from A4 Ward, under the care of her GP, I think. It shows Code A Is that right? Do you see just above the words "From A4 Ward"?
A Yes.

Q Then we can see on the right-hand side of the page, "To Daedalus Ward, GWM" and then the next of kin is set out. We can see "Nursing requirements: needs minimal assistance

A with feeding; needs full assistance with hygiene needs; ulcers to both legs dressed every other day with dry..." – is it Kalbstat?
A Yes.

Q And then, something "padding". What is the word before "padding"? Can you read it?
A I cannot quite read it.

B

Q Is it "conforming bandages"?
A Yes.

Q "Toe to knee; all pressure areas intact although buttocks are very red but not broken; blood sugars are quite erratic so" – is it 7 BMs?
A Yes, have been recorded.

C

Q BMs?
A Yes.

Q What are BMs? Blood...?
A It is a way of measuring the sugar in the blood.

D Q And "she is unable to inject herself". Then we can see that the drugs that she is on at that time are set out below.
A Yes.

Q Over the page, page 1002, that is signed by – do you recognise that signature?
A No. It is "RGN", but ---

E Q All right. Then we can see that there is a nursing care plan, but there seem to be a number of different sheets as we leaf through the following pages. The first one starts on 29 February, but then we go to 24 February and 22 February after that. We can get the original records in here if we want, but how did these nursing care plan documents work?
A They are actually designed so that a strange nurse can come on to the ward and read the nursing care plans, and she is supposed to be able to see exactly how to treat the patient and what has been done for the patient.

F

Q These seem to be individual sheets rather than a running record.
A Yes.

Q Is that because each nurse ---
A They were at the time – individual sheets.

G Q How did it work? Each nurse would fill in their own?
A Yes. At the end of each shift she is supposed to fill in the care plan and sign it.

Q If we go, for instance, to page 1007 – I just want to try and understand these records – do we see on 5 March 1996, is that your signature?
A Yes, it is. That says, "Dressing remains in place"; so I did not change the dressing.

H

A Q As I say, if we go back to 1005, could you shout out where you see an entry by you? I do not need you to deal with everything perhaps, but it is just to get an idea of how these are working. So at 1005 do we see your signature?
A Yes, on 24th of the second I say the catheter is draining.

Q And also 1 March?
A On 1 March, "Catheter draining satisfactorily".

B Q And 5 March?
A And 5 March, yes.

Q Why are you making notes on this document? This all seems to be to do with a catheter.
A Yes.

C Q So is this a document that is particular to show how the catheter is working?
A Yes.

Q Then if we go back to page 1007, is that a document particularly dealing with the ulcer on the legs?
A On the right leg, or on the left leg, yes.

D Q I think both of them, in fact; and over the page is the same. Then if we go to page 1009, we can see this is all about bathing the patient and washing the patient.
A Yes.

Q We can see your signature again on that.
A Yes.

E Q You, I expect, have no recollection of doing this at all?
A No.

Q For that reason I am not going to ask you about each entry, but it is just so that you can help the Panel and give us an idea of how these worked. Page 1010 is still a nursing care plan.
F A Yes.

Q But this now has a named nurse shown at the top of that.
A Yes, Code A

Q That is 22 February.
A Yes.

G Q Can we go to page 1013? This seems to be to do with analgesia.
A Yes.

Q Can you just talk us through this, please?
A On the 1st of the third I say, "Complaining of pain in shoulder on movement"; then I see on the 4th of the third she had physio.

H

A Q Can we start at the top? 27 February 1996, "Analgesia administered". This is not your entry, is it?
A No. "Fairly effective; able to help when dressing this morning."

Q Whose signature is that?
A Code A She was also an Code A

B Q I am sorry? Code A ..?
A Code A

Q Then we can see under that, "Right arm less painful, able to lift it above head height, and left arm..." – is it "less improved"?
A Yes.

C Q Then on 29 February, "Able to move arms for washing and dressing"; and then your entry on 1 March, "Complaining of pain in shoulders on movement". Would you try and grade the pain at all? We can see you have not here. Did you use a pain scale at the hospital?
A We did have a pain scale, yes, for analgesia.

Q But you have not recorded the level of the pain here.
A No.

D Q Underneath that we can see, the following day, "Slight pain in shoulders when moved".
A Yes.

Q That is somebody else. Then we can see on 4 March, as you mentioned, she was having analgesia.
E A Yes, and physio.

Q Then: Code A needs---" ?
A "--- reminding."

Q Means what?
A "Reminding".

F Q I appreciate it is not your note. "... needs reminding." Does that have any particular meaning to you?
A No. Unless she had been asked to do...

Q It follows from the note about physio – exercises, so I do not want to speculate too much, but it might be a note to say, "Remind Code A to do her exercises".
G A Umm.

Q Then we can see "analgesia increased". Then we have your note on 5 March: "Pain uncontrolled, patient distressed, syringe driver commenced."
A Yes. I think... I do not if we have a plan for the night, but I think I remember from the interview that I was told by the night staff how distressed she was. Here is a one here.

H Q Page?

A A Not recorded, perhaps.

Q Sorry, page what is the night plan?
A 1017.

Q Just have a look at that.
A But it does not seem to be recorded anyway on here.

B

Q If we go back to page 1015. How do you tell when it is a night plan? Sorry to ask you.
A Actually, I was looking for that. It did actually say, "Requires assistance to settle for night." I think that is probably the night plan. That was 1016.

Q At 1015 we can see that the patient had been given an enema on 2 March and then a
C further one on 3 March, and the unfortunate patient was leaking faecal fluid.
A Yes.

Q There is no note there of pain.
A No.

Q So your note on 1013, "Pain uncontrolled, patient distressed" would be based on what
D you were told by somebody else?
A Yes.

Q Would you have spoken to the patient?
A I am not sure the patient could speak. I cannot really remember her.

Q If you had spoken to the patient, would you have made a note about it?
E A Yes.

Q If the patient had complained to you directly about pain, is that something you would have noted or not?
A Probably, yes. Yes.

Q And so it was your decision, was it, on 5 March to begin a syringe driver?
F A Yes.

Q Just give me a moment.
A It would not have been mine alone because two nurses would start the driver anyway.

Q If we go ---
A It would not be mine alone.
G

Q No. If we go back to 975 – and this is not your note but it may assist.
A Which one?

Q There are loads of numbers, I am afraid, at the bottom of these pages but would you look for the number with two lines either side of it. In this case I think it is circled as well – 975.
H A Is it a written number, or printed?

A

Q It is a written number, handwritten. Shall I hold it up to you? Can you see from there or not?
A No. (The witness was shown the correct page)

Q We were looked at 5 March and your note "Pain uncontrolled, patient distressed, syringe driver commenced 09:30 hours" and here, on 5 March, we can see a note – is that Code A
B Code A? Code A do you know Code A 's writing or not?
A No, I do not remember it.

Code A It is.

Code A : Thank you. But you do not remember it?
A No.
C

Q "Has deteriorated over last few days." I am afraid I cannot read the next line.
A "Not eating or ---"

Q "Not eating"?
A "--- or drinking. In some ---"

D Q "In some pain."
A Yes.

Q "Therefore", I think it is "start subcutaneous analgesia."
A "Let family know."

Q Yes. Does that help you as to how you came to make your note at page 1013?
E A Yes.

Q Tell us. How did it work?
A Well, Code A would have come in and I would have told her how distressed the patient was and how much in pain she was. She would have seen her.

Q So you would have been revealing to Code A what you were told ---
F A What I was told.

Q --- by the night staff who did not make a note. Right. Then she would have done what?
A She would have examined the patient and decided what she was going to do.

Q We know that the syringe driver – I can take you to the drug chart if you like. Have a
G look at page 990 and page 991. In fact, I think perhaps we are going to see your initials. Do you have 991?
A Yes.

Q It is very difficult to read, I am afraid, but these are the best copies we can get and I think they are legible.
A Yes, it is my initials.
H

A Q I thought it was. Do we see at the top, "Diamorphine" – a variable dose between 100 and 200 mg?
A Yes.

Q Had you administered that dose?
A Yes.

B Q At what rate?
A 100.

Q 100 mg?
A Over 24 hours.

Q Yes. I know it is obvious, but why would you have started at 100 mg of
C diamorphine?
A Why?

Q Yes.
A Because in my opinion that was enough medication.

Q So who chose the dose? I mean ---
D A Not myself alone. Whoever was doing it with me. I think it was Code A
Code A We decided we would do the 100.

Q You decided you would do the 100. And how did you calculate that? How did you decide? I know it is the lowest dose.
A We decided to give the lowest dose.

E Q Okay. Did you form any independent judgment about whether it was write to give the patient 100 mg of diamorphine in a syringe driver?
A No.

Q We have heard quite a lot about syringe drivers. Can you just tell us a little bit about the process of charging them and what you would actually do?
A Two of us would go to the drug cupboard and take out the dose required and fill in the
F book, okay?

Q That is the drugs book?
A The drugs book. The old drugs book.

Q So that would show that you are withdrawing a controlled drug?
A That is right. And two RGN nurses would sign the book.
G

Q Right. And if you are going to administer a dose of 100 mg of diamorphine, and in fact in this case I think you also administered a dose of midazolam?
A 40 mg of midazolam/

Q And who decided? I know what you are going to say, but who decided 40 mg of midazolam?
H

A A The two of us would have said, "How much midazolam shall we put in" and we would say we would put 40, because it is the lowest dose.

Q Again, would you have questioned the conjunction of those two drugs, putting both in at the same time?
A We were used to using those two together.

B Q Right. That was the practice?
A When we were talking about the drugs rounds and the rounds the Code A used to do, we did not tell you but every week Code A would come from QA. We had the same Code A from QA who would look at these treatment cards every week to see what each patient was taking, whether the drugs were the right drugs, whether the doses were correct. If she felt they were not, then she would leave a note for Code A

C Q How could Code A know if the dose was correct. Because a dose –
A That is her job.

Q Yes, but the dose... You told us that you would decide the dose depending on the pain and the patient?
A Yes.

D Q How does the pharmacist ---
A If the patient cannot tell you exactly how much pain they are in, the safest method is to give them the lowest dose.

Q Right.
A And then assess the patient to see if that is correct.

E Q I understand. I understand. When you talk about "the lowest dose", you are talking about the lowest dose as prescribed?
A Yes.

Q By Code A ?
A Yes.

F Q Because you could have a much lower dose than 100 mg, presumably?
A Yes.

Q Tell us about how the drugs came. Are they in bottles? Are they in ---?
A They are in little vials.

Q Little vials?
G A It is powder.

Q And would there be a 100 mg vial?
A I believe so. I have not worked for some years now, as you appreciate.

Q If you saw that the prescription was for 100 mg of diamorphine, you would get a 100 mg vial, if there was such a thing?
H A Yes.

A

Q And you would get, are they, 40 mg vials of midazolam. Can you remember?
A I think that was in 10s, I think.

Q Again, just imagine we have never seen a syringe drive in our lives. How do you get this drug ---
A It looks like a syringe.

B

Q So do you use the needle of the syringe to draw up the amount of the drug?
A Yes, yes.

Q And is there a mixing process? Do you shake the syringe or does it all go in and get mixed up?
A It is all mixed anyway.

C

Q How do you connect that to the patient?
A You have a little needle connected to a tiny tube. The needle just goes under the skin of the patient with a---

Q You are pointing to your wrist?
A Yes. I am talking about the skin, not necessarily the wrist. It does not have to be the

D

wrist.

Q No. Where would you normally ---?
A If the patient was restless, then it would be quite a good idea to just put the syringe driver, the needle, in here.

Q And you are pointing when you say "here" to your shoulder?

E

A To your shoulder, to the little pad of flesh there.

Q Not the bony part, the fleshy part.
A Up there. The little fleshy part.

Q Yes?
A And then that little tube connects to the driver.

F

Q Again, why would you do that if the patient was restless? Why would you put it in there?
A So that it would remain in place.

Q So they could not dislodge it?
A So it would not dislodge.

G

Q Then do you put of some sort of tape over it?
A Yes, yes.

Q Then where does the syringe driver itself lie?
A Probably then it sits in a little case, a little cotton case, under the pillow.

H

Q Presumably this is an electrical device?

A

A It has a battery.

Q And so how would you actually start the machine going?
A There is a button to press, and a light will come on to show that it is actually working.

Q So on the basis of the prescription that you are given by Code A you withdraw the drugs from the controlled drugs cabinet with your colleague nurse; you draw the drugs up
B into the syringe; you would insert a small needle very often into the patient's shoulder and that would then be connected by a very small tube to the syringe driver itself?
A The tube can be varying lengths. It might be longer.

Q And that would like under the patient's pillow. And that gradually injects the drugs into the patient's system?
A Yes.
C

Q And it is designed to last – we have heard – a bit longer, in fact, than 24 hours?
A Yes.

Q Just in case somebody does not renew it in time.
A Umm.

D Q All right. Can we just go back, please, to your original note. I just want to make sure you have not made any other notes that we may be missing. Can we go back to page 1022, please? We just dealt with the note of the 5 March. Then we can see at the bottom of the page: Code A contacted by telephone, situation explained." That is your signature next to that, so you would have called Code A?
A Yes.

E Q And you would have explained what to him?
A I would have explained how poorly Code A was and asked his permission to set up the syringe driver.

Q Could we just look at the entry prior to yours on 4 March? Can you read this:

"Patient complaining of pain and having extra analgesia PRN"
F

PRN means "as required" does it not?
A Yes.

Q "Oromorph sustained release tablets dose increased to 30 mg" – I think that means "BD", twice daily, does it not?
A It does.
G

Q Yes?
A Yes.

Q The nurse there is?
A Code A

H Q That is Code A again. Is that a male Code A or a female Code A

A A She is female.

Q That would seem to indicate, would it not, that the patient was on 60 mg of effectively Oromorph which is a form of morphine, is it not? Are you all right?
A Yes.

Q Okay. The patient was on 60 mg of oral morphine a day - yes?
B A 60 a day, yes.

Q Sorry – 60. Yes, 60 mg a day. And then the next day you commence her, on instruction, I understand, on 100 mg diamorphine and 40 mg of midazolam. Were you ever taught anything about conversion rates?
A Yes, we were.

C Q You were?
A Yes.

Q When were you... When did you have that ---
A I cannot remember them now. I have not worked for four years.

Q Tell us what you know about conversion rates?
D A I know there is a conversion rate.

Q That is a good start. Can you tell us any more than the fact that there is a conversion rate. Can you tell us what the conversion rate is between oral morphine ---
A I cannot. I am sure Code A will tell you when he comes over.

Q We will look forward to that. Can you say whether, when you start with oral
E morphine, you should go up and down if you are transferring to a subcutaneous dose?
A That, I do not know.

Q Would you have known at the time?
A I would have known at the time, yes.

Q This change, presumably, did not trouble you. Would you have done something about
F it if you had been?
A Yes, if I had felt that that was incorrect – do not forget there were two of us doing it, not just me – and if we felt it was incorrect, we would have rung Code A and asked for clarification.

Q Do you remember ever ringing Code A ?
A No, I never needed to.
G

Q In ten years working on this ward, you say you never needed to call Code A
A No, well, yes, I called her on certain occasions when it was necessary.

Q What would have triggered it, what would have made it necessary?
A What made me call her?

H Q Yes?

A I remember calling her because somebody's blood sugar was something like 20 and I wondered what to do about it; that is rather high.

Q Specifically about the sort of doses of diamorphine?
A No, I did not question her on any doses.

Q You did not ever question her on any doses?
B A No, I do not think any of us did.

Q Can I ask why not, did it never arise?
A It just did not arise and at the time that was the dose that was given.

Q If we turn over the page to 1023, you can see that the patient died Code A Code A Can I ask you to look at the top entry. I am sorry to use you as a sounding board.
C Code A the syringe driver starts and the day that this patient died:

"Seen by Code A medication other than through syringe driver discontinued as patient unrousable."

Two things to ask about that. Patients becoming unrousable as a result of the injections of diamorphine, did that ever give you cause for concern or is that part of the norm; how did it
D work?
A I think it was just normal.

Q So when you started a syringe driver with diamorphine, you felt it was normal for the patient to become unconscious?
A No, not all patients became unconscious when they had a driver.

E Q Would it concern you at all if a patient was unrousable, meaning, presumably, if you shook them they would not wake up. Would that have caused you any concern, or not?
A I do not know.

Q The second thing I wanted to ask you was that "medication other than through syringe driver discontinued", and again it may be obvious from what you just said, but the other medication, presumably, would be oral medication, would it?
F A Yes.

Q Would there be times when a patient was on a drip for fluids and things like that?
A Yes.

Q What was the practice once diamorphine started. Were drips continued, discontinued, was there any regularity as to what happened?
G A I think if the patient was on an IV drip, then that would continue.

Q Even though a syringe driver was started?
A Yes.

Code A I do not think you made any other notes about this patient. I am now going to move on to another patient. Sir, I do not know if you feel that the witness should have a
H break.

Code A She has been on the stand for an hour and 15 minutes. We are going to give you a break now and we will all take a break. It will be about 15 minutes and you will be taken to a room where you can get some refreshment. Please do not discuss the case with anyone in the interim.

Code A Can I repeat it and reinforce it. (To the witness) This is not directed at you particularly at all, but for all nurse witnesses, and I know your representative will know the rules. You must not discuss with any other nurse, nor indeed with the nurse representative, the evidence that you have given.

Code A Fifteen minutes please.

(The Panel adjourned for a short while)

Code A

Code A you have made a note in relation to the various patients that we have here and I am going to ask you about a patient called Code A I think you were interviewed by the police in relation to her?

A Yes.

Q I was not going to take you through every other patient that we have, we have 12 patients, unless you have specific recollections of any of them?

A I do not.

Q I am going to ask you about Code A our Patient E. You may want to take up her file, which you will find if you put away the file on your desk and take up Patient E. Right at the beginning of that you will find a chronology. I mention in passing that we are all in discussion about the chronologies. I have spoken to Code A this morning, Code A has been working on them and we have not forgotten about it. They are quite lengthy documents, so it will take a while to get them together. We are still working on the chronology that we have. To remind ourselves about this patient. For you, Code A to remind yourself as well, she was taken, as we can see on the second page of the chronology – do you have a chronology right at the beginning of that, the document on its side?

A Yes.

Q On 29 July she was taken into the Royal Hospital Haslar after a fall at a nursing home for a fractured right neck of femur. You told us that the Gosport War Memorial Hospital had an Accident & Emergency Department. Did it have an Accident & Emergency Department in 1998?

A I think so.

Q Did it have a ward to look after patients, or were they transferred if they needed ongoing care?

A Yes.

Code A Sorry, Code A could I ask the witness to turn her microphone on.

Code A This patient was taken to the Royal Hospital Haslar. She underwent an operation on 30 July and then we can see that she was transferred on 11 August to Daedalus Ward. We know that on 13 August she had another accident in the sense that, having had her hip repaired, she was found on the floor at 1.30 lunch time and it seems she dislocated her hip again. She then headed back to the Royal Hospital Haslar. She was operated on again and then on 17 August she came back to Daedalus Ward. Do you have a recollection of this patient?

A I did not meet her until she came back to the ward. I was on leave when she was first admitted.

Q I think for the period from 11 August you were away.
A I was on leave, yes.

Q You cannot comment on any of that?
A No.

Q You were there...
A I met her when she came back from the Haslar.

Q ... on 17 August when she came back?
A Yes.

Q Would you turn to page 51, we can see a note, under the Nursing Care Plan – and I am only going to ask you about 17 August onwards – that the patient was readmitted on 17 August. On 17 August she was given Oramorph 10mgs in 5mls and Oramorph we have heard a lot about. Is that a liquid morphine?
A Yes.

Q Is it taken on a spoon or a little cup. How would the patient actually take that drug?
A Possibly on a spoon, yes, teaspoon perhaps.

Q That would indicate, obviously, if a patient is on oral morphine that they must be able to swallow?
A Yes.

Q Did you find that patients sometimes reacted badly to Oramorph, or did you not have that experience?
A No, I did not find that.

Q It was always all right, was it?
A It seemed to be.

Q If we go to the back of the bundle and we go to page 294, I think the last note we are looking at, would that be a note from the Royal Haslar?
A On page 294?

Q Yes.
A This looks like Haslar's.

Q Would you have access to the Royal Haslar notes?

A A No.

Q What would you get at the Gosport War Memorial Hospital?
A We would probably get a letter with the patient.

Q If we turn right back to page 8 – I do not think we have managed to find a better copy of this – is that the sort of letter you are talking about?
B A Yes, something like that. I could not read this one.

Q It is dated 17 August and it gives a brief description of what has happened to her. In the second paragraph I think it talks about a knee splint – no, a canvas---
A "Knee immobilising splint to discourage any further dislocation".

Code A Would be your understanding of that be? Sorry, reading on, I think it is
C suggesting that she should stay for four weeks.

Code A You may say "this should stay in situ".

Code A I am grateful, thank you. "This should stay in situ for four weeks".
A It is like a triangular cushion which goes between the tops of her legs to keep her legs straight.
D

Q "When in bed it is advisable to encourage..." is it "abduction"?
A Yes, that is what I am talking about.

Q "By using pillows or..."?
A "Abduction wedge" I think that might be.

E Q "She can however mobilise", and then at the bottom "fully weight bearing". At your hospital you would have got a transfer letter like this, would you?
A Yes.

Q This one, presumably, for this patient?
A Yes.

F Q If we turn to page 58 of these notes and then 59, the ones with the two lines either side, we can see there seems to be an entry at the bottom on 18 August?
A Yes.

Q "Complete bed bath given". That is not your note I do not think?
A That is not my writing.

G Q Over the page, also 18 August, is that, "Night oral care given frequently"?
A Yes.

Q Let me ask you about your dealings with this patient. She was transferred back from the Haslar on the 17th. Do you remember there being a problem with her transfer?
A Yes, I remember her transfer.

H Q Tell us about that.

A A I came back from coffee and I could hear this patient screaming as I came back down the ward. She was obviously in a lot of pain and a lot of distress. The two support workers who were on the ward came to tell me that this patient had been transferred. She was transferred on a sheet and not the normal canvas. The canvas is quite taut and thick and they felt that she was not lying correctly in the bed, which she was not, and they were not happy with her transfer.

Q What would be the effect, as far as you are concerned, of not transferring the patient
B on a canvas sheet?

A She would not be lying correctly. As they said, she had to have her legs in abduction and she probably was not because she was wobbling around on a sheet. She was in a lot of pain and we did have her x-rayed and she had a large haematoma on this hip where she had had the operation.

Q Haematoma being a---

C A Being a large collection of blood where the two pieces of bone had been rubbing together.

Q Can that cause a patient pain?

A Causing the patient a lot of pain, a lot of distress, yes.

Q Do you remember meeting the patient's Code A at any stage?

D A Yes, I do.

Q Was she there on the 17th?

A They were Code A Code A were there. The Code A was telling me that she was an ex-nursing officer and, because there was just myself on the ward, she helped me re-position Code A and put her legs in the correct position.

E Q When this care assistant ---

A Make her more comfortable.

Q When this care assistant came to find you, is that the first you realised the patient was in pain?

A Yes, she was transferred whilst I was off the ward.

F Q Do you know how long the patient had been screaming for?

A I do not, but I was only gone for about 20 minutes, so it was during that time she was transferred.

Q So you helped the daughter to level the patient out, as it were, so that she was more comfortable?

A Yes, she helped put her in a correct position.

G

Q Did that help her?

A That did help her.

Q Could you go to page 47? I am sorry to dot around this bundle. We can see there is a contact record at page 47.

A Yes.

H

Q Do you have a recollection of this?
A Yes, I do.

Q It is your writing, I think?
A Yes. I did ask Code A if I could give Code A some Oramorph and she said yes, and I gave her 2.5 mg in 5 ml. They told me that she must be transferred back to Haslar if she dislocated again, and that is why Code A ordered the X-ray and that is how we knew she had a haematoma.

Q That Oramorph that you gave, of course you would not have been able to give it – and I am not saying there was anything wrong with it – but you would not have been able to give it unless there had been a prescription from Code A
A Yes.

Q Or from a doctor who was allowed to prescribe controlled drugs.
A Yes.

Q Keep your finger in page 47, please, and also turn up page 63. We are beginning to get a bit more used to reading these charts and we can see that the first entry under "As required prescription" is Oramorph 10 mg in 5 ml. It is a bit difficult to read but I think we can make an educated guess that that is the prescription. Do you accept that?
A Yes, I do.

Q Then, to the right of that, we can see in the first four columns that it is given first of all back on 11 August, when you were away on leave, at 2.15 in the afternoon – no, I am wrong, I am sorry – 11.15, I think it is, in the morning, 10 mg. Is that Code A ? Whose is that initial? It is a pure assumption on my part because it looks like 'Code A' but it might not be.
A It is Code A

Q Then other nurses have made their entries below.
A Yes.

Q There is a gap obviously between 14 August and 17 August, when she has been off at the Haslar having her hip fixed. Then on 17 August do we see another entry?
A Yes.

Q Tell us about that, please? Who is that?
A The first one is the one that I gave, isn't it, at 13:00 it says in here? My actual time I have put is 13:05. That is the on I gave.

Q Whose initial is that next to it?
A That is Code A That is because the two of us drew the – as I was saying, two trained nurses do each controlled drug.

Q But only one of you has to ---
A Either of us could sign this, and he actually signed it.

Q You would have given that to the patient, presumably on a spoon or in a little cup?
A Yes, but you can see that I did ask Code A first if I could give it to Code A and she agreed.

A

Q Absolutely, and the patient was clearly in pain?
A Yes.

Q Then we can see that it is given again, I think. It is a bit difficult to read the time. Let us just see if Code A .. (reviews document) No, I do not think he could read the time either.
B A I cannot read that. Maybe Code A can.

Q It seems to be given again on 17 August and then, in total, there are four doses given of 2.5 ml for the first three and then, in the evening at 8.30, is 5 ml given? If you look to the right-hand side ---
A Yes.

C Q 17 August, 20:30, 5 ml. That is not you, I do not think?
A No, that looks like Code A again.

Q That obviously would have been a dose given hopefully before the patient went to sleep. Was it your practice that you remembered to give a higher dose at night, to ensure the patient rested through the night, or can you not remember?
A I cannot answer for him, if Code A gave that one. I do not remember. I do not recall
D giving it myself.

Q That is why I asked you about *your* practice. Was it your practice?
A Possibly if you had given those tiny doses and they were not helping, then he decided to give the 5 ml then.

Q Keep that page open but go back to page 47, and just go back to your note – to link all
E of this up. 13:05, "In pain and distress; agreed with Code A to give Code A Oramorph 2.5 mg in 5 ml; Code A reports surgeon to say he..." ---
A "... Code A must not be left in pain."

Q "...to say Code A must not be left in pain if dislocation occurs again. Code A contacted and has ordered an X-ray." Then we see in the afternoon, "X-ray at 15:45; film seen by Code A "
F A It is to go to radiologist. That is for reading.

Q Then, "For pain control overnight and review by Code A in the morning."
A In the morning, yes.

Q Then the following day, "Reviewed by Code A ". Whose writing is this?
A It is Code A s.
G

Q We can ask him about it, but I think we can see that the treatment was discussed and Code A has noted, "They agreed to use of syringe driver to control pain to allow nursing care to be given". Are you able to interpret that or not?
A Yes, I can read it.

Q Then tell us.
H

A A It is practice on the ward, before giving Oramorph or before giving a syringe driver, to discuss what we were going to do with the relatives and to discuss the treatment.

Q If you were giving, first of all, Oramorph, would you expect the patient to remain rousable or not?
A Yes.

B Q I want to ask you about a drug called midazolam, because I think this patient was given midazolam together with her diamorphine. Before we turn to that, I want to ask you about your understanding of midazolam and what it was used for.
A This patient had dementia, Alzheimer's. That is one of her diagnoses. So she was quite restless and distressed as well as in pain, and midazolam was given as a sedative.

Q So it was a drug with a sedating effect.
C A Yes.

Q If we go to page 63, which is the drug chart, can we concentrate on midazolam first of all? Can you recall what part you played in the administration of the midazolam?
A I can see that I drew it here on the 20th of the eighth, when I renewed the syringe driver.

D Q It seems to have been started before you, though. Is that right?
A Yes.

Q Again by Code A ?
A Yes.

Q Midazolam, would that be being administered by way of syringe driver?
E A Yes.

Q If we go two pages on, to page 65, we can see diamorphine was also being given. Yes?
A Yes.

Q If you look – just to help you – two entries up from the bottom, does that appear to be
F Code A 's prescription for a variable dose of between 40 and 200 mg of diamorphine?
A Yes.

Q Starting on 18 August?
A Yes.

Q So this is the day after this patient has come back from the Haslar and has been
G transferred on her sheet?
A Yes.

Q Can you help us as to your recollection of the decision to use midazolam as well as diamorphine with this patient?
A To make her more comfortable, I think.

H Q The diamorphine was started at what dose?

A A Forty. She only actually had 40; over 24 hours she had 40.

Q Prior to that, she had been on Oramorph. If we go back to page 63, to try to follow this through, she had been on Oramorph on 17 August and I think she had had – but I will be corrected – about 25 mg, effectively, of morphine; because it is 10 mg in 5 ml, is it not?
A Yes.

B Q And she, on that day, is given 7.5 ml in total during the day and then 5 ml at night. Yes?
A Yes.

Q The day after that she is started on 40 mg of diamorphine.

Code A The early morning of the 18th.

C

Code A Yes, I am grateful. (To the witness) Going back to page 63, we can also see she is given two doses of Oramorph ---
A During the night.

Q Is that just after midnight and the second at four o'clock in the morning?
A Yes.

D

Q So she has had ---
A Twenty.

Q 20 mg cumulatively in those two 5 ml. Then the next day, or that day rather, she is started on diamorphine, and the lowest dose prescribed would appear to be 40. Does that seem to be right?

E A Yes.

Q Can I just ask you this, and I appreciate you did not start this patient on 40 mg and, even if you had, it would not have been your decision. You have spoken about your knowledge about the conversion rate. Did you have any understanding of a thing called the "analgesic ladder"?
A Of course, yes.

F

Q I did not mean that to sound rude, but we need to know what your state of mind was. What was your understanding of what the analgesic ladder was all about?
A It is all about starting on the lowest analgesia, paracetamol, and rising up the ladder.

Q As it is necessary.
A However, you have to remember that possibly she could not swallow. I cannot

G remember. We are talking about 13 years ago, aren't we?

Q I understand.
A So if she could not swallow the tablets....

Q When it comes to increasing a dose, if the patient remains in pain, you are working through the analgesic ladder; but say you have a patient to the point where you have to use

H

morphine in one form or another – Oramorph, diamorphine, an opiate – what was your understanding at the time of the rate of increase?
A We did not increase it very often.

Q Right. I did not ask you that, though. What was your understanding of how it was meant to work? Of the rate of increase? If you felt that a patient was still in pain ---
A We would probably ask for guidance before we did increase it any further.

Q From whom?
A From probably Code A or Code A if she was around.

Q We can see from the drug chart that on 18 August the patient was started on 40 mg of diamorphine ---
A Over 24 hours.

Q Yes, that is a given. I accept that. And 20 mg of midazolam, in the syringe driver. When we see your signature, as we do on page 63, does that indicate that you were starting a fresh syringe driver?
A Yes. Every 24 hours it would have to be changed. It would be empty.

Q Of course, the needle presumably remains in place.
A Yes, probably. Although, no – thinking about it, I think we did change the needle as well every 24 hours.

Q And a completely fresh syringe would be used?
A Yes.

Q Would you use an old syringe or would you use a completely fresh syringe?
A No, there is one special one. It is called a Graseby syringe driver.

Q And new drugs would be drawn up according to what you decided to administer.
A Yes.

Q There is something I meant to ask you. Would you ever put a syringe driver in when the patient was asleep?
A No, I should not think so.

Q An answer like that, "I should not think so" – I am not sure how much it helps us. Can you remember ever doing it?
A No. I will say "no" then.

Q With the last patient that we were looking at, Code A – I do not want to go back through it – but when you inserted the needle into her, and you thought you might have done it into the fleshy part of the back, would she have been awake or asleep?
A Awake.

Q So she would have been able to talk to you?
A I honestly cannot remember. We are talking about a long time ago. I think the last patient was nine years.

A Q Let us just look at the other drugs, please, on page 63. You have dealt with the Oramorph, which was stopped on 18 August at 04:20. We can see that the diamorphine which was in fact prescribed on 11 August by Code A – and that was a variable dose between 20 and 200 mg? The second one down?
A Yes.

Q Is that right?
B A Yes.

Q But that does not ever appear to have been given.
A No.

Q Then hyoscine, the next one down – are we still on the same page, page 63?
A Yes. I see them.
C

Q What is causing you concern?
A No. I am just.... No.

Q What are you looking for?
A I am not.

D Q I see. Page 63, hyoscine, 200-800. Is that a drug to deal with secretions?
A Yes.

Q Can you recall now whether secretions were an issue for people on diamorphine?
A Secretions sometimes are an issue, yes. I can see that Code A did not have very much.

E Q Very much what?
A Hyoscine. She probably did not need it.

Q She probably did not need it? Does your initial appear?
A Yes, in the middle, on 20th of the 8th I used it.

Q Why would you have used it?
F A Presumably she needed it then, so I used it, but like I am saying, it is not just me that used it. Two of us would be doing this together.

Q Okay. Then we have dealt with the midazolam and then, over the page, at page 65 at the top is that lactulose?
A Lactulose, yes; that was her bowels.

G Q And when we see a cross?
A That means it was not given.

Q It was not given. So it was not given on the 18th and it was not given on the 21st?
A Umm.

Q But when we see the initial "B", this seems to have been given on the 17th?
H A Yes.

A

Q Haloperidol. What are the effects of that drug?
A Again, that is used for restlessness and agitation.

Q Does that have a sedatory effect?
A I can see that she had that. When she was given that, I was not actually on the ward, so I cannot say the effect it had on her.

B

Q No, but what is the purpose? Had you ever administer haloperidol before?
A For restlessness and agitation.

Q Does it have a sedating effect?
A Yes.

C

Q Then underneath that we can see Oramorph has been crossed out. I am sorry – Oramorph is there, but that particular prescription of Oramorph has not been given. That is 10 mg in 5 ml from 12 August. Then there is another prescription for Oramorph underneath that and then there is the prescription for diamorphine and haloperidol. Can you help us with this? None of these prescriptions seem to have been crossed through. If we go back to the two pages before, does that mean that they all remain live prescriptions, as it were? Do you understand what I am asking you?

D

A I understand what you are asking.

Q Can you help us?
A Yes. I can see that we did not use the syringe driver on the first page because it was re-written on this page – on page 65.

Q That is what I am trying ---

E

A Yes, I can see.

Q --- to get at.
A I can see what you are talking about.

Q The first prescription ---
A But I cannot explain why it is not crossed through.

F

Q No, but you can tell us about how things should be done. You have been a nurse for many, many years. If you wanted to stop a prescription, to say, "No, this one is not valid any more," what would the doctor have to do?
A Cross it through.

Q Cross it through? Can you help us? If the prescription on page 63 is still a live one,

G

can you help us as to why it would be necessary to write a further prescription ---
A No.

Q Page 65 --- at a higher dose?
A No, I cannot.

Q You cannot. I am not saying you ever ---

H

A Unless this dose was necessary, was felt necessary.

A

Q Yes, okay. I am not saying you would ever have done this, but you have live prescriptions here for Oramorph, diamorphine, hyoscine and midazolam, lactulose obviously, haloperidol, two more for Oramorph, diamorphine again and more haloperidol, none of which had been crossed through?
A No. Did it not say in the nursing notes that her drugs were not given after the syringe driver?

B

Q I just want to concentrate on these drugs charts for a moment. Would that give a nurse authority to administer any of these drugs?
A It would give them authority, but then none of them would administer those drugs?

Q No, I understand. Okay. In fact there is one we have missed, page 67. This is haloperidol?

C

A Oh, PRN.

Q And what is ---
A And the date on there is the 13th, is it not?

Q Yes.
A Which was when she was first admitted.

D

Q Well, the second time.
A The second time was the 17th, was it not, or the 18th?

Q Yes, all right. This is actually, I think, the second time. She is admitted the first time on 11 August. Then she has a problem. But in any event, this is 13 August and this says, "If noisy". How would this be given, this type of prescription?

E

A It is liquid. It is 2 mg in 1 ml, 0.5.

Q So that does not go into a syringe driver?
A Well, she was not on a syringe driver anyway, was she?

Q That prescription would have been oral, would it?
A Yes, it says oral on the prescription.

F

Q As a nurse, what would "If noisy" signify to you? Does it mean what it says?
A If the patient was distressed, agitated.

Q And then you can give the haloperidol? Right. One other matter I wanted to ask you about is what I think you refer to in your police interview, is it "subcup" or "subcut" – giving fluids? What is the expression?

G

A It is giving fluids, not through a vein, but through subcutaneously.

Q Right. You have already dealt with this, but I think in your interview you indicated that you thought there was research to prove a patient would probably be more comfortable without subcut. I just wanted to explore with you what you were talking about. The patient ---
A I think there is research to prove that.

H

A Q To prove what? Just explain to us.
A In those days there was. To prove that when the patient was close to death? Is that what you are talking about?

Q Yes.
A Yes. That they are more comfortable without the hydration.

B Q So let us just try and explore that a little bit. If you felt a patient was close to death, does that mean you would withdraw hydrating fluids?
A I do not know what the form is now.

Q Do not worry about now, but when you were a nurse, if you felt a patient was close to death would you take any action in relation to their hydrating fluids?
A No.

C Q So who would?
A What do you mean?

Q You have just told us that you thought there was research to show that a patient would be more comfortable. Is that something that was ever done when you were a nurse – withdraw hydrating fluids?
D A I remember that research when I was a nurse, yes.

Q Is it something when you were a nurse on the Gosport War Memorial Hospital that was ever done or can you not remember?
A I cannot remember.

Q And would you just look through the prescription charts, the drugs charts, that we
E have just been looking at? Are there any other entries by you that we have missed, as it were? Just on the drugs charts for the moment. Are there any other entries by you?
A No, no. We have covered the ones that I ----

Q Right. Finally, on that last topic could you go to page 299, please, at the back of the bundle. Is this a fluid chart from the Haslar?
A This is Haslar, yes.

F Q And if we go to page 299 we can see what the patient was taking orally on 15 August. She had some squash. Then is it co-codamol?
A Co-codamol, yes.

Q And that is a pain relief?
A Yes.

G Q We can see what she was having intravenously in the second column?
A Yes.

Q So the first column is her oral liquids that she was able to drink down herself - yes?
A Yes.

H

A Q Then the second column is her intravenous fluids. Then we can see that at 9 o'clock on 15 August her cannula was removed. That would mean that from then on she was just taking fluids normally?
A Yes.

Q And we can see that she had water and tea and juice and the like. Over the page much the same – that is 16 August, and then the 17 August before she came over to the Gosport
B War Memorial Hospital - yes?
A Yes.

Q Were there any fluid charts in the Gosport War Memorial Hospital? I am sorry if I have missed them. I am not saying there were not.
A I do not recall her drinking like that when she was admitted to us.

C Q From the time that you were dealing with her, from the 17th?
A She was in such distress, I do not recall. I recall sending her meal back that day to the kitchen to have it minced because she could not eat it.

Q When you say "on that day", do you mean on the 17th, the day of her admission?
A Yes, on the day she was re-admitted.

D Code A Thank you very much indeed. Would you wait there, please.

Cross-examined by Code A

Q I am going to be asking you some questions on behalf of Code A I am afraid it is more than just one or two, but I will try and keep it as confined as possible to cover the topics that we need to cover. I would just like you to deal with two particular things before I ask
E you more about background and so on. With regard to intravenous fluids, at the time we are concerned with was there a period of time when the Gosport War Memorial Hospital did not provide fluids intravenously?
A Yes.

Q Later on – is this right – intravenous equipment was supplied?
A Yes.
F

Q So they could do just that. During the period of time that we are concerned with with regard to the patient you have been asked about, in fact intravenous fluid was not supplied?
A No.

Q And equipment was not there? Yes?
A Yes.
G

Q And the second particular thing I wanted to ask you about was something you dealt with a few minutes ago, and you were asked about the process of increasing the medication. Obviously we are concerned with controlled drugs here, increasing controlled drugs. I am sorry if this is all a bit basic, but we just need to check it with you. If the doctor, Code A – whoever it was – prescribed a particular dose of a controlled drug you, and all the other nursing staff in your experience, would administer what the doctor had prescribed?
H A Yes.

Q It is just a set dosage.
A Umm.

Q Just taking that simple example, if you, as a member of the nursing staff formed the opinion that that dose was not enough to control the patient's pain, would you take steps to report that to somebody?
A Yes.

Q And if you were the person seeing Code A when she was at the hospital, say in the morning, or at any other time, you would report that fact to her?
A Yes.

Q And if you reported the fact to somebody superior to you in the nursing chain, say to Code A you would expect him to pass that information on to Code A ?
A Yes.

Q In the normal course of events?
A Yes.

Q So that the doctor could decide, having heard that the pain was not being controlled, that the dose could be increased?
A (The witness nodded)

Q You have told us already that where the doctor had prescribed a dose with a range to it, whether it is 20 diamorphine to 200, whatever it might be, where there was a dosage prescribed with a range, you and the other staff so far as you are aware would normally start at the lowest dosage in the range?
A Yes.

Q I want to ask you this by way of generality. Say you started the patient at 20, if a particular dose – in this case 20 – did not seem to be achieving the object, it was not controlling pain, would you – I appreciate that it is not just you making the decision; it is always you with a senior colleague – endeavour to contact the doctor, Code A ?
A Yes.

Q Do indicate why it was your view that the dosage should be increased?
A Yes.

Q Normally speaking, that would be the procedure followed?
A Yes.

Q Is that right? If, however, when Code A was not available , or you could not contact her, were there occasions when a more senior member of the nursing staff than you would have the power, have the authority, to increase the dose?
A Yes.

Q Within the range prescribed by the doctor?
A Yes.

Q But is this right as a matter of normal procedure – only in cases where Code A could not be got hold of?
A Yes.

Q And the ultimate decision in terms of the nursing staff for increasing, or whatever it might be, would be a more senior nurse than you?
A At least two.

Q I appreciate it is two all the time but you always have to be with somebody more senior?
A Yes.

Q And they ultimately are the ones giving the say-so?
A Yes.

Q Obviously you worked together with them for years?
A Of course.

Q And knew them very well. Thank you for dealing with that, just by way of general procedure. We may have to come back to it in relation to other questions that I ask you. In terms of what you have been asked in the past, you were interviewed by the police, I think, back in the year 2000?
A Yes.

Q We will all understand if you do not remember dates, and if there is anything particularly important about a particular date I will make it clear. You were interviewed under caution?
A Yes.

Q Not a very nice experience, I should not imagine?
A No.

Q But you dealt with the matters you were asked about and it very much, in the interviews in 2000, concentrated on the case of Patient E, Code A ?
A Yes.

Q As well as asking you some general matters about procedure at the hospital?
A Yes.

Q Then you made a witness statement. That is a witness statement to the police on 15 December 2004?
A Yes.

Q So some four years later, and that very much concerned itself with the patient you have already spoken to us about, Code A - Patient B. Then you also made a statement to the GMC producing those earlier statements and records?
A Yes.

Q May I ask you something generally about Code A Obviously you have worked with her for a number of years. You have already told us. Did you find her to be a hard-working and responsible doctor, so far as you could judge?
A Extremely.

Q Did you also find her to be somebody who had a complete commitment to the patients' best interests?
A Absolutely.

Q And I would just like you to deal with this in case there is some suggestion in the air, and you can speak as one of the nurses who were there for many years, was there ever a case in your experience when you or any other nurse to your knowledge administered analgesics simply to keep the patient quiet?
A Definitely not.

Q In case there is any suggestion, to shut them up, because they were giving trouble?
A Definitely not.

Q Did Code A in your view of her, in your experience of her, ever give you the slightest indication that she was prescribing in order to achieve a purpose like that?
A No, she did not.

Q In general terms, we all have our little ways and manners, and way of behaving, but in general terms did you find Code A to be somebody who was approachable?
A Extremely approachable.

Q And was she somebody who listened to what the nursing staff had to say or ignored it, or what? How would you describe it?
A No, she listened to the nursing staff all the time.

Q Did you find that you, if you wanted to express a view about something, could always approach her?
A Yes, she listened to our views all the time.

Q I would like you to help us, again with a general matter, with regard to the patients who you dealt with over those years. We are concerned, in particular, so far as you are concerned, with the period 1995 to 1998 or thereabouts. We appreciate, obviously, you carried on working there for a number of years. In general terms, did the pressures on your ward, Daedalus, increase in terms of the needs of the patients?
A The pressures increased very much.

Q In general terms, was it the case that you were dealing with, in terms of continuing care, patients who were obviously, in general terms, often elderly and very frail?
A Multiple diagnoses.

Q This is something you explained to the police, multiple medical problems?
A Yes.

Q This is just a general picture?
A Yes.

A

Q Problems such as Parkinson's Disease, Alzheimer's, dementia of one sort or another?
A Stroke.

Q Stroke, and in general terms patients who were highly dependent?
A Highly dependent, yes.

B Q Normally needing two nurses to cope with their ---
A Most often needing two nurses.

Q --- daily needs?
A For daily needs.

Q I may have to come back to some generalities, but I want to turn back to the patient
C you have already been asked some questions about, Code A Patient B. It is back to that patient and then I will come on to the position with regard to Code A Patient E, in a moment. I am going to ask if you could have in front of you the file with regard to Code A Code A Patient B. I am going to take you through some of the documents, and maybe there will be one or two extra documents where there is a record of you doing something that you have already been asked about. I am going to try, not only to assist you in answering any questions but also for the assistance of the Panel, to take the entries you made in relation to
D that patient's records chronologically, just try to take it through in sequence. The earliest one that involves you is, if would you turn towards the end, on page 1018. It has other numbers as well, it says 88 of 103, which I think is something to do with "Pressure Sore Documentation"?
A That is right.

Q Do you see at the bottom on the left your signature?
E A I do.

Q It is dealing with a recording that this patient had a right leg ulcer on admission on 22 February. We can see the date early on. I think that is the earliest record where you have made an entry. I am not asking you about the detail. The Code A is shown as Code A To follow the history through, would you go back in the bundle this time to page 1005, which I think is one you have already been asked about and I am trying to take this through in
F sequence. Do you have that?
A Yes.

Q That shows incidents with regard to the catheter, is that right?
A Yes.

Q Recording that the catheter is draining and so on?
G A Yes.

Q We can see your signature and we are familiar with that. Further on to page 1009, can we see your signature again relating to bed baths?
A Yes.

Q These are all part and parcel of the normal nursing records that would be kept with
H regard to patients?

A A Yes.

Q On please to page 1012 where we can see two entries by you relating to, "Bed rest due to painful joints" and so on, then "Bed rest maintained" giving us an idea of the sort of picture that was painted in terms of these records with regard to patients. This is all 24 February.

B I would like to move on to a letter date. I think this note refers to something you mentioned in the course of your evidence anyway. Would you move turn to page 1022, the typewritten number 1022. It is a page you have looked at and I am trying to keep the chronology in a sensible order. This is in relation to 29 February. Can we see just over halfway down the page, part of the summary, a date 29/2/96?
A Yes.

C Q I think that is an entry by you?
A It is.

Q "Blood sugar at midday", and you show the figure of 20. "Code A contacted, ordered", and I think it says, "10 units Actrapid".
A Actrapid, yes.

D Q Actrapid, whatever it is, and signed by you.
A Yes.

Q Is that the occasion you mentioned in your evidence when you said you phoned Code A because you had a concern?
A Yes.

E Q That was one occasion you could remember?
A Yes.

Q The action was taken pursuant to her verbal permission, or verbal opinion, as to what should be done?
A Yes.

F Q That is 29 February. On to 1 March, another entry by you, which is at page 997, the prescription sheet relating to MST. Do you see that? You had better pick out the entry by you, yourself, on the sheet. It is in relation to MST, I think we can see it, perhaps, just over halfway down, "MST 20". Can we pick up your initials on the right?
A Yes.

Q "Code A" is you, is it?
G A Yes.

Q What did you understand MST was given for, in general terms?
A For pain.

Q In what form is it given to the patient?
A Orally.

H

A Q I think it is just that one entry, is it, by you or your initials appear, perhaps, twice. Does that make sense?
A Yes, 10 o'clock.

Q That is on 1 March. I am not going to ask you to turn up these pages because we have seen them already in relation to the catheter on the catheter sheet on 1 March. There is a record by you that the catheter is draining satisfactorily. There are other nursing records but I
B am not going to ask you or the Panel to go through them all because we are all familiar with your signature. We have records on 1 March where, "Pressure sore areas were dressed", she was given a blanket bath, "bed rest maintained" and, in a particular case, suppositories being given with no result and an enema being given. We can check all those in the records, we do not need to spend the time to look at each one. Four days later, on 5 March, so far as you are concerned, would you look at page 1003, can we pick up your signature on the right-hand side, about one third of the way down the record. Is that you?
C A Yes, that is me.

Q This is part of the nursing care plan dealing with pressure areas being dressed and so on and, again, without my turning up or asking everybody to turn up all these pages, on 5 March there are other records where we can see you dealing with the draining of the catheter, the dressing remaining in place, that she has been washed and bed rest maintained. They are the same general matters where you were obviously on duty and attending to that
D patient?
A Yes.

Q We need to turn to a page we have already looked at, page 1013. We have seen that on that sheet the 1 March, the complaining of pain in the shoulder is there. That is going back slightly in dates, but it is your entry that we have already covered. We move down to 5 March on that particular page, "Pain uncontrolled, patient distressed, syringe driver
E commenced 9.30 in the morning. Code A informed". In the scale of things, with your experience, when you recorded that "pain uncontrolled", what is that saying – it may be obvious?
A On the medication that she was taking, her pain was not controlled.

Q Tell us about the procedure, you say "Code A informed"?
A Either myself, or perhaps Code A if he was there, would have rung the Code A to tell him
F how poorly Code A was and, with his permission, we were going to start Code A on some morphine on the syringe driver over 24 hours.

Q Again, this would be, in your experience, part of a normal procedure?
A This was the normal procedure.

Q If it was the view of the doctor concerned and the medical staff were carrying out the
G doctor's authorisation as it were and the patient was going to be put on to a syringe driver, normally the relatives – if they were not at the hospital and assuming there was a relative with whom contact could be established – would be informed?
A Would be informed. We would always have their consent before giving a controlled drug.

Q Had you, yourself, ever carried out this task?
H A Oh yes, frequently.

Q I appreciate everybody is different and patients are different and you had to deal with different relatives and so on, in general terms what would you be saying to a relative?
A What would I be saying to you, if it was your relative? "Code A had a really bad night last night, he is an awful lot of pain. We can no longer give him oral medication because he cannot swallow it any more".

Q For whatever the reason might be?
A Yes. "We would like to start him on a syringe driver", and I would explain to you what a syringe driver does and the fact that it delivers a tiny dose of this medication over 24 hours, "Which means Code A is not going to be comfortable for a little while and then uncomfortable until we can give him another dose of the drug". This drug delivers the same dose over 24 hours.

Q You would be explaining the advantage of using the syringe driver?
A Yes.

Q When you carried out this task, did you yourself ever encounter any relative who indicated that they did not want the syringe driver to be commenced?
A No, we had a patient once who was on, I think it was, perhaps, oral morphine and we could not actually give it without ringing their relative to say. She wanted to know every time we gave her relative this particular drug and we did. We complied with her wishes and we did that. But that was only once over the years that I worked there.

Q Something you said earlier in the evidence, I want to make sure I understood properly. What if a patient was being put on Oramorph, in other words this was the first time that morphine in any form was being administered to the patient, would you normally try to inform any relative about that?
A Yes. Yes, I did not give the patient we were talking about who came back in from Haslar in great distress, I did not give her any Oramorph without asking Code A first their permission.

Q That was the case of Code A ?
A Yes.

Q In general terms it was the normal procedure ---
A We would not give it without informing the relatives.

Q Did you ever, in your experience, encounter a relative, or have contact with a relative, who said in effect, "I do not want you to give my relative..."
A No, only the one occasion I have mentioned. I cannot even remember the lady's name.

Q There is another note with regard to the same patient on 5 March. I am not going to ask people to turn it up, but it is two pages on 1015, where we can see your signature saying that, "She continued to leak faeces", just part of the nursing care plan, so that would normally be noted down?
A Yes.

Q Lastly, on this particular date, this particular topic if we can move on again in the bundle to 1022, we can see that the matter which was recorded on the other document we looked at a moment or two ago on 5 March, the entry by you talking about, "Pain uncontrolled, very poor night" and exactly the same information, not expressed in identical form but conveying the same picture, Code A contacted by telephone, situation explained". I think we have covered that.

A Yes.

Q Bearing in mind the sort of patients you were caring for at the hospital, when you recorded "very poor night" with an elderly frail lady who was in distress, what picture are we to get from that? Because people can use words in different ways.

A It is the picture of a very restless patient in lots of pain.

Q I appreciate that obviously you are not a doctor, but did you feel that, if you had any concern about either the type of medication prescribed or the amount of medication prescribed, you could make a point?

A Yes.

Q Did you ever have occasion in the time you were there, and in the period that we are concerned with up to 1999-2000, to query the medication, either by way of its type or the amount of the dose, with any doctor?

A I cannot recall querying a dose.

Q I would like to ask you about something you mentioned in your evidence when you were being asked questions by Code A You spoke about Code A Do you remember you were being asked questions about ---

A Yes, I remember. The ward round.

Q --- more than one drug being prescribed at the same time, and so on?

A Yes.

Q What is the picture there? Code A would come in?

A She used to come across from QA every week and then she would go through our stock of drugs, order what was needed, go through everybody's treatment card, check that the drugs given were the correct dosage, the fact that some drugs you cannot give with other drugs, et cetera. She would make a note of anything that she wanted Code A to look at, and perhaps change something. And every week she would do this.

Q So that is a regular ---

A It is a regular occurrence.

Q --- visitor and inspection in that sense.

A Yes.

Q Was Code A somebody called Code A ?

A Yes, she was.

Q So she would obviously be seeing not only the physical stocks of the drugs, but would she be seeing the prescription?

A She would be seeing everybody's prescription and what they were prescribed.

Q So she would be seeing the documents which showed, in some cases, a dose range for diamorphine or midazolam, whatever it was?
A Yes.

Q And would be seeing where drugs were combined in a syringe driver and would be seeing where that occurred.
A Yes. If they could not be combined, then she would say so.

Q May I ask you too about another isolated point, but it is one that may come up in other aspects of this case; that is, the Barthel score. Are you familiar with that?
A Yes.

Q What is the significance of the Barthel score, and tell us what would happen if you had to sort it out yourself?
A This lady had a very high Barthel, I recall. We have already looked at it. I think it was 21; therefore she would have been nursed on an air bed, which means ---

Q I am asking you about one thing and I was going to ask you about another. When you say "nursed on an air bed", is that something to do with their skin condition?
A Yes.

Q Is that something called Waterlow? Have I got it right?
A Yes, a Waterlow score.

Q What is the difference between the Barthel score and the Waterlow score? What are they dealing with?
A Waterlow is purely pressure care and Barthel is general nursing care.

Q Dealing with Waterlow, the higher the rating, or whatever you call it, or the higher the points ---
A Score.

Q --- does that mean more of a problem?
A Yes, it does. This lady, I believe she had bilateral leg ulcers, apart from everything.

Q All right. I am leaving that for the moment and just dealing with it generally. Waterlow, the higher you are the worse off you are.
A Yes.

Q Barthel score, the lower you are the worse off you are. Is that right?
A Yes, that is right.

Q Did you yourself ever complete a sheet or card relating to a patient's Barthel score?
A Yes, it was something we had to do when the patient was admitted; it was part of the procedure.

Q We have seen examples already, and I am not going to take you through them – whether they can feed themselves and so on.
A Yes.

A

Q If somebody rated zero on the Barthel score, in your experience what would that indicate to you?
A Quite self-caring. Self-caring almost.

Q I am sorry – the Barthel score is zero. Is that good in terms of the patient?
A No, it is not good.

B

Q It may be difficult to remember which way round they were.
A It is not something I have done for some years. You will have to excuse me.

Q I think when you were being interviewed by the police, you told them ---
A That was four years ago, the last interview. Well, five years ago, actually.

C

Q Five years ago. I think when you were speaking to them about this, and you were talking about Code A you were talking about the Waterlow pressure score prevention – and we have already covered that. In her case, that is Code A I think she was 27, which was pretty much on the high side. Then the Barthel score, you were indicating to them – this is page 19 of interview number two – and the patient you were dealing with there, again Code A "...because she scores nought, she is totally dependent".

D

A Yes. I believe she was paralysed left and right side.

Q I am pausing for a moment to see whether I need to ask you anything more about the first patient we were dealing with, Code A Again, perhaps a matter of generality but it arises in her case. We have seen the record of the syringe driver being commenced and your note of it. In general terms, assume that Code A had, in anticipation, in advance, prescribed the administration of diamorphine and midazolam – let us just take those two as an

E

example – to be administered subcutaneously. That is what she has done in anticipation. First of all, this. The reason for Code A or indeed any other doctor who did it in terms of prescribing in anticipation, was to prevent there being a gap between the failure of one form of pain relief and the start of something to deal with pain relief more appropriately.
A Yes.

Q In case the doctor was not immediately to hand.

F

A Yes.

Q No doubt on a number of occasions when there was an anticipatory prescription like that, Code A could be spoken to on a morning round and could give a specific instruction to start.
A Yes.

G

Q Because in order to administer the medication subcutaneously you have to be using a syringe driver, normally a syringe driver would not be started – in other words, the patient would not be put on a syringe driver – unless Code A had specifically authorised it.
A Yes.

H

A

Q If somebody rated zero on the Barthel score, in your experience what would that indicate to you?
A Quite self-caring. Self-caring almost.

Q I am sorry – the Barthel score is zero. Is that good in terms of the patient?
A No, it is not good.

B

Q It may be difficult to remember which way round they were.
A It is not something I have done for some years. You will have to excuse me.

Q I think when you were being interviewed by the police, you told them ---
A That was four years ago, the last interview. Well, five years ago, actually.

C

Q Five years ago. I think when you were speaking to them about this, and you were talking about Code A you were talking about the Waterlow pressure score prevention – and we have already covered that. In her case, that is Code A I think she was 27, which was pretty much on the high side. Then the Barthel score, you were indicating to them – this is page 19 of interview number two – and the patient you were dealing with there, again Code A, "...because she scores nought, she is totally dependent".

D

A Yes. I believe she was paralysed left and right side.

Q I am pausing for a moment to see whether I need to ask you anything more about the first patient we were dealing with, Code A Again, perhaps a matter of generality but it arises in her case. We have seen the record of the syringe driver being commenced and your note of it. In general terms, assume that Code A had, in anticipation, in advance, prescribed the administration of diamorphine and midazolam – let us just take those two as an

E

example – to be administered subcutaneously. That is what she has done in anticipation. First of all, this. The reason for Code A or indeed any other doctor who did it in terms of prescribing in anticipation, was to prevent there being a gap between the failure of one form of pain relief and the start of something to deal with pain relief more appropriately.
A Yes.

Q In case the doctor was not immediately to hand.

F

A Yes.

Q No doubt on a number of occasions when there was an anticipatory prescription like that, Code A could be spoken to on a morning round and could give a specific instruction to start.
A Yes.

G

Q Because in order to administer the medication subcutaneously you have to be using a syringe driver, normally a syringe driver would not be started – in other words, the patient would not be put on a syringe driver – unless Code A had specifically authorised it.
A Yes.

H

Q Were there ever any occasions which you can recall where a syringe driver was started – subcutaneous analgesia is prescribed – and Code A was not consulted, or her opinion or authorisation sought?
A I cannot remember an occasion.

Q If there was such an occasion, it would be somebody senior to you – if Code A could not be obtained for some reason and the on-call doctor could not be obtained or could not come out – it would be somebody more senior to you who would actually have the final say-so.
A Yes.

Q So in the case that we looked at, with regard to Code A you made it clear in your evidence that Code A must have given the authority to start the syringe driver.
A Yes.

Q In the cases when that occurred – in the case of Code A you have told us – she would have examined the patient and decided what to do.
A Yes.

Q Was it your experience that in the case of a patient who had, let us say, developed a problem overnight and Code A was informed in the morning of the problem, whatever it might be, she would carry out some examination of the patient – normally?
A Yes.

Q Because you have told us that what you would do, or you and the other nursing staff would do, would be to draw her attention in the morning to anybody who had a particular problem that had developed.
A That is right, yes.

Q Would that therefore also apply, on any occasion that you can recall, when the report to Code A was that the patient had been suffering overnight and the existing medication did not appear to be controlling the pain, the discomfort, the anxiety?
A Yes.

Q In your experience she would normally carry out an examination?
A Yes.

Q As well as discuss the matter with you?
A Yes.

Q I want to ask you one other matter before we turn to the case of Patient E, Code A Code A Patients being unrousable – if a patient was unrousable, and assume that this is not a patient who is in terminal decline, normally speaking would the issue be raised as to whether the medication they were on was too strong, too much – in an ordinary circumstance?
A Yes.

Q If you found a patient was unrousable, you would obviously want to find out the reason.
A Yes.

Q On this ward, for all sorts of obvious reasons, patients on occasion died. They were very ill when they came; they were very frail, and they died.
A Yes.

Q Obviously something that you saw more than once. Yes?
A Yes.

Q As you became more experienced as a nurse, did you find that you were better able to make a judgment, not as a doctor but as an experienced nurse, as to whether a patient appeared to you to be entering a terminal phase?
A I do not think you can always make that assumption, in my experience. I have called patients' relatives in and, by the time they have come in, the patient was sat up, eating something. It is not an easy thing to do.

Q I am not going to disagree with that for a moment. Not an easy thing to do, but did you find your experience and your ability to make a judgment about it improved as time went by?
A Yes.

Q You could get it wrong, of course.
A Yes.

Q In the case of a patient who was in the terminal phase of their life, you would find presumably that, when analgesia was administered subcutaneously, diamorphine and midazolam, they would at some stage become unrousable.
A Yes.

Q So was your judgment as to the significance of a patient being unrousable dependent on what stage of their care they were at? It may be that I have expressed that badly. Assume an ordinary case where a patient has pain. They are not, in your view, in a terminal phase. They have pain which needs to be controlled and it needs to be controlled by subcutaneous analgesia. That is necessary, but it is not the case that they appear to be in a terminal decline. All right? Imagine that sort of circumstance.
A Yes.

Q If such a patient became unrousable, would you want to wonder and investigate why?
A Yes, we would call a doctor.

Q In such circumstances it may well be that it was because the dosage was too high. Yes?
A Yes.

Q What I am trying to get at is not that case but a case where the patient is in terminal decline and they are therefore having to be given the diamorphine and the midazolam subcutaneously to deal with the situation, their pain, and so on; but they are, in your view – being blunt about it – dying.
A Yes.

Q In such a case, was it your experience that a patient might well be unrousable?

A A Yes.

Q In that last phase, whether it lasted a day or two days or whatever it was. Yes?
A Yes.

Q I am going to turn now to what you told us about Code A

B Code A the witness has now been on the stand since 11:15. I anticipate that this patient will take some time for you to deal with.

Code A It is more than ten minutes.

Code A On that basis, we will take a slightly earlier lunch so that you can go into the next phase of your questions. We will return at ten minutes to two. (To the witness) Code A
C Code A please do not discuss the case with anybody during the lunch adjournment.

(Luncheon adjournment)

Code A Welcome back, everyone. (To the witness) This is just to remind you that you remain on oath. Code A

D Code A I want to turn to ask you some questions about Code A as you have already told us. You first encountered her as a patient when you had come back from your holiday or break, or whatever it was.
A Yes.

Q And she had been re-admitted to the hospital, having been back to the Haslar in circumstances of which you were made aware. Correct?
E A Yes.

Q Do you have the collection for Patient E, the file? The one I would like you to look at please is the file marked "E" – Patient E. Would you look there, please, at page 34. We can see your name in the bottom left hand section and you are the named nurse?
A Yes.

F Q Would you just indicate what the significance is of you being in this particular case the named nurse. What does that mean?
A I was supposed to be the main nurse who liaised with the patients and I was the one they could come to if they needed anything.

Q With the ---?
A With the patients' relatives.
G

Q The patients' relatives – yes. So you are their link person, if you like. Yes?
A I was the go-between.

Q Any other particular duty that you had?
A You are the patients' advocate.

H Q Yes?

A A You are there to stand up for the patient.

Q You have told us that when she was re-admitted, you could remember this particular incident anyway. You had been on a coffee break of perhaps 20 minutes?
A Yes.

Q And during that time she must have been admitted - yes?
B A Yes.

Q And is it right that the first person to contact you about her or to point out there was a problem was, I think, a care assistant, as you described her?
A Yes.

Q Would that be the same thing as a support worker?
C A Yes, it is a support worker.

Q I think you were able to remember when you spoke to the police about this back in 2000 that the person who came to you to tell you about the problem was somebody called Code A ?
A Yes.

D Q What was it she was concerned about?
A She came to tell me – I could hear the patient was upset and in great pain – that she was transferred whilst I was at coffee break and that the paramedics transferred her on a sheet instead of the normal canvas, which is obviously much thicker than the sheet.

Q So you were aware that that was ---
A I was aware that there was this problem.
E
Q Caused by ---
A Also she said that she did not think she was lying correctly, and that was probably again adding to her discomfort, but she did not want to move her. She wanted me to do it.

Q I see.
A She was waiting for me.
F
Q Is this the right sequence: after she had spoken to you and told you what the position was ---
A Yes.

Q --- you went to the room where the patient was?
A I went to the room, introduced myself to Code A
G
Q So Code A ---
A Had a look ---

Q Hold on. Sorry.
A Code A were there.

H Q Code A ?

A A Code A yes.

Q Right. And was the patient still screaming?
A Yes, she was. So I checked her and found out she was not lying properly. I mentioned it to Code A and one of them – one of Code A I should say – said, "I will help you. I am an ex-nursing officer."

B Q Thank you. Thank you for that. She helped you?
A She helped me ---

Q You got her into a better position ---
A She helped me position the patient.

Q And did that alleviate the pain and distress?
C A She seemed a little more comfortable.

Q Was she still screaming, or had she stopped?
A Yes, she was still screaming.

Q Still screaming?
A Yes.
D

Q Thank you.
A Which is why we eventually gave her some Oramorph.

Q It was obvious to you from any conversation you had with Code A Code A that they were not at all happy about the transfer from the Haslar?
A No, they were not. We also knew – we had had a communication from the rest home
E where she came from to say that there had been whispers of suing the rest home.

Q So you knew when you ---
A We knew there were problems.

Q You knew, without going into unnecessary detail I hope, you realised from what you had been told that Code A were ready to complain if they felt they had a reason to
F complain?
A Yes, yes.

Q I think also at that stage, or at least in relation to that same day – please tell me if this is wrong – there was a problem with Code A being able to take the food that somebody was trying to feed her with?
A Yes, yes.
G

Q And then you got somebody to go and mince the food?
A That is right, yes.

Q Back in the kitchen, and have it brought back?
A Yes.

H Q Did that seem to work?

A A No, she did not actually want it.

Q She did not want it?
A She was quite poorly, actually, when she arrived, and looking at the transfer letter, the fact that she could stand and weight-bear... That was quite hard to believe.

Q Did you sometimes find that patients arrived at the Gosport War Memorial Hospital
B with perhaps an impression that their physical state was rather better than it actually was?
A Yes. Yes. We also gathered that they were coming for a rehabilitation. They were told this, when it was obvious to all that perhaps that was not going to happen.

Q Did that sometimes affect, in your view, the view that relatives had as to the prospects for the relative who was a patient in your hospital? Did they sometimes have a rather unrealistic ---
C A I think sometimes they did have unrealistic expectations, and that did not help.

Q In any event, on the day that you saw Code A in the way you have described, did you later on go into the room again and have a look at her because she was still in pain?
A Yes.

Q Again, I am using what you told the police in the year 2000 for this. Did you indicate
D to one of Code A – that you would like to give Code A something to relieve her pain?
A Yes, yes. I asked if I could give Code A a small dose of Oramorph and they agreed.

Q Did you speak to Code A ---
A Yes.
E

Q --- Code A about it?
A Yes, I did. He agreed with me, and we administered the dose between us.

Q And we can see, as we have already looked at in the file at page 46 – if we can just turn that up again, please. We have the record of really what you have been telling us about just now at the bottom of the page. On the 17th – the day we are talking about – you set out
F the position with regard to, "To remain in straight knee splint," and so on. All the detail is there. Is that your writing over on the left: "No canvas under patient ---"?
A Yes.

Q "Patient transferred on sheet by crew." Then, over the page, still the same day, we can see a further note that you made:

G "In pain and distress – agreed with Code A to give her mother Oramorph 2.5 mg in 5 mls.

Code A reports surgeon to say Code A must not be left in pain if dislocation occurs again."

So that is something Code A was telling you?
H A Yes.

Q That she had been told by a surgeon at Haslar?
A That is right.

Q Is that it?

Code A contacted and has ordered an X-ray."

Was that you who would have contacted her?
A Yes.

Q And she had indicated – what – over the telephone?
A Yes.

Q "Get an X-ray."
A Yes.

Q That takes care of your notes in relation to that. I would like to ask you a little bid more in terms of Code A did you find that she was somebody who, even when she was able to eat, had great difficulty eating?
A Yes, I think she did.

Q I think you described it in this way to the police when you were seen by them: "I think even before she had the medicine she was having great difficulty problems [eating]"?
A Yes.

Q "Eat and drink", you said.
A Yes.

Q Obviously she was somebody who was in great pain and had multiple problems?
A Yes.

Q When she was put on the syringe driver is it right that there was some discussion between you and Code A ? Perhaps I can take it in stages. Did it become clear to you from what Code A said to you that he had already spoken to the relatives about this?
A Yes, yes.

Q And the doctor?
A Yes. That would be normal practice.

Q And so it was, as it were, a decision in which the relatives – in this case the sisters – were involved?
A Yes.

Q And obviously nobody, in terms of confining it simply to you and to Code A but nobody wanted to leave any patient in distress and pain?
A No.

Q And I think you also told the police that in your view a couple of days before she died you had got the impression that she was starting to die?

A A Yes.

Q And described her as being very poorly?
A Yes.

Q Did you get the impression at any time that you had dealings with them when they were at the hospital, that Code A had any complaints about anything?
B A At our hospital?

Q Yes.
A Yes. Yes, I did.

Q Would you help us with that?
A One of the support workers became quite friendly with her. She was very much into
C astrology, this girl. She did the Code A charts and they sort of became friendly. We were invited to a spiritualist meeting.

Q It is not your fault. I am going to stop you there.
A Yes.

Q Because I think you were going on to say something about a spiritualist meeting
D which had taken place some time later. Is that right?
A No. That was before Code A died.

Q All right. Sorry. Go on. I am confining it to the period when she was still alive.
A Yes, yes. In Chichester. I went myself with Code A and another support worker to this meeting.

E Q Pause there. Was the meeting that you went to after Code A died?
A No, before she died.

Q Before?
A Before she died.

Q All right.
F A It was very peculiar because they went round the actual meeting, people saying what they did, this sort of thing, and apart from saying what she did – which was not much, it was not anything at all, I do not think – she said something about what awful treatment Code A had had in the War Memorial. This is in front of the three of us. She obviously got us there to complain about the War Memorial.

Q This is before her mother had died?
G A Yes, yes. It is actually in the interview. I did tell the police.

Q I appreciate that. I was just trying to make sure that it was a time before Code A had died rather than later.
A We did not actually meet them after she died.

Q So apart from that, when there was this thing being said at the meeting, did either of
H Code A ever complain to you directly about the treatment?

A Not directly to me. And in fact after Code A died, she gave about nine presents to the staff, mainly books and things, and then she left. She gave Code A s chair to the ward, which was one of these electric type things, quite expensive chairs. She gave that to the ward. I do not think we had any complain for a few weeks.

Q Sir, may I just indicate this to the Panel. There are some other notes made by this witness in relation to the patient Code A There are not very many of them and they are B all, if I can use the expression, relating to mundane matters, but since we know what this witness's writing looks like, I do not think it is necessary for me to go to that file and take the Panel through it or, indeed, take the witness through it. My learned friend, Code A and I can agree it, I am quite sure, if there is any difficulty. I am not going to go into any further records.

(To the witness) May I just ask you please about one other matter. Again, in general terms – C all right – obviously you have been able to remember certain things with regard to the patient, Gladys Richards ---
A Yes.

Q --- that you told us about. The other patient we talked about, you were not really able to remember ---
A No.
D

Q --- anything of any significance. Would you just give the Panel some idea of the amount of patients who you must have seen at the Gosport War Memorial Hospital?
A I do not have the numbers.

Q What are we talking about? Hundreds or thousands, or what?
A I should imagine it would go to thousands.
E

Q Over the period of time you were there?
A Yes.

Q Finally, would you help us with this. I have asked you some questions about Code A Code A already. It is clear from your evidence that she was somebody who was obviously very busy. Yes?
F A Yes.

Q Was she somebody who took time to speak to relatives? How would you describe her ---
A Yes, she did take time to speak to relatives.

Q Sometimes relatives would be there when she came in the afternoon?
G A Yes.

Q Would relatives ever be there in the morning when she did her morning round?
A No, normally that was perhaps a bit too early.

Q It tended to be later on in the day?
A Yes.
H

Q We have heard evidence about her coming back at lunch time or in the afternoon?
A Round day, the day Code A did her round.

Q Those would be the sort of occasions when relatives might be there and she might be able to speak to them?
A I think they were able to make an appointment as well on round day, when the round had finished, if they needed to come into the office and talk.

Q Might there be occasions when she came in on her own deliberately in order to see a relative?
A Yes.

Code A: Thank you, that is all I need to ask you.

Re-examined by Code A

Q Just a few questions from me. In relation to Code A was asking you about the normal procedure and why a patient would be put on to syringe driver. You have been asked questions in this case – you do not have to look it up – it is file B, page 1013 and you said to him, "We would say that the patient is having uncontrolled pain and cannot swallow any more". Did the two of those have to go together before you would initiate a syringe driver?
A If the patient cannot swallow, it has to be administered some other way.

Q I understand that?
A It is either a syringe driver or ---

Q If a patient could swallow, would there be any reason to switch?
A No.

Q You told us a bit about Code A and you mentioned somebody, I think, is it Code A?
A Yes, that is her name.

Q Is it Code A?
A Yes, I think he was over occasionally.

Q The prescription sheets, the sort of documents we have looked at already on which Code A would fill in a prescription and then the nurse administering it would put their initial and the time of the administration, where would those notes be kept?
A At that time, I believe, by the bed.

Q What notes would be kept by the bed and which notes would be kept in a cupboard?
A I believe then the treatment card was by the bed and the care plans, the care plans you have been reading from.

Q The drug charts?
A By the bed.

A Q We also know that because controlled drugs were used too, you had to keep a record of the controlled drugs in a Controlled Drugs Record Book. I am holding one up just to show the Panel and we can exhibit these in due course if it is necessary. These books would be kept for each ward?
A They were locked in the cupboard, the controlled drug cupboard.

Q They would be a record of every controlled drug that was withdrawn for
B administration?
A Yes.

Q So, by way of example, this is a book I am looking at for Dryad Ward commenced June 1999 and it has a list of all the controlled drugs in it. When you told the Panel that the pharmacist would come and check the dosage, can you tell us what they would be looking at, which documents Code A would look at?
C A She would check that book as well when she came over so that the amount of drugs in the controlled drug cupboard had to tally with the book, and then she would check each prescription for each patient.

Q Are you saying that she would go round the ward and look at the prescriptions at the end of each bed?
A Yes.
D

Q What would they be looking for?
A She would be looking for dosage, she would be looking at the drugs that were prescribed for that particular patient, whether they should be given together or, if there were any discrepancies then she would contact Code A

Q Did you ever know her to object to the drugs that were being given?
E A I have known her leave a few notes about different things.

Q About what?
A Not about dosages, no, but, perhaps, there are certain drugs which cannot be given together. I cannot give you an example, but I do know.

Q Did you ever know her to haul anybody up, Code A or anybody else, to say, "Hang
F on, you should not be giving that much"?
A She would do.

Q In relation to one of these controlled drugs?
A No, no, I do not think that ever happened anyway.

Q You told us also that you, I think, were there when Code A made examinations?
G A Yes.

Q When she made an examination, did you see her making a note of the examinations or would somebody else make a note of an examination on her behalf?
A Yes, I would see her making the notes.

H

Q You were also asked by Code A about patients being unrousable, and I think it was being put to you that if a patient was coming towards the end of his or her life, there would come a point when that patient would become unrousable?
A Yes.

Q Is that what you were agreeing with?
A Yes.

Q I want to understand what you were saying?
A Yes.

Q If you had any concern about it, you would bring it to the attention of Code A ?
A Yes.

Q Did you ever say to Code A "I am very concerned, this patient is unrousable"?
A I cannot recall.

Q Or the medication being reduced as a result?
A No, I cannot recall.

Q Dealing with Code A , you told us, and it must have been distressing for everybody concerned on 17 August when this patient was screaming and you had to reposition her, do you know who would have put her in the bed, who would have been responsible for this patient?
A I would imagine it was the ambulance people that did that actually.

Q Would ---
A Deposited her in the bed.

Q I am sorry, can you say that again?
A Put her in the bed.

Q Would anybody have been there from the nursing staff to make sure that things were done properly?
A Yes, the support workers were there, but they knew it was not right.

Q They knew it was not right?
A They knew she should have been transferred on a proper canvas which is much thicker than a sheet.

Q When it was brought to your attention that the patient was screaming, Code A were already there?
A Yes.

Q In relation to that patient, you told us that the fact that she could stand and bear weight was hard to believe?
A Yes.

A Q Do you have Patient E's file, I want to know what your evidence is about this. Page 8 is the transfer note from the Royal Hospital Haslar. We can see the note at the bottom, page 8 of Patient E:

"When in bed it is advisable to encourage abduction by using pillows or..."

is it "abduction wedge"?

B A Yes.

Q

"She can however mobilise fully weight bearing."

"Fully weight bearing", presumably, does not mean that she can dance down the corridor?

A It does not mean to say she can walk, but I did not actually see her mobilised.

C

Q Are you saying you do not believe that note?

A I am saying she was a poorly old lady screaming in pain, but I did not see her mobilised. I did not see her stand.

Q When she was at the Gosport War Memorial Hospital from 17 August when you were dealing with her, did you ever see her out of bed?

D A No.

Q Would it have been any part of your function to try to mobilise a patient who needed mobilising?

A Yes.

Q Was any effort made to mobilise this patient?

E A I think she was too poorly.

Code A That is all I ask, thank you.

Code A Members of the Panel have indicated to me that they would welcome at this stage some time to discuss amongst themselves the questions that the Panel will be putting to the witness. Therefore, what I propose is that the Panel will remain in the room

F and I will ask everybody else to withdraw and we will call you back as soon as we are able. Code A, you will be taken to somewhere to await and we will try to get you back as soon as possible. We are aware that you have spent a considerable amount of time on the stand and we are grateful for that.

(The Panel adjourned for a short time)

G

(Questioned by THE PANEL)

Code A Welcome back. Thank you, Code A for allowing us to hold you back still further. The Panel are now in a position to put their questions to you. We are going to start with questions from Code A who is a medical member of the Panel.

Code A You will be familiar because you were entered in the notes as a named nurse.

H A Yes.

Q On these wards, where you worked, Daedalus and Dryad, was each patient allocated to a named Code A or did all of Code A look after the patients?
A Code A looked after the patients on Daedalus Ward.

Q For each of these two patients that we have discussed today, Code A was the Code A of the case?
A Yes, I think so.

Q It is just as a matter of enquiry because it caught my eye, who was Code A - I have lost it?
A I do not know.

Q You do not know who Code A was?
A No.

Q He was on the head of a sheet at Gosport. You said towards the end of your questioning by Code A that, at times, relatives, and indeed the doctors and nurses at the hospital sending you patients, might have had unrealistic expectations of the outcome?
A Yes, we did feel that.

Q That when they arrived you thought, "Well that is not going to be possible"?
A Yes.

Q Can it work both ways, that you might have had, at times, unrealistically pessimistic views?
A No, I do not think we did.

Q For instance, I think you said that sometimes you could call a relative in because you were very worried that the patient was ill, but when they got in ---
A I did say it was very difficult to actually say if someone was dying or not because, occasionally, we would call relatives in and perhaps they would be sitting up eating when they arrived.

Q You would agree at any particular point in a patient's management, at any particular moment, that may not indicate what is going to happen next?
A Yes.

Q We have dealt with two patients and, although they are quite different patients in what happened to them before they came to Gosport, the same things happened when they got to Gosport. The first was a lady who was a little demented, no she was quite demented, I think, and before transfer she had been mobilised after a fall and she was walking about with a Zimmer and some help, and she was described as being quite well. On the day she went into your ward at Gosport, she received a dose of morphine Oramorph?
A Yes. She had had a transfer from one hospital to our hospital. She had a haematoma on her wound, which I guess was causing her great pain.

Q Your assessment of that patient seems to be different from the assessment of the people who sent her to you in that ---
A This is how we found her on our ward.

Q You felt that she was in great pain and she received ---
A Not just myself, the staff on my ward.

Q Yes, generally she was found to be in great pain and given a dose of Oramorph and she never regained consciousness?
A Yes, she did. It was a tiny dose when she arrived, 2.5. If you recall from the drug sheet, she had more than one dose that day actually.

Code A I am sorry to interrupt. I want to make sure we have not crossed wires. I want to make sure Code A and the witness are talking about the same patient. I think the witness is talking about Patient E, talking about the haematoma. I wondered if that was the patient Code A had in mind.

Code A No, it is Patient B actually.

Code A It is just that the witness may be answering about Patient E.

Code A Let me generalise it a bit more because I am trying to understand the mechanisms of decision making. The generalisation is that patients – either of these patients could be used as an example – came in and had some Oramorph and certainly one of them never regained consciousness thereafter. The treatment regime continued to eventually become subcutaneous diamorphine.
A Not on that day.

Q No, but through the next few days. For instance, the lady who came in in agonising pain who was screaming in pain, we have evidence that she received a dose of morphine and she never spoke again, Oramorph?
A I did not think she spoke very much on that admission. I did not actually see her on her first admission, I was actually on leave, but on her second admission when she had to have a dose of Oramorph, I do not think she spoke very much at all.

Q She went on to have more Oramorph and then subcutaneous and so did the other lady we spoke about today. Both of these ladies were unconscious at least at some point, certainly by the time they were on diamorphine subcutaneously. Each day the pump was changed?
A After 24 hours it would be empty.

Q On each day the pump, the syringe driver, was continued until they died. Neither of those patients regained consciousness before they died. How do you, a very experienced nurse, you have worked there for 10 years with Code A on the elderly care ward, how do you assess, how do you make up your mind, what an unconscious patient needs in the next syringe driver? First, why do they need it again, can you help us with that. What are the pointers, what are you looking for?
A To keep the patient comfortable and pain free.

Q How do you know the patient is comfortable, how do you know whether the patient has pain?
A We can only assume that the patient is comfortable if they cannot tell us.

A Q So why would you continue?
A It is not my decision to continue.

Q It is not?
A No.

Q But you are part of the team and I am trying to understand ---
B A I am part of the team, yes, but ultimately it is not my decision.

Q Of course it is not, but you are an important person. You, the nurses, are important people in informing the doctor as to how the patient is.
A Yes.

Q If it is the doctor's decision or if it is a joint decision, nevertheless your input is very
C important. So how would you know whether a patient still needs to continue that pump driver, that dose?
A The only answer I could give is that you do not give it and you just let the patient be in pain.

Q That is right; so how do you know whether, by reducing or stopping the painkiller, the patient will still be in pain or not?
D A By observation. You would not know any other way.

Q But the pump is not stopped and the dose is not reduced; the patient remains unconscious. So how do you know whether the patient might perhaps not have been in pain any more if the dose was reduced or stopped?
A We do not.

E Q You do not. So what is the object of continuing this drug regime? Is it that a decision has been made that there is nothing more to be done for this patient; that this patient is now terminally ill? Is that the reason why the syringe driver is changed every day, continuing the same dose or increasing it? (Pause) Is it because somebody has made a decision that there is nothing more to be done for the patient because nothing can be done for the patient? (Pause) I am not asking you if you made that decision.
A I know you are not. I have told you, the decision is not mine.
F
Q Absolutely, but you are part of a team.
A I know.

Q I am trying to understand, and we want to know, if that would have been the case: that you continue these drugs, these pumps, because the team, if you like, or the doctor – whoever – has made a decision, an executive decision, a care plan decision, that "We can't do
G anything more for this poor patient who has been in terrible pain and we are now into terminal care".
A I cannot answer you.

Q You cannot answer for either of these two patients?
A No.

H Q Why do you think then that no fluids were exhibited to these patients?

A A No what?

Q No fluids were given.
A I think we have been over that, haven't we?

Q Let me put it a different way. If you thought that a patient had the chance of getting better ---
B A I do not orchestrate a patient's treatment; I carry out orders and do them.

Q I take issue with that slightly. You are a registered nurse.
A Yes.

Q With professional responsibilities, with training, with experience.
A Yes, but I do not prescribe drugs.
C

Q No, but you give drugs. You deliver the drugs; you administer the drugs.
A Mmm.

Q And you are not on trial here.
A I feel as though I am on trial.

D Q I apologise if I make you feel that way.
A I feel as though I am on trial.

Q I am trying to understand whether, in these patients in this ward, decisions were made, rightly or wrongly – and often rightly – that the patient ---
A I think that decisions were made in the patient's best interest.

E Q How was that communicated?
A I do not know what you mean.

Q When that decision has been made, how would everybody understand that it had been made?
A When an order is given and a decision is made, it is made, isn't it? We all know.

F Q But how is it given? Perhaps that is how I should put it. How is it given?
A Everybody knows how poorly the patient is.

Q But what if you are ill the next day and somebody has to come in? How do they know that that decision ---
A Because we all work the same.

G Q So it is word of mouth?
A And written word.

Q Written?
A Mmm.

Q So, in your experience, in that unit it was written down that a patient would be
H designated as – what? For terminal care?

A A No. The patient was on a syringe driver.

Q For pain?
A For pain. Syringe drivers are given in lots of cases, as you know yourself, for lots of drugs, for the ease of giving the drug over a 24-hour period, to have no troughs and peaks.

Q So I come back to what I suppose was my original question. How do you know that
B the patient still needs it for pain if they are unconscious?
A We do not.

Q And so ---
A I do not know how we could know.

Q By reducing the dose and finding out?
C A Possibly, yes, by taking it away and seeing if they are in pain.

Q But that was not done with either of these patients.
A No.

Q Would that be usual in that unit?
A Yes.
D

Q That is all I needed to ask, thank you.

Code A The next Panel member is Code A She is a lay member.

Code A My question is about the syringe driver but in general terms, and really about the communication with the patients' relatives. First, I think you started off by saying at
E some point that you informed the relatives about it before.
A Yes, someone would speak to the relatives.

Q One of the things I wanted to clarify was whether you informed them or whether you sought their consent.
A We did both. We sought their consent and informed them.

F Q Before you went ahead?
A Oh, yes.

Q Would that be a one-off or would it happen as things ---
A Certainly on our ward it would happen with each patient.

Q With that patient, you would inform and seek consent initially ---
G A Yes.

Q ...and then that would be it, and then you would carry on making adjustments.
A Yes. We would probably see the relatives again when they came in to see the patient.

Q If there were any changes in the dosage or anything like that, would they be party to---
H A Yes, we would inform the relatives.

Q At each stage?
A They would be kept informed all the way along.

Q What form would that take? Would it be face to face or ---
A Face to face or by the telephone if they were not there.

Q I think you gave us an example of how you might put it to them. Would you use the same language each time? Do you have a script?
A Hopefully we would use as sensitive language as we could.

Q So you would be adjusting it, depending on the circumstances?
A Yes.

Q Would you have anything to assist you, like a checklist, *aide-mémoire* or script, or anything like that?
A No, we are taught how to speak to relatives.

Q Are there key things you need to say to them?
A Pardon?

Q Are there key things, key statements that you need to make when you are seeking consent?
A Yes.

Q Could you give me an example of what essential things you would have to say?
A I would say to you, "As you know, Code A has been very poorly for some time and we think she could benefit from a dose of Oramorph. Would you be happy if we gave it to her?" Most people will say, "I would like Code A to be comfortable and pain-free, please".

Q Would you explain exactly what it is?
A Yes. If we were using a syringe driver we would explain exactly what it is.

Q In your experience, are most people familiar with a syringe driver? Do they know what it is?
A Occasionally someone is but, no, mostly they would need to hear about it.

Q So you would explain it? You would explain what it is?
A Yes, although it is used at home as well, I think, by the district nurses.

Q You mentioned that you would record that you had informed or ---
A Oh, yes, we would always – we should always record that we have informed the relatives.

Q So it does not always happen?
A It might escape, if we are called away to another patient. If we are very busy, there are times when perhaps the written work....

Q What if you cannot get hold of the relatives?

A We normally manage to get hold of the relatives somehow. Either they come in to see their relative or we can get them on the telephone, or leave a message to ask them to come in.

Q But you do not go ahead until you have actually ---
A Not normally, not till we have spoken to the family.

Q When you say you speak to the family, is it the named next of kin?
B A It would be best if the named nurse could do it, but obviously they are not always there or they might be on leave. It could be somebody else who does it.

Q What I actually meant was do you speak to a specific person in terms of relatives?
A We would speak to the next of kin if we could.

Q So it has to be the next of kin?
C A Yes.

Q When you are explaining to the next of kin, obviously you talk about the advantages but do you talk about the possible disadvantages or risk associated, or the consequences associated of going on?
A Yes.

D Q What would they be?
A I would say the advantages are there are no troughs and peaks, and this drug would be administered over 24 hours whereas, previous to using the syringe driver, we would give the dose four-hourly probably; so the patient will be very comfortable perhaps for two, maybe three, hours and then quite in pain, and have to wait a whole hour before we could give the dose again, till the four hours were up. Therefore to use the syringe driver is much better.

E Q In terms of consequences, for instance if the patient would become unconscious and therefore not able to communicate with their relatives, is that explained to the relatives as a possible consequence?
A Yes, we would explain what is happening.

Q I think that is all, thank you.

F Code A who is a lay member of the Panel.

Code A Good afternoon, Code A It has been a long day.
A Yes.

Q I have a few questions, I am afraid. I shall keep you as little as I possibly can. Am I right in saying that you worked on the ward for ten years?
G A Yes, probably over that.

Q Over ten years?
A Yes, a little over.

H

Q Did you work with Code A throughout those ten years? Was she there for ten years?
A Maybe not at first, because I did work on the children's ward when I joined the hospital; but then the children's ward was taken away.

Q So you had worked with Code A for a number of years anyway?
A Yes, a number of years.

Q Did I hear you say that you started there in the Eighties?
A Started where?

Q Did you start at the hospital in the Eighties?
A I think it was 1983.

Q My colleagues touched on the syringe driver – and this might sound a basic question to you, but I have no connection with hospitals – but did you get any training in the use of a syringe driver?
A Lots of training, yes. At St Mary's, in QA, War Memorial.

Q Is it a very in-depth training on it, or does somebody show you?
A Well, yes. It is quite a simple instrument actually, like most of them are when you sit down and look at it. And this was 13 years ago, so it had been going some time then.

Q So you were well versed in the use of it then?
A Mmm.

Q Did that training incorporate the types of drugs that you would be using?
A Yes. Say we were using Oramorph, morphine --

Q And diamorphine?
A Yes. It is a derivative of morphine.

Q And the mixture of different types of drugs?
A Yes.

Q You know when you said that you administer drugs and you administer them impairs – there are two of you ---
A The controlled drugs, yes. That is the law.

Q And it is always two?
A Yes, it has to be two.

Q There were occasions when you were the senior of those two?
A Yes.

Q And I am right in saying that you said that you would follow the prescriptions and you, in those ten years, never had to increase the amount?
A I cannot recall. Yes, that is what I said.

A Q You would give the minimum?
A Yes.

Q May I ask you to turn to pages 63 and 65? We are on E. Are you with me?
A Yes.

Q Do you recognise the handwriting?
B A Are you on 63?

Q Page 63 or page 65.
A Yes, I have got both of them here. Yes, I recognise most of that handwriting.

Q That is Code A s handwriting?
A Yes.
C

Q Would you say that this is a normal sheet that is not necessarily just for this patient but this is the type of thing that she would write for every patient?
A Yes.

Q Are these prescriptions – let us say, for instance, page 65 and the diamorphine, 40 to 200. Can you see that?
D A I have seen it, yes.

Q Would that be normal for her, to write those amounts?
A Yes.

Q For me, that seems to be quite a wide ---
A It is a wide range, yes.
E

Q Forty to 200. You would always start with 40.
A Yes.

Q You said that you had never had to change it ---
A I do not think so.

F Q But if someone else on, say, the day before had been up from 40 to ---
A I think they would have probably used the same.

Q Yes, but if they had gone up from 40 to, say, 60 and it was your turn the following day to administer the drug, you would have started at the 60, would you?
A If they had, you mean?

G Q Yes.
A Yes, probably I would have followed on.

Q You have told us that you are trained in this. If you are increasing the dosages, what is a normal increase from, say, 40? What would you normally increase to?
A What would I go up to after 40?

H

A Q Yes.
A Perhaps it would be 60. From 40 perhaps to 60. But I cannot recall ever going up.

Q But that would be the normal, to go up to about 60?
A Yes.

Q Then you would obviously not increase that for some time at least, because you would
B see how the pain was monitored.
A Yes.

Q I think it was you who told us that Code A would be there at least every morning, at between eight and eight-thirty.
A Yes.

C Q And sometimes in the afternoons?
A Yes, if we called her in.

Q My question is, if you would only increase it in, say, twenties or maybe forties, and the doctor would be there within 24 hours under normal circumstances, why is there such a range between 40 and 200? I do not understand why that seems appropriate or necessary.
A I see what you are saying.
D
Q But that was how it was done normally?
A Yes, I have seen it before.

Q Were all the nurses happy about this range of prescription?
A I never heard anybody comment on it.

E Q There had never been any comments ---
A No, I never heard any comment on it.

Q No comments in the past?
A No.

Q Nothing complained about years ago?
F A No. Because it is there, you do not have to use it, do you?

Q But it is there so you can use it?
A You could, yes.

Q But you had never heard any complaints previously or anything like that?
A No.
G
Code A I think those are all the questions I have. Thank you very much.

Code A Thank you, Code A Now it is Code A who is a lay member of the Panel.

Code A: You explained to us that the purpose of the nursing notes, when different
H nurses come on duty, they pick them up and they can have a look and know how ---

A A This is what is supposed to happen, yes.

Q --- to deal with the patients.
A Yes.

Q I am looking at page 1013 and Patient B. Code A
A I think I have it.

B Q If we look at the 4th of the 3rd, I get the impression that here is someone with slight pain in the shoulders when moved, so she has the physio exercises, and "Code A needs reminding," but because there is a slight increase in pain the analgesia is increased. Then the next date, the next day, "Pain uncontrolled. Patient distressed."
A I believe that was overnight, the "pain uncontrolled".

C Q Yes, yes.
A Because the driver was started at 9.30 in the morning.

Q So you commence. Is that you who commenced that?
A Yes.

Q Is that your name?
D A Yes, it was me.

Q But this patient could take medication orally. If we turn to 1017. I understood from that, if I look at the 2nd of the 3rd, "Took medication well." I am interested in where the notes are that help me to understand why we have moved from oral medication to syringe driver.
A Yes. That was at night, I believe, that 2nd on the 3rd. So it was three days later that I started the ---

E Q The syringe driver. But I do not have a note there that indicates to me why the pain in the shoulder is increasing and I find nothing that helps me to understand why we have moved from "Took medication well," to a syringe driver?
A There is not a reason.

Q So that seems quite a step forward.
F A It was obviously reported to me on the 4th of the 3rd, but not actually written in her care plan.

Q Right. So you can throw no light on that one really?
A Seeing as I started it on the 4th.

Q Because I understood, it is only when patients could not take it orally that you started
G to use a syringe driver?
A Yes. That was two days later.

Q Yes. It is quite a progression without a note?
A It was quite a long way for a poorly patient, but obviously the night staff actually had not written in since the 3rd.

H Q Right? So you are talking again about it like being a progressive deterioration?

A A This is what is supposed to happen, yes.

Q --- to deal with the patients.
A Yes.

Q I am looking at page 1013 and Patient B. Code A
A I think I have it.

B

Q If we look at the 4th of the 3rd, I get the impression that here is someone with slight pain in the shoulders when moved, so she has the physio exercises, and "Code A needs reminding," but because there is a slight increase in pain the analgesia is increased. Then the next date, the next day, "Pain uncontrolled. Patient distressed."
A I believe that was overnight, the "pain uncontrolled".

C Q Yes, yes.
A Because the driver was started at 9.30 in the morning.

Q So you commence. Is that you who commenced that?
A Yes.

Q Is that your name?
D A Yes, it was me.

Q But this patient could take medication orally. If we turn to 1017. I understood from that, if I look at the 2nd of the 3rd, "Took medication well." I am interested in where the notes are that help me to understand why we have moved from oral medication to syringe driver.
A Yes. That was at night, I believe, that 2nd on the 3rd. So it was three days later that I started the ---

E

Q The syringe driver. But I do not have a note there that indicates to me why the pain in the shoulder is increasing and I find nothing that helps me to understand why we have moved from "Took medication well," to a syringe driver?
A There is not a reason.

Q So that seems quite a step forward.
F A It was obviously reported to me on the 4th of the 3rd, but not actually written in her care plan.

Q Right. So you can throw no light on that one really?
A Seeing as I started it on the 4th.

Q Because I understood, it is only when patients could not take it orally that you started
G to use a syringe driver?
A Yes. That was two days later.

Q Yes. It is quite a progression without a note?
A It was quite a long way for a poorly patient, but obviously the night staff actually had not written in since the 3rd.

H Q Right? So you are talking again about it like being a progressive deterioration?

A A Yes, yes.

Q Rather than the improvement for the patient?
A Umm.

Q Are you saying it was another patient, where it was seen that the patient was progressing towards death?
B A No, no. I do not think we thought at that time. We just thought her pain was uncontrolled.

Q The other way. What we do not seem to know is, what has suddenly happened to this shoulder to make it worse, that the pain became uncontrolled?
A Who are we talking about?

C Q Code A
A Code A ? She was... Not quite sure... But the diagnosis we had was a brain stem CVA, which was a left and right paralysis.

Q Right?
A Of the body.

D Q Right?
A So she was actually paralysed.

Q Okay. You probably cannot help me further, then, to understand, to make sense of those notes. Thank you. One other thing, and I think it follows on really from some of the questions that Code A was asking you. You made a statement as you were giving your evidence, and this was relating to Code A and talking about her
E progressive deterioration. You said some things about when the patient starts to die. What does that mean – "a patient starting to die"?
A I do not know.

Q "Starting to die."
A I do not know that either. I do not recall saying that now.

F Q Just that I made quite a note of that.
A No. I cannot tell you when a patient starts to die.

Code A Right, okay. I will leave that one then. Probably I heard something that you did not say. Okay, thank you.

Code A You are very nearly there. I am the last member of the Panel and I
G suppose, by definition, my job is a bit of a sweeper, and I will attempt to sweep up a number of points. First of all, just following on from the evidence that you have just given in respect of Patient B. I think I heard you say that she was paralysed?
A Left and right. Brain stem CVA.

Q From the neck down? I am not a medical member so you will need to help me.
A Her left side. I think I am right in saying that her left side and her right side were
H paralysed.

Q From the neck down, that would be, would it?
A Umm.

Q It is just that on the page that you were referred to, 1013, I note that in the higher part of the page, the second entry, for 28 February – this is 1996, yes.
A Oh yes. I can see she was ---

Q "Right arm less painful able to lift it above head height."
A Maybe my diagnosis is not right. I am thinking back.

Q I am not going to hold you to it because ---
A I am not sure whether this was 11 or 13 years, but ---

Q It is very confusing when there are so many different records, so many different patients and, as you say, so much time has passed and then you have a variety of people firing questions at you from different corners. I do understand how difficult that can be. Clearly that was not right?
A No.

Q Obviously she was able to move. The question that had been asked earlier about the syringe driver – I think you had said that if a patient could swallow, then a syringe driver would not be instituted because there would be no reason. You only use that when the patient is not able to take the ---
A It is used in the medical profession for people. Sometimes people walk around with them in their pocket. It is so they can have whatever drug they are having ---

Q I should be more specific.
A --- gradually over the 24 hours, or continually over the 24 hours.

Q But syringe drivers on these wards with these sorts of cocktails that we have been looking at appear again and again.
A Yes.

Q In those circumstances you would not put somebody onto a syringe driver if they were able to swallow.
A Yes.

Q Is that the point you were making?
A Yes.

Q You also said to us that if you were going to put somebody onto a syringe driver, you would not do it if they were unconscious. That was in response to a question ---
A Yes.

Q --- I think from Code A As a non-medic, my rather naïve question is, "Why not"? Is there a reason why you would not?
A Would they need it? I do not know if they are not, and you do not know that they are in pain. Would they be? I do not know.

A Q I am just trying to understand where your answer came from because of course the question would have been again this kind of syringe driver with these kinds of drugs in these circumstances. So I take it from what you say that your point is you would not administer if they were unconscious because if they were unconscious they would not be in pain, so there would be no point. Is that the ---
A Yes.

B Q That clarifies that one too. Thank you very much. On the matter of consent that I think was particularly dealt with by Code A you told us at an earlier stage today that we would always get consent before starting them on a controlled drug. If in the normal course of events you were required to start somebody on a controlled drug and you were able to contact the patient's relative, you would give them the information that that was what you wish to do and, as you have said, you would explain why and you would get the consent. Having got the consent to put them on to a morphine or a morphine-type, would you need
C then to get consent to put them onto a driver or, if you had already got the consent, would it have been necessary?
A Yes. It was normal. It was normal to see the relatives before we started the driver, or at least talk to them.

Q Why was that? What is the significance of the driver?
A So that they were kept informed of their relative's condition.
D
Q But if the driver is just containing the same sorts of things – they are opiates designed to keep them pain-free – and you already have permission, is it necessary or is it just a matter of fact?
A It is something. It is a matter of form that we did.

Q Would you say that everybody always did, or that that was your practice?
E A Yes, yes. On this particular ward, we did.

Q And I think again, picking up from what my colleague had asked, I think you have told us that the words used would depend upon who you were talking to?
A Yes.

Q So, for example, if you were talking to somebody who had only a very basic grasp of
F medical matters, you might be a lot less specific than if you were talking, for example, to a retired nurse whom you would tell very clearly?
A It did not matter who we were talking to. We just tried to make them understand what we were doing, the treatment we were ---

Q Fundamentally what you were doing was giving opiates for the purpose of relieving pain?
G A Yes, yes.

Q And it was your job to make sure they understood that?
A Yes, yes.

Q You said that you were a named nurse?
A Yes.
H

Q One of your duties was rather colourful – that you were a patients' champion?
A Advocate, I said.

Q Advocate.
A Same sort of thing really, just the nurse to look after their interests if they were unable to, and to liaise with their relatives on certain matters – things that they needed, or washing, or whatever.

Q So you would be there to fight their corner, as it were?
A Yes, if they needed somebody. Yes.

Q If they were not able to do so. If they were unconscious, for example ---
A Yes, yes.

Q --- you would be the one to question if, for example, a driver should continue?
A Well, we would not give the okay for a driver. We would not take the place of the relatives, but...

Q But if you were the champion or the advocate, it would be part of your role to question whether the driver should continue once it had been instituted?
A Yes, yes.

Q And did you ever do that, as a matter of interest?
A I never stopped it, no.

Q Did you ever query, as an advocate for a patient, any of the prescriptions that had been given by any doctor?
A No, no.

Q Not this one.
A No.

Q Was that because on the whole the doctors that you worked with were always good professionals and there was not a need to do so?
A There was no need to do so, yes.

Q You have been very complimentary about Code A You have told us that from your experience she clearly had the best interests of her patients at heart and you told us that she would always see patients' relatives ---?
A Yes.

Q --- when that was needed.
A Yes.

Q How would you describe her?
A I would describe her as looking after each patient's interests.

Q And with the ---
A She had their interests at heart.

Q And when she was seeing the relatives of patients, how would you describe her bedside manner, for want of a better word?
A It was good. It was good.

Q Would you say that all your colleagues would agree with that particular assessment?
A Yes, yes.

Q Code A I think, asked you earlier about the views of your fellow nurses, about the sort of drug regimes that we have been looking at in these records and asking whether they were normal.
A Do not forget we had a Code A look at them every week on the ward.

Q Yes, absolutely, and I understand ---
A So why would we question her?

Q Indeed. I understand you to say that there is a Code A who would come in once a week and who would conduct an audit and had a whole system of checks and balances, including checking to see the appropriate ---
A Checking the treatment, each treatment card.

Q And no doubt that gave you some comfort?
A Of course.

Q Because that is a responsibility that you do not have.
A Yes.

Q But were you aware around 1991, for example, of any difference in opinion amongst some nursing colleagues about, for example, the use of diamorphine?
A I was not aware, and I do not think it took place on the ward where I was working.

Q So you were not aware?
A No.

Q But you have subsequently become aware of something?
A I have become aware, but it did not actually take place on Daedalus Ward.

Q Right. I am not going to ask you about ---
A I was not actually ---

Q --- what you have become aware of afterwards. It was really what you were aware of at the time that you were working.
A No, I was not really.

Q And finally, can I look briefly with you at the matters of admission, and when patients first came in and we had been shown the sorts of referral letters that you were given, and you have explained to us that unfortunately the nursing notes do not come on to you from the releasing hospital, which of course must make life more difficult for you than it would be if you knew precisely what had been happening. Fortunately, though, within the system is an assessment by a doctor, and we have seen in these files and others numerous assessments conducted by Code A There is a particular phrase that we see that comes up time and

time again, that you will no doubt be familiar with. It is: "I am happy for nursing staff to confirm death." Am I right that that is something that you ---
A That was written.

Q Yes. It was a common phrase within the ward, would you say?
A Yes.

Q And what did it mean?
A It meant that the nurse in charge could do the confirmation.

Q The confirmation of?
A Or two of you usually would perhaps.

Q The confirmation of?
A Of the death.

Q So it is at that stage, assuming that there is going to be a death?
A If it did.

Q I am sorry?
A If. If it occurred.

Q Yes. If a death occurred. Was it a signal to the nurses that this was one of those patients they are going to have to take a particular care because death was regarded as being ---?
A No, I do not think so.

Q Would it be a normal thing to have ---?
A Yes.

Q In all admissions?
A Umm.

Q Somebody comes in ---
A Yes.

Q --- for rehabilitation, recovering from a broken wrist?
A We did not actually have anybody come for rehab with a broken wrist. Not this ward that I was working on. I have had heard a story of a man coming in a broken wrist. It did not come in on this ward.

Q So on your particular wards, then, this was a common occurrence?
A On our particular ward we would have patients in with perhaps nine diagnoses. It may be a stroke or what had happened to them last, but they all had a string of diagnoses.

Q And some, or all of them, would have had that note at the beginning?
A Yes.

Q Saying, "Happy to confirm"?
A Some or all.

Q Did you ever see any patient who had that on their notes at admission, or very soon thereafter, leave the ward recovered, or did they always die?
A I cannot answer that. I do not know.

Q Because you do not remember?
A I do not remember.

Q That is absolutely fair. The length of time that has elapsed makes it quite impossible, and perhaps it was an unfair question. Very well. I think that is all I have. Where we go now is that I ask each of the barristers, I am afraid, whether they have any questions arising out of the questions that the Panel have asked. Is that okay? Are you fit to go on with that now, or do you need a break? I know you have been ---
A No, no. We need to get home. We have a long way to go.

Q Very well. Then let us go straight across to Code A and see what questions he may have.

Further cross-examined by Code A

Code A Sir, I do have some. I will try and keep them as short as possible as far as you are concerned. Back to Patient B, Code A Do you have that file in front of you?
A Yes.

Q You will remember that a member of the Panel was suggesting to you that the case of Code A Patient B, and the case of Code A, although they had different backgrounds, that there were similarities in relation to what had happened to them at Gosport. It was suggested that they had been rendered unconscious as a result of morphine very soon after their arrival. Do you remember the suggestion being put to you?
A I remember the suggestion, yes.

Q I would like to use you to take a look at the history to see what similarities there are. Looking at Patient B, Code A if you look at the very beginning of the file, there is a helpful chronology. It saves you looking through masses of pages. This is the history. Do you see that it shows how she went into Haslar following a collapse?
A Yes.

Q I am taking it shortly. That was in March 1995 and the year we are concerned with, February 1996, she goes into Haslar following a fall. On 6 February, this is still in the Haslar, she is commenced on Amoxicillin and she is prescribed coproxamol and dihydrocodeine, which is administered – in other words she gets it – until she is transferred to Gosport. That is on 6 February. Over the page, still at Haslar, the 8th, "Seen by a physiotherapist"; 13th she is seen by a Code A geriatrician; the 16th, Code A "Transfer recommended"; 20 February, "Reviewed by physiotherapist", still at Haslar; over the page, there she is on Daedalus on 22 February.
A Yes.

Q On that date, assuming that is right, she is prescribed the same drug that she was already on at Haslar.
A Yes.

A

Q There is no change when she arrives at the Gosport War Memorial Hospital. Code A is the person who deals with that. Following on, let us look at the history, 23 February she is not unconscious; 24 February she is not unconscious; over the page you can see that Code A has changed the prescribed drug to MST, which is morphine sulphate tablets. Is that right?
A Yes.

B

Q Still not unconscious. 25 February it is administered, still not unconscious; 26 February, the same drug is administered and on that date, as you can see at the top of the following page, some four days after she has been admitted to Daedalus, Code A does what we have been calling an anticipatory prescription because she prescribes diamorphine?
A Yes.

C

Q If the staff had thought it appropriate to administer the diamorphine, if they had, they could have contacted the doctor?
A Yes.

Q And said, "We think it is time to start". That does not happen, you can see, because on 27 February, the next day, the morphine, the MST continues, and on 4 March, that is almost a week later, four, five, six days later, she is still on morphine sulphate, still conscious.

D

"Reviewed by Code A" on 5 March and then on that date the diamorphine is administered subcutaneously. Do you see that?
A Yes.

Q Can we take it that she was not unconscious throughout that period of time?
A Yes.

E

Q Can we tie that point up and turn to a page you have looked at before, page 1013. You can see that she is obviously conscious on the dates covered by that page until we get to the bottom.
A Yes.

Q You will have noticed that the analgesias administered are "fairly effective". She is less painful on 28 February, there is some movement in the right arm. On 1 March she is

F

obviously conscious because she is complaining of pain and slight pain on the 2nd. On 4, March can you see that ---
A What number are you on?

Q Sorry, 1013 at the bottom.
A I cannot find 1013.

G

Q Page 1013?
A It is not the printed 1013?

Q It is a typed or printed ---
A You were talking about 28 March, were you? This one only goes up to 06/03.

Q That is the page I am asking you about. I ran through the top dates showing that she

H

is obviously not unconscious, she is conscious. On 4 March she is seen by the physio. Let us

look at the exercises when you were asked about your recollection of whether she was immobile in terms of her arms. On 4 March the physio appears to be recommending turns of the head to the right, that is three turns?
A Every two hours.

Q And five neck retractions every two hours, obviously not involving the use of the arms, at least if I am reading it right it does not, but "Code A needs reminding", so she does that. "Analgesics increased", "Pain uncontrolled, patient distressed". Does that mean, again, that she was not unconscious, she just had a pretty bad night?
A Yes.

Q The syringe driver was commenced at 9.30 and you followed up your normal procedure of explaining matters to Code A and informing him?
A Yes.

Q Pain was controlled by the syringe driver on the record on 6 March. I think we can see that that appears to be a rather different history to the history of Code A who is the lady who came in on readmission to Gosport?
A Yes.

Q Can we turn to her so we can see whether there is any similarity. Would you turn to the file for Patient E, Code A Looking at the very beginning of the file again, do you see there is the chronology, do you have that?
A Yes.

Q We can see it goes back quite a way in the early part of 1998. Can we move on to 11 August, which is the third page in on the chronology. She has been operated on at the Haslar, she comes into Daedalus on 11 August, is reviewed by Code A as we can see on the 11th. Code A prescribes Oramorph and also does an anticipatory prescription for diamorphine and the other drugs, midazolam and so on, and that is on the 11th. She is reviewed by the nursing team on the 12th. Oramorph is administered but none of the diamorphine anticipatorily prescribed to be administered subcutaneously is administered. She stays on Oramorph on the 13th. She does not stay in the Gosport War Memorial because she has a fall and is readmitted to Haslar on the 14th.

She comes back, having been administered in the Haslar – it may be wrong – Oramorph. Back to Daedalus on the 17 August which is when you first saw her. You described what happened when she was in a great deal of pain from the unfortunate transfer, it would seem?
A Yes.

Q The Oramorph is administered, as it had been before she left. She is reviewed again on the 18th and that is the first day when the diamorphine is administered. That goes on in the way we can see on the chart with regard to that lady.
A Yes.

Code A That is all I wanted to deal with you so far as any questions from me are concerned.

Code A ?

Further re-examined by Code A

Code A: Not very many questions. Dealing with that last patient, just for the Panel, the drug chart at the Haslar is at page 286 onwards. I think midazolam was prescribed in that period and Oramorph was prescribed, but not administered. I want to return to Patient B again, page 1013, which we have already spent quite a lot of time on. Code A just took you through it and I will not go through all of it, but it appears that right up until 4 March she was able to speak. Are you with me?

A Yes, I am with you.

Q She is seen by the physio, he recommends some exercises for her and he says, "Elsie needs reminding. Analgesia increased". Can we take it from that that the patient at that stage still must have been talking?

A Yes.

Q On 5 March you told us that that note that you made, "Pain uncontrolled, patient distressed" came from the night nurses?

A It must have done, must it not, because it was first thing in the morning?

Q That is what I want to ask you about. How do we know that it did not come from the patient herself?

A I can only assume because it is not actually written down and it should have been written on her night chart that she had a really poor night.

Q I understand that, but this is your note?

A If she had said to us in the morning, "I have a very painful shoulder", she had said that before, we would not have administered a syringe driver for that.

Q When you decided to administer this, would she have been talking to you or would she have been already ---

A I cannot say, can I?

Q That is why I ask you?

A It is 11 years ago.

Q That is why I asked you earlier, would you have given a syringe driver to somebody who was unconscious?

A No, no I would not. I assume she was given it because she had had a very painful night.

Q The only note you have comes from the nursing staff.

A From me.

Q If the patient is awake and talking to you, we have heard a lot about relatives' consent, what about the patient giving consent. Would you have asked the patient for consent...

A Yes.

Q ... to start a syringe driver?

A Yes.

A

Q You would?
A I could have asked the patient if she would like some morphine for her pain.

Q That is different in a sense. Would you have said specifically to a patient, "We would like to start you on a syringe driver, is that all right?"
A I could have done.

B

Q Would you have made a note of that,"Patient consents to syringe driver"?
A Like I say, she had been complaining of pains in her shoulders right from the first.

Q She has pain from her shoulders all the way along and I wonder what triggers---
A Even the 28th. I said she was distressed, so I assumed she had a really distressing, painful night.

C

Q It follows on from a day when she had some physiotherapy?
A Which may have caused pain, of course.

Q Would you have thought a syringe driver was the appropriate answer to that?
A It depends how much pain she was in, does it not? I obviously thought she was in a lot of pain. Previous to that, even on the 27th, she was complaining of a painful shoulder and
D we did not put her on a syringe driver then.

Q You told us earlier, and I am afraid I had not picked up on this but it came from questions that I think Code A asked you, that you did not have kits for intravenous fluid. Is that right?
A No, I do not think we did then.

E

Q If the effect of a syringe driver is that the patient becomes unconscious, the effect of that equally is that they cannot take fluid any more. Is that right?
A Yes.

Q If they cannot take fluid any more and you do not have any intravenous kits, what is going to happen to the patient? What effect is that going to have on their body?
A (Pausing to review documents) I am just looking for a fluid chart and I cannot find
F that.

Q If the patient becomes unconscious because a syringe driver has started, is there an effect not only from the opiates but also from the fact that the patient is not getting any fluid?
A We always gave the patient mouth care and moistened their mouth.

Q Yes, I understand that. It is to make the patient more comfortable. But is that going
G to rehydrate the patient?
A No, it is not enough.

Q Was there any system for rehydrating a patient once the syringe driver had started?
A Yes, we used to give the patient a sub-cut, but I cannot remember if we gave it when Code A was on the ward.

H

Q I am sorry, just explain that, could you? A "sub-cut"?

A A We place a little needle under the skin, in the subcutaneous part of the skin. The actual needle has a tube on it, which is connected to an IV bag; so we could actually give the patient fluids.

Q I am not a medical person, so I might have misunderstood. When you said you did not have any intravenous kits, I assumed that was what you were talking about.
A That is IV, into the vein. I cannot remember if we had the sub-cut on the ward at this
B time when Code A was there.

Q If you did not, would there be any other way of getting hydration into the patient?
A No.

Q If you did have a sub-cut, intravenous kit, would that be noted on the record somewhere?
C A It should be, yes. There should be a chart for it.

Q When you get consent, as you spoke about to a number of Panel members, from one of the patient relatives – and that is to the start of a syringe driver – would you explain to the relative, "But we don't have any system for rehydrating your mother/your father"?
A We would explain if they asked us, yes.

D Q I am sorry? You would explain if they asked you?
A We would have explained if they had actually asked, yes.

Q If they did not ask...?
A Yes, we would explain.

Q You would explain?
E A Mmm.

Q The effect of that would be what on the patient?
A I mentioned before that there was research at one point to show that that was more harmful for the patient.

Q Is that when the patient is in the last stages of life?
F A In the last stages, yes.

Q It is when the patient is dying. You do not want to rehydrate them.
A Yes, but I should imagine that is why the sub-cut was brought in: for wards that could not use the IV.

Q One last topic, and it is very short I promise you. This is in relation to Patient E and
G her hip. Do you remember when she came back she had a haematoma?
A Yes.

Q The doctor was asking you about how you make a decision about the level of pain relief that that patient would need, if you would ever wake them up again. Do you remember that discussion you had with him? If the patient is unconscious, how do you tell that they still need pain relief?
H A I said I cannot understand how anyone can ascertain that.

Q No, we understand that. Is there any active measure that can be taken to relieve a haematoma?
A I am not sure. Not being a surgeon, I cannot really answer you.

Q Do haematomas sometimes resolve spontaneously?
A Yes.

Q Would you have any way of knowing whether that haematoma resolved after the X-ray or not?
A Unless we gave another X-ray, I do not know.

Q Or woke the patient up and asked if it still hurt?
A But we did give her 2.5 mg of Oramorph at the time. It was only a small dose, for her pain.

Q Not from the 18th onwards.
A When she came; when she actually was admitted on the ward, that is what I gave her.

Code A that really is the end. Thank you very much indeed for coming to assist us today. I know it is very hard, particularly when you have to take so many questions from so many different people over such a sustained period, and we are extremely grateful to you for maintaining your patience and good humour. You are free to go.

(The witness withdrew)

Code A Do we have any news of Code A ?

Code A We do. We have finally made contact with her. We gather that she did not realise that she was meant to come today. I have to say that my instructing solicitors had made quite strenuous efforts to ensure that she did know, and it is a surprise and unfortunate that she did not.

We have rescheduled her at the moment, after much discussion, for 30 June, which is something of a sort of clear-up day before we start on the expert, and we have made it very clear how important it is that she does attend on that day. In a sense, it is actually a good thing she did not come today, because we would have run out of time to hear her. As a result of that, we are essentially still on track; but, as one can see from this last witness, we do think that things are going to go rather slower with the nurses, who we are beginning to get to.

The next event, as it were, is the reading of Code A s statement; but you, I expect, will want a bit of time to change gear and have a look at Patient I, Code A s opening and note. Then tomorrow, other than that reading, we have three relatively short witnesses for you. They are all coming to talk about Code A and no doubt you will want time to read that as well. We are therefore in your hands as to how you want to play this.

Code A I am not going to ask the Panel to embark on any more reading today. It has been a long, difficult day, I think, for all of us, but a useful day none the less.

A What I propose is that the Panel will start here at 9.30 tomorrow as normal and will use the first 30 minutes to reacquaint themselves with Patient I; then we can hear the statement read. Then I guess that it will be another period of study before we get on to the witnesses.

Code A Sir, I do not think that you have Patient I's medical records yet.

Code A No, we do not.

B

Code A I do not know if that is included in the 30 minutes that you are giving yourselves.

Code A No, probably not. I think that would be over-ambitious.

Code A Can I say that Patient I's notes are about the thinnest so far, if that is any

C encouragement to you; nevertheless, they will take a bit of time. I would have thought that you might want to set aside an hour.

Code A Shall we say not before 10.30, unless you are otherwise requested to attend?

Code A Yes, certainly.

D

Code A Sir, can I deal with one matter arising from the transcript of yesterday? I do not know if you have it in front of you.

Code A We can swiftly do that.

Code A I just have one, what I hope is a typographical error, because it was me

E speaking at the time. It is Day 6, page 41E. The question I think I asked was, "But was she", meaning Code A "telling you that your Code A *'s* condition, sadly, was rather poor?" The word has come out as "benzodiazepine's".

Code A Yes, they are not phonetically similar but I think that you are probably right.

F Code A I am grateful. I think the answer that the relative gave, Code A was "I cannot think of the *word* at the moment", not "ward".

Code A Again, I think that is likely.

Code A I raise it while it may still be fresh in the memory. I will not trouble you

G again if there is an error as small as the second one, but the first was rather a departure from what I think I said.

Code A Any careful scrutiny of minutes will always reveal a few like that, but that is clearly quite an important one; so thank you for that.

Code A Perhaps we can ask Code A to check all the transcripts!

H

Code A What an excellent idea! As he has been so under-employed so far, it seems only fair that he carries his share!

The Panel adjourned until 9.30 a.m. on Wednesday 17 June 2009 and the parties were released until 10 a.m.

ust Box Nbr: W249365221
KP Box Nbr: 249365221
Date: 19/11/2010
Box Type: 1.4
File Seq: 00003
EM205
Location Id: EM-06-WH-1-CB-0019-4-07-03
Column Id: 0101214271
File Descr: 00167673
AUDIT FOR DE - FILE
B
* 000003471481208 *